Overview of the State Demonstrations under the Financial Alignment Initiative

Edith G. Walsh, Director
Aging, Disability and Long-Term Care

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Outline

- Background
- Status of implementation
- Goals and activities of the CMS evaluation

Background: The Financial Alignment Initiative

- Created by the Medicare-Medicaid Coordination Office (MMCO) and Innovation Center at the Centers for Medicare & Medicaid Services (CMS) to test integrated care models.
- The goal: to develop person-centered care delivery models integrating the full range of medical, behavioral health, and long-term services and supports (LTSS) for Medicare-Medicaid enrollees
- Expectation that integrated delivery models would address the current problems associated with the lack of coordination of Medicare and Medicaid benefits, financing, and incentives.

Demonstration Models

- Capitated Models
  - State, CMS, and health plans enter into three-way contracts, and the plan receives a blended rate to provide comprehensive coordinated care.
- Managed Fee-For-Service
  - A State and CMS enter into an agreement by which the State would be eligible to benefit from Medicare savings if interventions improve quality and reduce costs.
- Alternative Model
  - Minnesota only, administrative alignment across Medicare and Medicaid within the existing MSHO program.

Demonstration Status

- 8 demonstrations have been implemented
- 5 MOUs have been signed with anticipated implementation in 2015

State	Model Type	Implementation Date
WA	MFFS	July 1, 2013
MN	Other	September 13, 2013
MA	Capitated	October 1, 2013
IL	Capitated	March 1, 2014
VA	Capitated	April 1, 2014
CA	Capitated	April 1, 2014
OH	Capitated	May 1, 2014
CO	MFFS	September 1, 2014
WA	Capitated	2015
SC	Capitated	2015
MI	Capitated	2015
NY	Capitated	2015
TX	Capitated	2015

Goals and Intent of the Financial Alignment Initiative Evaluation

- Provide rapid-cycle monitoring of demonstration implementation
- Evaluate the impact of the demonstration on the beneficiary experience
- Monitor and evaluate the demonstration's impact on quality, utilization, access to care, and cost
- Demonstration level, not plan or MFFS coordinating entity level, focus

Evaluation Questions

- What are the primary design features of each State demonstration and how do they differ from the State's previous systems?
- To what extent did each State implement its demonstration as designed? What factors contributed to successful implementation? What were the barriers to implementation?
- What impact do these demonstrations have on the beneficiary experience overall, by State and for beneficiary subgroups? Do beneficiaries perceive improvements in how they seek care, choice of care options, how care is delivered, personal health outcomes and quality of life?

Evaluation Questions, continued

- What impact do the demonstrations have on cost and is there evidence of cost savings in each State? How long did it take to observe cost savings in each State? How were these savings achieved in each State?
- What impact do these demonstrations have on utilization patterns in acute, long-term, and behavioral health services, overall, by State, and for beneficiary subgroups?
- What impact do these demonstrations have on health care quality overall, by State, and for beneficiary subgroups?

Evaluation Questions, continued

- Does the demonstration change access to care for medical, behavioral health, long-term services and supports (LTSS) overall and for beneficiary subgroups, by State? If so, how?
- What policies, procedures, or practices implemented by each State in its demonstration can inform adaptation or replication?

Evaluation Approach

- Aggregate design developed as an overall framework. State-specific evaluation designs developed to tailor the overall framework for each State's unique demonstration.
- Intent to treat research design: identifying the target population, not just the enrolled population, to minimize selection bias
- 2 years of predemonstration data used to establish baseline
- Unique comparison groups for each demonstration

Evaluation Approach, continued

- Ongoing monitoring of implementation as data become available.
- Annual reports with descriptive data, including comparison groups.
- Final multivariate analyses using difference in differences approach.
- Within State and cross-State analyses
- Annual actuarial analyses of cost savings for MFFS States

Evaluation Approach, continued

- Impacts on cost, utilization, access, and quality
- Variation by subpopulation, including health conditions, residential status, and other beneficiary characteristics
- Identify relevant, measurable factors from implementation analysis to include in multivariate models
- What other aspects of the demonstrations affect utilization patterns and cost, access to care, and quality outcomes?

Data Sources for the Evaluation

- To achieve these goals, the evaluation is using a variety of data sources.
  - Primary Data from States
    - Collect quarterly aggregate information and implementation updates from States through the State Data Reporting System (SDRS)
    - Collect quarterly beneficiary-level data using finder files provided by the States
    - Conduct site visits, beneficiary focus groups, and key informant interviews
  - Administrative Data from CMS
    - Analyze Medicare and Medicaid enrollment, claims, and encounter data
    - Nursing Home Minimum Data Set
  - Other information
    - For example, incorporate relevant findings from beneficiary survey reports obtained from States, CMS or other entities

Implementation Monitoring and Evaluation

What intervention has each State developed? How is implementation progressing? What is contributing to degree of success?

