DRAFT EVALUATION PLAN
New York Department of Health

New York Medicaid Redesign Team Section 1115 Demonstration

Start Date of Demonstration Period: November 30, 2016
End Date of Demonstration Period: March 31, 2021

DEMONSTRATION EVALUATION

Overview

In compliance with the Special Terms and Conditions (STCs) set forth under New York State's Medicaid Redesign Team (MRT) section 1115 demonstration agreement, the New York State Department of Health (NYSDOH) will conduct an ongoing comprehensive evaluation of the effectiveness of the demonstration in achieving the stated goals for improving access to health care for the Medicaid population, improving the quality of health services delivered, and expanding coverage with resources generated through managed care efficiencies to additional low-income New Yorkers. The Demonstration includes several key activities including enrollment of new populations, quality improvement, and coverage expansions. The evaluation plan assesses the degree to which the goals of the Demonstration have been achieved and/or activities of the Demonstration have been implemented. The plan is in adherence with the evaluation standards set forth in Section XI(2) and in and in 42 CFR 431.424.

Evaluation of Delivery System Reform Incentive Program (DSRIP), Health And Recovery Plans (HARP), and the Self-Direction Pilot will be conducted separately.

A draft of this evaluation was made available for public comment from December 20, 2016 to January 10, 2017 on the NYSDOH website. No comments were received.

Technical Approach

The evaluation plan was designed to focus on the following domains of the Demonstration:

- Individuals Moved from Institutional Settings to Community Settings for Long Term Services and Supports
- Managed Long Term Care (MLTC)
- Medicaid Managed Care (MMMC) / Temporary Assistance to Needy Families (TANF)
- Twelve-Month Continuous Eligibility Period
- Express Lanes Eligibility Mainstream

Within each domain of focus, major Demonstration goals and activities were identified. The specific questions to be addressed by the evaluation were based on the following criteria:

1. Potential for measurement, including (where possible and relevant) baseline measures that can help to isolate the effects of Demonstration initiatives and activities over time;
2. Potential for improvement, consistent with the key goals of the Demonstration; and
3. Potential to coordinate with the NYSDOH's ongoing performance evaluation and monitoring efforts.

Once research questions were selected to address the Demonstration's major program goals and activities, specific variables and measures were then identified to correspond to each research question. Finally, a process was developed for identifying data sources that are most appropriate and efficient in answering each of the evaluation questions.

All available data sources will be utilized. The timing of data collection periods will vary depending on the data source, and on the specific Demonstration activity.

While the Demonstration seeks to generate cost savings and promote quality care, observed changes may be attributed to not only the Demonstration itself, but also external factors, including other State- or national-level policy initiatives and overall market changes and trends. For each Demonstration activity, a conceptual framework was developed depicting how specific Demonstration goals, tasks, activities, and outcomes are causally connected to serve as the basis for the evaluation methodology. Chosen methods aim to account for any known or possible external influences described above and their potential interactions with the Demonstration's goals and activities.

Analysis Plan

To the extent possible, credible contextual information will be gathered that attempts to isolate the Demonstration's contribution to any observed effects as well as describe the relative contributions of other factors that may influence the observed effects. This will include documenting any relevant legal, regulatory, or policy changes or other trends – including the sequence, scope, and duration of such changes – at both a State and national level that are likely to influence the observed outcomes.

Where possible and relevant, the evaluation will incorporate baseline measures, and account for secular trends, for each of the selected variables included in the evaluation. Data for each of the targeted variables and measures will be collected regularly so that changes in outcome measures and variables can be observed on a longitudinal basis. The evaluation will compare rates of performance and measures with State and national benchmarks, where relevant and feasible. Incorporating benchmark measures will allow for external comparisons of Demonstration measures to State and national trends, further isolating the impacts of the Demonstration by controlling for external factors influencing the observed effects.

The evaluation features described above (analysis of qualitative contextual information, the use of baseline measures, ongoing data collection, and benchmarking) represent quasi-experimental means by which the evaluation team will determine the effects of the Demonstration. Evaluation conclusions will include key findings associated with individual research questions addressed as well as integrated information combining the results of individual evaluation questions to make broad conclusions about the effects of the Demonstration as a whole. In addition, the evaluation will include specific recommendations of best practices and lessons learned that can be useful for NYSDOH, other States, and CMS.

External Review

A competitive bidding process will be used to contract with an independent entity to conduct the evaluation, in which a Request for Proposals (RFP) will be developed and issued by NYSDOH. This RFP will describe the scope of work, the major tasks, and contract deliverables, with a period during which potential bidders can submit questions. Proposals received will undergo review by a panel of NYSDOH staff, using a scoring system developed for this RFP. Eligible bidders must not be employees or entities of the NYSDOH, and not have any business relationship with any administrative or provider entities involved in Demonstration activities. Applicants will be evaluated on the basis of related work experience, staffing level and expertise, environment and resources, data analytic capacity, and ability to act as an independent, unbiased third party in conducting the evaluation.

Commented [MKP(1]: OHIP was not definite on this (the RFP part). I thought they hinted that they may be able to piggy back this onto an established contract.

Commented [ASR(2R1]: We should confirm who will oversee this procurement/contract.

Commented [WU3R1]: Good point. JM

Evaluation Activities

Individuals Moved from Institutional Settings to Community Settings for Long Term Services and Supports

The broad goals of New York's Home and Community based services expansion (HCBS) program are to assess the impact of the demonstration on: 1) Improve care coordination; and 2) Improve patient safety and quality of care for consumers. Toward these goals, the following evaluation questions will be addressed using the data set from Money Follows the Person:

Goal 1: Improve care coordination

Question 1: For the HCBS Expansion population that transitioned from an institutional setting, what was the average time in nursing facility prior to transition?

Question 2: For the HCBS Expansion population that entered a Managed Long-Term Care plan (MLTC) after transitioning from an institutional setting, what are the demographic characteristics?

Goal 2: Improve patient safety and quality of care for consumers

Question 1: For the HCBS Expansion population that entered MLTC after transitioning from an institutional setting, what percent had an emergency room visit in the last 90 days? What are the rates for falls requiring medical intervention and how have they changed since 2012?

Question 2: For the HCBS Expansion population that entered MLTC after transitioning from an institutional setting, what percent return to the nursing home and how long on average are they staying in the community before re-entering a nursing facility?

Evaluation

NYSDOH will perform the calculation of the proposed evaluation questions annually. The NYSDOH has extensive experience with the computation and evaluation of quality performance measurement with a variety of service delivery entities, such as hospitals, managed care organizations, managed long-term care organizations, and nursing homes.

Data Sources

Uniform Assessment System-NY (UAS-NY) Community Health data

The MLTC plans are required to collect and report to the NYSDOH information on enrollees' levels of functional and cognitive impairment, behaviors, and clinical diagnoses. This information is collected at enrollment and then semi-annually thereafter. The UAS-NY is an electronic system based on a uniform data set, which standardizes and automates needs assessments for home and community based programs in New York. The UAS-NY is based on the interRAI suite of assessment instruments. interRAI is a collaborative network of researchers in over 30 countries committed to improving health care for persons who are elderly, frail, or disabled. With the UAS-NY, functional status data demonstrates its importance to inform eligibility for the MLTC program, provide the basis for the MLTC plans' care management planning processes, and facilitate a plan's identification of areas where the patient's status differs from optimal health or functional status.

Assessment data are submitted by plans to the UAS-NY electronically as assessments are conducted, and are added to the database upon submission. Each year, MLTC UAS-NY submissions are created into two static assessment files. One containing the most recent

assessment for enrollees in each plan from January through June. The second containing the most recent assessment for enrollees in each plan from July through December. These two files will be used to describe and evaluate the MLTC plan performance.

Money Follows the Person (MFP) data

The cohort for this evaluation will be defined by participation in the MFP program and utilize their tracking system. In January 2007, the federal Centers of Medicare and Medicaid Services (CMS) approved New York´s application to participate in the Money Follows the Person Rebalancing Demonstration Program. The MFP Demonstration, authorized under the Deficit Reduction Act and extended through the Affordable Care Act, involves transitioning eligible individuals from long-term institutions like nursing facilities and intermediate care facilities into qualified community-based settings.

Minimum Data Set (MDS 3.0)

MDS 3.0 is a federally required standardized assessment and the basis of the comprehensive assessment for all residents of long-term care facilities. NY will use this data to calculate the member's time in a nursing facility prior to discharge to the community.