- Interviews and site visits with state staff and stakeholders
  - Two sets of site visits planned for each State
  - First scheduled to occur within 6 months of implementation
  - Quarterly telephone contact for updates
- Quarterly inputs by States into a State Data Reporting System
  - Aggregate data on eligibility, enrollment, disenrollment, number of plans or coordinating entities (e.g., Health Homes)
  - Text entries about demonstration developments

Beneficiary Experience

- What impact do these demonstrations have on the beneficiary experience, overall, by State and by subgroups? Do beneficiaries perceive improvements in access to care, choice, care delivery, personal health outcomes and quality of life?
  - Focus groups
  - Integrating findings from surveys conducted by health plans, States or other entities (e.g., CAHPS)
  - Stakeholder interviews
  - Information on grievances and appeals
  - Information about enrollments and disenrollments, access to care and outcomes from claims and encounter data

Inclusion of Survey Results Collected by Others

- The RTI evaluation does not include fielding a survey, but will incorporate information from relevant surveys into annual and final reports.
- Possible survey sources:
  - CAHPS to be fielded by the implementation contractor in the Managed FFS States
  - CAHPS, HEDIS, HOS results for Medicare-Medicaid Plans (MMPs) in capitated model States
  - State-specific survey efforts, e.g., Personal Experience Survey

Quality Measures

What impact do these demonstrations have on health care quality, overall, by State and by subpopulation?

- RTI to calculate quality measures for the evaluation
  - Calculated using existing claims, encounter and Nursing Home Minimum Data Set (MDS) data
  - Unit of analysis is the demonstration as a whole, not health plans or MFFS coordinating entities (e.g. Health Homes).
- States and MMPs to report demonstration quality measures to CMS
  - Current published MOUs, Three-way Contracts, and Final Demonstration Agreements provide information about the QMs
  - Information each State and MMP reports will be integrated into evaluation annual and final reports as available

Quality Measures- Selection Process

- Core set of measures that could be determined using administrative data so that data would be available across States or across models
- Claims-based measures selected on relevance to the demonstration from CMMI's Priority Measures for Monitoring and Evaluation
- HEDIS measures (capitated model demonstrations only) selected based on relevance to the duals population. At the time of measure selection there were no standardized, endorsed measures for dually-eligible beneficiaries.

Quality Measures- Examples

- RTI to calculate quality measures within each demonstration
  - Quality measures include 30-day all-cause risk-standardized readmission rate, ambulatory care case sensitive admissions (AHRQ PQI #90 and #92), Preventable ED visits, ED visits excluding those resulting in inpatient admission or death, and cardiac rehabilitation following hospitalization for cardiac event.
  - LTSS measures include long-stay facility use measures, and short and long-stay quality measures
  - A full listing of the quality measures is available in the Aggregate Evaluation Design Plan, posted on the MMCO website

Utilization and Cost Analyses

- What impact do these demonstrations have on utilization patterns and access to care for acute, long-term and behavioral health services, overall, by State and for beneficiary subgroups?
- What impact do the demonstrations have on costs, and is there evidence of cost savings? How long did it take to observe savings in each State? How were these savings achieved?
  - The RTI team will analyze Medicare and Medicaid claims and encounter data as well as encounter data from the Medicare-Medicaid Plans
  - MDS data will also be used to monitor facility admissions
  - Monitoring and evaluating a range of service utilization patterns and costs
  - Trends for some measures will be monitored and reported quarterly for use by CMS and the individual State; some measures will be reported on annually and presented in annual reports
  - Impact of the evaluation on specific outcomes will be analyzed using multivariate analysis incorporating comparison group data presented in the final report

Reports

- Aggregate Evaluation Plan
- State-Specific Evaluation Plans
- Ongoing monitoring of implementation for CMS and State as data become available
- Annual reports (state-specific and aggregate)
  - Descriptive data for demonstration and comparison groups
- Final reports (state-specific and aggregate)
  - Overall impact analyses of the demonstrations on quality, utilization and costs

For More Information

Normandy Brangan, Contract Officer's Representative,
The Center for Medicare and Medicaid Innovation, CMS
Normandy.Brangan@cms.hhs.gov

Jennifer Baron, Technical Director,
Medicare-Medicaid Coordination Office, CMS
Jennifer.Baron@cms.hhs.gov

MMCO Website http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/

Financial Alignment Initiative Website http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html

Aggregate Evaluation Design Plan http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html