Managed Long Term Care (MLTC)

The broad goals of the New York Managed Long-Term Care (MLTC) program evaluation are to assess the impact of the demonstration on: 1) Improving care coordination for Medicaid's highest risk/highest cost population; 2) Improving patient safety and quality of care for consumers; 3) Reducing preventable acute hospital admissions; 4) Improving satisfaction for consumers. Toward these goals, the following evaluation questions will be addressed:

Goal 1: Improve care coordination and manage costs

- Question 1: How has enrollment in MLTC plans increased since 2012?
- Question 2: What are the demographic characteristics of the MLTC population? Have they changed since 2012?
- Question 3: What are the functional and cognitive deficits of the MLTC population? Have they changed since 2012?
- Question 4: Are the statewide and plan-specific overall functional indices decreasing or staying the same since 2012?
- Question 5: Are the statewide and plan-specific average cognitive functionalities decreased or stayed the same since 2012?
- Question 6: What are the per member per month (PMPM) costs of the population?

Goal 2: Improve patient safety and quality of care for consumers

- Question 1: What percent of members did not have an emergency room visit in the last 90 days since the previous assessment? What are the rates for falls requiring medical intervention and how have they changed since 2012?
- Question 2: To what extent are enrollees able to receive timely access to personal, home care and other services such as dental care, optometry and audiology?
- Question 3: Are enrollees accessing necessary services such as flu shots and dental care?

Goal 3: Reduce preventable acute hospital admissions

- Question 1: What is the rate of potentially avoidable hospitalizations? Is the rate stable or decreasing?

Goal 4: Improve satisfaction for consumers

Question 1: What is the percent of members who rated their managed long-term care plan within the last six months as good or excellent?

Question 2: What is the percent of members who rated the quality of care manager/case manager services within the last six months as good or excellent?

Question 3: What is the percent of members who in the last six months rated their home health aide/personal care aide/personal assistant, care manager/case manager, regular visiting nurse or covering/on call nurse services were usually or always on time?

Question 4: What is the percent of members who rated the quality of home health aide/personal care aide/personal assistant services within the last six months as good or excellent?

Evaluation

Annually, New York will perform the calculation of the proposed evaluation questions. The Department of Health has extensive experience with the computation and evaluation of quality performance measurement with a variety of service delivery entities, such as hospitals, managed care organizations, managed long-term care organizations, and nursing home.

Data Sources

Uniform Assessment System-NY (UAS-NY) Community Health data

The MLTC plans are required to collect and report to the NYSDOH information on enrollees' levels of functional and cognitive impairment, behaviors, and clinical diagnoses. This information is collected at enrollment and then semi-annually thereafter. The UAS-NY is an electronic system based on a uniform data set, which standardizes and automates needs assessments for home and community based programs in New York. The UAS-NY is based on the interRAI suite of assessment instruments. interRAI is a collaborative network of researchers in over 30 countries committed to improving health care for persons who are elderly, frail, or disabled. With the UAS-NY, functional status data demonstrates its importance to inform eligibility for the MLTC program, provide the basis for the MLTC plans' care management planning processes, and facilitate a plan's identification of areas where the patient's status differs from optimal health or functional status.

Assessment data are submitted by plans to the UAS-NY electronically as assessments are conducted, and are added to the database upon submission. Each year, MLTC UAS-NY submissions are created into two static assessment files. One containing the most recent assessment for enrollees in each plan from January through June. The second containing the most recent assessment for enrollees in each plan from July through December. These two files will be used to describe and evaluate the MLTC plan performance.

Satisfaction data

In 2007, the NYSDOH, in consultation with the MLTC plans, developed a satisfaction survey of MLTC enrollees. The survey was field tested and is now administered by the NYSDOH's external quality review organization, IPRO. New York State sponsors the biennial MTLC satisfaction survey. The survey contains three sections: health plan satisfaction; satisfaction with select providers and services, including timeliness of care and access; and self-reported demographic information.

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Mainstream Medicaid Managed Care (MMMC) and Temporary Assistance for Needy Families (TANF)

The overarching goals of the New York MMMC program's evaluation are to assess the impact of the demonstration on: 1) Expanded MMMC enrollment; 2) Improved health care access for MMMC/TANF beneficiaries; 3) Continued improvements in the quality of care; and, 4) Reduction in the number of uninsured New Yorkers. Enrollees who are eligible through Temporary Assistance for Needy Families are included in this evaluation and can be evaluated separately.

Toward these goals, the following evaluation questions will be addressed:

Goal 1: Reduce the number of Uninsured New Yorkers

- Question 1: What is the number of uninsured in New York?
- Question 2: How has expanded Medicaid eligibility affected health coverage for low-income uninsured adults?
- Question 3: Has enrollment in the expansion group (Essential Plan enrollees) changed the proportion of other 'traditional' MMMC categories?
- Question 4: What are the demographic characteristics of the expansion group and how do they compare to 'traditional' MMMC?

Goal 2: To expand MMMC enrollment

- Question 1: What percentage of eligible Medicaid recipients are enrolled in managed care?
- Question 2: What is the enrollment by plan type, region, enrollee characteristics, and eligibility category?
- Question 3: What is the cost per member per month by various aid categories and demographic characteristics?

Goal 3: To improve health care access for MMMC enrollees in New York

- Question 1: Has increased adoption of Patient-Centered Medical Home (PCMH) and Advanced Primary Care (APC) qualifications among Medicaid providers increased access to primary care?
- Question 2: Has the proportion of Medicaid providers with PCMH recognition changed?
- Question 3: Are there any barriers to access to care or changes in beneficiary to provider ratios?
- Question 4: What is the utilization of after-hours care?
- Question 5: What are the differences in access to care for MMMC subpopulations? Does utilization of services vary by population subgroups (race/ethnicity, rural/urban, aid category, age, gender and special needs)
- Question 6: Are MMMC enrollees satisfied with their access to care?

Goal 4: To continue to improve the quality of care

- Question 1: What are the trends in quality of care for as defined by standardized measures of quality for the following domains and measure types: preventive care, chronic condition treatment, potentially preventable use of ER and inpatient admissions.
- Question 2: How does quality of care for NY MMMC compare with national benchmarks?
- Question 3: What is the gap in measures of quality and satisfaction narrowed between NY MMMC and commercial plans?
- Question 4: How has the expansion of the demonstration into new populations been implemented into measurement of these groups? Has quality changed for members whose behavioral health benefits were moved into MMMC?
- Question 5: Are there any disparities in quality of care for Medicaid enrollees? Does quality of care vary by population subgroups (race/ethnicity, rural/urban, aid category, age, gender and special needs)

Question 6: How has provider compliance with Medicaid prenatal care standards improved prenatal care for enrollees? Has use of 17-P increase for eligible prenatal patients? Is the use of long-acting, reversible contraception methods increasing?
Question 7: What are the rates of potentially preventable Emergency Department visits (PPVs) and inpatient admissions (PQIs)?
Question 8: What is the utilization of tobacco cessation products and counseling?

Evaluation

New York will perform the calculation of the proposed evaluation questions annually. The Department of Health has extensive experience with the computation and evaluation of access, utilization, satisfaction and quality performance measurement with a variety of managed care plan types, populations and provider types.

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Commented [MKP(8R7)]: And again, NY or the third party?

Methods

MMMC and TANF enrollees will be identified through enrollment data. The analyses will be done on a statewide or perhaps regional level and will include either all MMMC when applicable such as Goal 2; Question 1 or if applicable based on demographic characteristics such as gender. In the case of measures that require a sample, such as satisfaction, the results will be extrapolated to the general population. Where applicable, relevant risk adjustment methodologies will be used.

Data Sources

Medicaid data warehouse - This robust dataset includes enrollment and eligibility data and claims and managed care encounters. Several 3M products are used to evaluate members clinical risk and a number of preventable event measures. These data will be used to stratify members into sub-populations in order to better understand patterns of care.

Provider Network Data System and Panel Data – These data contain information about the providers in their managed care plans' networks (PNDS) and members' assigned primary care physicians (Panel). These data allow for evaluation of provider capacity, but also evaluation by provider characteristics such as PCMH recognition.

PCMH File – Monthly data received from the National Committee for Quality Assurance (NCQA) containing the PCMH certification level for all recognized providers in New York State. Can be matched to the panel data described above to allow for evaluation by PCMH recognition.

CAHPS – The Consumer Assessment of Healthcare Providers is a nationally recognized satisfaction survey asking members about access to care and their experiences with their health care providers and health. It is administered to a sample of MMMC enrollees annually alternating between adults and children.

OHIP/EQRO Access & Availability Surveys – Access and availability surveys conducted on a regular basis to ensure timely access to types of providers is available to MMMC members

QARR – New York State's quality reporting system for health plans contains annually submitted data for quality measures for HEDIS as well as NYS-specific measures

NCQA reports – National Committee for Quality Assurance publishes reports containing Medicaid and Commercial performance benchmarks. CMCS publishes annual Medicaid child and adult

reports using their required core measure sets. These data will be used to compare NYS to national benchmarks.

Medicaid Prenatal Care Provider Reporting – Medicaid prenatal care providers submit data for prenatal care screening and services that can be used to evaluate standards of care.

New York State of Health (NYSoH) Enrollment – Since the inception of the Affordable Care Act, Medicaid enrollees who are not eligible for cash assistance enroll through the NYSoH rather than through local Departments of Social Services (LDSS).

Twelve-Month Continuous Eligibility Period

The Twelve-Month Continuous Eligibility initiative, initiated in 2014 with the Affordable Care Act Marketplace, is to prevent lapses in Medicaid coverage due to fluctuations in recipient income, and applies to Medicaid recipients eligible under Modified Adjusted Gross Income (MAGI) guidelines. MAGI eligibility groups include the following:

- Pregnant women;
- Infants and children under the age of 19;
- Childless adults who are: not pregnant, age 19-64, not on Medicare, or could be certified as disabled but not on Medicare;
- Parents/Caretaker relatives;
- Family Planning Benefit Program; and,
- Children in foster care.

MAGI recipients remain eligible for Medicaid until renewal after a 12-month period, during which time recipients are not required to report changes in income, and such changes are not considered even if they are reported by the recipient. Changes in eligibility would be made only in the cases of death, moving out of state, or voluntary disenrollment in Medicaid.

Evaluation of the Twelve-Month Continuous Eligibility for MAGI Individuals program is to provide information to program managers on how effectively continuous enrollment is being implemented, the potential health care benefits associated with 12-month continuous eligibility, as well as possible effects on health care costs. Such information could potentially be used to make program modifications toward increasing effectiveness in preventing lapses in coverage, and/or to ensure greater inclusion of subgroups that may be underserved with this initiative, and to encourage use of preventive services resulting from increased Medicaid coverage to prevent more severe disease and, in turn, prevent potentially higher costs.

<u>The broad goal of the Twelve-Month Continuous Eligibility initiative is to limit gaps in Medicaid coverage due to fluctuations in recipient income. Toward this goal, the following questions will be addressed</u>:

Question1: What is the distribution of enrollees within select continuous enrollment categories, i.e., 12 months, 24 months etc.?
Question 2: Does the continuous enrollment differ by demographic or clinical characteristics?
Question 3: Did Medicaid's average months of continuous enrolment increase following the implementation of continuous eligibility as compared to pre-implementation?
Question 4: Was there an increase in the percentage of Medicaid beneficiaries continuously enrolled for 12 months following implementation of continuous

eligibility as compared to pre-implementation?

Question 5: How do outpatient, inpatient and emergency department visits compare pre and post implementation of this policy? How have costs been impacted as a result of the change in utilization?

Hypotheses

1. Given the mechanism of 12-month continuous eligibility to prevent lapses in Medicaid coverage, months of enrollment per member will show an increase over the four years following the implementation of 12-month continuous eligibility as compared to the four years preceding its implementation.

2. The use of primary care and other preventive services will increase following the implementation of 12-monthy continuous eligibility. This is expected due to the anticipated continuity of coverage resulting from the initiative.

3. Health care costs for primary care and selected preventive care services will increase following the implementation of 12-month continuous eligibility, given the expected increase in utilization of these services.

4. Total cost of care per recipient will decrease following the implementation of 12-month continuous eligibility. This result is expected because fewer lapses in coverage should occur in the NYS Medicaid population, making preventive care more accessible and thus preventing a more severe illness that is more costly to treat.

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Evaluation

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The NYSDOH will perform the calculation of the proposed evaluation questions annually. The NYSDOH has extensive experience with the computation and evaluation of quality performance measurement with a variety of service delivery entities, such as hospitals, managed care organizations, managed long-term care organizations, and nursing homes.

Methods

Commented [MKP(11]: Previous two sections do not describe methods. We are however supposed to have detailed methods.

MAGI Medicaid enrollees will be identified, based on aid category codes, in the enrollment data from January 1, 2014 through December 1, 2018. Medicaid enrollment history for these recipients will be used to determine the number and proportion of recipients who had at least one 12-month period of continuous enrollment during this time period.

To understand the characteristics of MAGI recipients that receive 12-month enrollment, those with 12-month enrollment over the 4-year period will be compared to MAGI recipients not showing 12-month enrollment in their enrollment histories. Demographic variables on which comparison will be made include sex, race, and age. Additionally, the presence or absence of chronic diseases will be compared between these two groups as of recipients' first month of enrollment Medicaid occurring on or after January 1, 2014. Comparisons will be made, using chi-square analysis, on the presence or absence of conditions such as HIV/AIDS, diabetes, serious mental illness, asthma, cardiovascular disease and kidney disease. Clinical Risk Group (CRG) categories and/or diagnosis codes on claims will be used to determine the presence of these conditions.

Medicaid enrollment data will be used to determine months of enrollment per recipient. This will be determined for each of the five years prior to implementation of 12-month continuous eligibility (January 1, 2011 – December 1, 2013) and each of the five years following implementation (January 1,

2014 – December 1, 2018).

An interrupted time series design[1] is proposed to test hypotheses assessing the effect of the 12-month continuous eligibility initiative on Medicaid enrollment. This is a quasi-experimental design in which summary measures of the outcome variable (annual months of enrollment per member, in this case) are taken at equal time intervals over a period prior to program implementation, followed by a series of measurements at the same intervals over a period following program implementation. This design was chosen in consideration of the fact that a control group is unlikely to be available, limiting the ability to separate the effects of this initiative from other statewide health care reform initiatives that are ongoing (e.g., DSRIP, the Affordable Care Act). Given the limitation resulting from the likely absence of a comparison group, this design is advantageous in that potential confounders (i.e., other health care reform initiatives) are minimized in that they would have to occur contemporaneously with the introduction of 12-month continuous eligibility in order to exert a confounding effect, which is unlikely, but is recognized as possible nonetheless. This design also has the advantage of accounting for secular trends in the enrollment months per member, to which other health care reform initiatives may contribute.

Segmented regression[2] will be used as the primary analytic strategy in the analysis of data under the interrupted time series design in testing hypotheses. This analysis enables the evaluation of changes in the level and trend in the outcome variable, while controlling, as necessary, for such biases as secular trend, serial autocorrelation, and seasonal fluctuation in the outcome variable. A potential issue to address over the study period is change in characteristics of the Medicaid population over time. This could occur through increased enrollment of younger and healthier people into Medicaid, and/or increased movement of older and sicker people from Medicaid fee-for-service to managed care, either of which could confound the effects of the 12-month continuous eligibility initiative on member months of Medicaid enrollment. This will be addressed through adjustment of the outcome variable by standardizing on factors such as age, sex, and health status (e.g., Clinical Risk Grouping[3], Charlson Comorbidity Index[4]), or inclusion of population-level measures of these variables as covariates in the model. Additionally, stratification will be used to assess differential program effects on months of Medicaid enrollment by recipient subgroups (e.g., sex, race, age, NYS region, mental health status). Results will be stratified by demographic and clinical recipient subgroups to assess differential program effects.

Commented [MJM(12]: Do we need to be this prescriptive?

To test the hypothesis that that the percentage of recipients continuously enrolled for 12 months will increase in the years following the implementation of this initiative, the dependent variable will be the proportion of enrollees continuously enrolled over a 12-month period, in each of the five years prior to implementation of 12-month continuous eligibility, and the five years after. Again, potential confounding due to changes in the Medicaid population will be controlled through standardizing the outcome variable on factors such as age, sex, and health status, or inclusion of such variables in the model, with stratification on various recipient subgroups to assess differential program effects.

The interrupted time series design will also be used to evaluate cost and utilization of primary and preventive care before and after program implementation. To control for the effect of year to year fluctuation in Medicaid enrollment on service utilization and cost, per member per year rates will be computed as the dependent variable in each analysis, for each of the four years prior to, and four years after, the start of the 12-month continuous eligibility initiative.

Medicaid claims data will be used to identify primary care and selected preventive services, including well-care, screening for cancer and management of chronic disease. Costs associated with these services, as well as total care costs, will also be determined from Medicaid claims, to be used in computing the outcome variables for the second and third hypotheses, respectively. To compute per

member per year rates for each of these services, the total number of services of each type paid by Medicaid each year will be determined, and divided by the total number of months of enrollment over all recipients for that year and the resulting quotient multiplied by 12. Cost per member per year associated with primary care and preventive services, and for total health care costs, will be computed in the same manner.

Prior to implementation of the 12-Month Continuous Eligibility Initiative, Medicaid enrollees were subject to loss of coverage in the event that their incomes rose above the eligibility threshold. In order to quantify the number of MAGI enrollees who would have lost coverage using the previous eligibility criteria, Medicaid enrollment staff will maintain a record of reported changes in income received from enrollees. Such records will be used from the inception of the program, if available, or retention of these records will begin as soon as is logistically feasible to do so, and will be maintained on an ongoing basis. Given that Medicaid enrollees are not required to provide information on changes in income until time of eligibility renewal after 12 months, individuals who would otherwise have lost coverage will likely be undercounted.

Commented [JMM13]: Do they know this now?

Express Lanes Eligibility

Express Lane-like Eligibility refers to a Medicaid procedure in which individuals applying for Temporary Assistance (TA) are automatically considered for Medicaid enrollment without having to file a separate application. The underlying rationale is that Medicaid eligibility determination and enrollment can be facilitated given that, in most cases, applicants for TA are also eligible for Medicaid given the lower income threshold for the former. While Express Lane Eligibility does not represent a newly implemented Medicaid enrollment procedure, it's authority under the 1115 Waiver, applied to adults, is a recent change.

Given the program objective of increasing access to health insurance through Medicaid by streamlining the application and enrollment process, the following questions would be addressed in the evaluation:

Question 1: How many and what percentage of Medicaid recipients are enrolled through Express Lane-like Eligibility?
Question 2: What are the demographic and clinical characteristics of Medicaid beneficiaries enrolled through Express Lane-like Eligibility as compared to those not enrolled through this mechanism?

Methods

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Evaluation of the Express Lane-like eligibility initiative will provide feedback to program staff regarding the number and characteristics of Medicaid recipients enrolled through this mechanism, providing insights into how effectively the program reaches potential recipients in terms of both number and characteristics. Information gained could potentially be used to enroll potential recipient groups who may be underrepresented in this enrollment mechanism.

While Express Lane-like eligibility is not a new Medicaid enrollment procedure, tracking of the number of recipients enrolled into Medicaid under this mechanism will be begin as soon as possible after November 30, 2016, the start date of Medicaid Redesign Team section 1115 demonstration. The number and percentage of recipients enrolled through the Express Lane-like eligibility mechanism will be determined monthly and annually over the duration of the demonstration.

Medicaid claims and enrollment data will be used to compare recipients enrolled through the Express Lane-like mechanism to those enrollees who did not, on demographic and clinical factors. A list of enrollees through this

mechanism over a selected two-year period during the demonstration will be used to identify those individuals in the database. It is anticipated that a two-year period will be a sufficient time frame in order to identify a sufficient number of enrollees to allow comparisons to be made. From the claims and enrollment data, demographic (age, sex, race/ethnicity, New York State region) and clinical information (presence or absence of chronic diseases, such as mental illness and diabetes, maternal/delivery, etc.) will be extracted, with comparisons to be made between Express Lane-like enrollment vs. non-Express Lane-like using analytic procedures such as chi-square analysis.

References

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2. Gillings, D, Makuc, D, Siegel, E. Analysis of interrupted time series mortality trends: An example to evaluate regionalized perinatal care. American Journal of Public Health 1981;71;38-46.

3. Averill RF, Goldfield NI, Eisenhandler J, et al. *Development and Evaluation of Clinical Risk Groups (CRGs).* Wallingford, Conn: 3M Health Information Systems. Final Report to the National Institutes of Standards and Technology, US Department of Commerce; 1999.

4. Charlson, M.E., Pompei, P., Ales, K.L., & Mackenzie, C.R. (1987). A new method of classifying prognostic comorbidity in longitudinal studies: Development and validation *Journal of chronic diseases, 40*(5):373–383.