



STATE OF NEW YORK
EXECUTIVE CHAMBER
ALBANY 12224

ANDREW M. CUOMO
GOVERNOR

March 4, 2021

Norris Cochran
Acting Secretary
U.S. Department of Health & Human Services
200 Independent Avenue, S.W.
Washington, D.C. 20201

Dear Acting Secretary Cochran:

Pursuant to the terms of the New York State Medicaid Section 1115 Demonstration Medicaid Redesign Team (MRT) Waiver (11-W-00114/2), New York State (the State) is pleased to submit the enclosed waiver extension proposal to the Centers for Medicare and Medicaid Services (CMS) for its approval.

Waiver Extension Proposal

Without question, the MRT Waiver has been a resounding success. Together with CMS, we have expanded coverage to uninsured New Yorkers, improved care for the over six million New Yorkers who rely on the Medicaid program for comprehensive health coverage, shifted to paying for value rather than volume, and made substantial progress in reshaping our health care delivery system with the Delivery System Reform Incentive Payment (DSRIP) program. Since the inception of the MRT Waiver, the State has generated over \$65 billion in State and federal savings. To ensure that this progress can be sustained, the State is requesting a three-year extension of the MRT Waiver, which is set to expire on March 31, 2021.

This proposal seeks an extension of all current programs and authorities in the MRT Waiver, along with technical amendments to align with planned programmatic changes to the transition of Medicaid managed care benefits to the fee-for-service program as well as the expiration of the DSRIP program. This waiver extension proposal contains no changes to eligibility, scope of benefits, or cost-sharing requirements.

New York has fully complied with federal transparency requirements in preparation for formally submitting this waiver extension proposal. The State transmitted tribal and public notices referencing the preliminary proposal draft (December 1, 2020), conducted virtual public hearings (January 21, 2021 and January 27, 2021), and received over 720 comments. The State's engagement with stakeholders informed the structure and substance of this submission and have been addressed in the attached extension application. Upon review of a previous draft of this waiver, CMS determined that the application structure meets its technical and notice

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requirements.

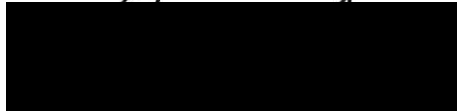
Forthcoming Demonstration Proposal

The COVID-19 pandemic has drastically impacted the health care delivery landscape. Responding to the COVID-19 pandemic has required the State to learn many lessons about coordinating an effective and massive response within the existing health care system, while at the same time exposing systemic issues that have created gaps in care among underserved and vulnerable populations. Accordingly, the State has necessarily been identifying new and larger programmatic changes to its Medicaid program in response.

The State anticipates submitting a new demonstration proposal and concept paper to CMS designed to address the inextricably linked health disparities and systemic health care delivery issues that have been both highlighted and intensified by the COVID-19 pandemic. In New York, the COVID-19 pandemic has been particularly detrimental to vulnerable populations. Achieving an equitable recovery from the COVID-19 pandemic requires a massive effort across all sectors of the health care delivery system. The State looks forward to engaging with CMS on this important proposal when submitted.

The cooperation between CMS and the State continues to be critical to the success of the MRT Waiver. We look forward to working closely with CMS during the review of our waiver extension request and the forthcoming demonstration proposal. If you have any questions, please contact Donna Frescatore, New York's Medicaid Director, at 518-474-3018.

Sincerely,



ANDREW M. CUOMO

Enclosures

cc: Liz Richter, Acting Administrator, Centers for Medicare and Medicaid Services
Howard Zucker, M.D., J.D., Commissioner of Health, New York State
Anne Marie Costello, Acting Director, Center for Medicaid and CHIP Services
Donna Frescatore, Medicaid Director, New York State

NEW YORK STATE MEDICAID REDESIGN TEAM (MRT) WAIVER

1115 Research and Demonstration Waiver
#11-W-00114/2

MRT Waiver Extension Request

New York State Department of Health Office of Health Insurance Programs

One Commerce Plaza
Albany, NY 12207

March 5, 2021



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Introduction

The State of New York (“New York” or the “State”) is requesting a three-year extension of the existing Section 1115 Medicaid Redesign Team (“MRT”) waiver demonstration, which is set to expire on March 31, 2021. ***This extension proposal seeks a continuation of all current programs and authorities in State’s current waiver demonstration, and the following two programmatic amendments:***

- **A Transition (Carveout) of the Non-Emergency Medical Transportation (NEMT) Benefit from Managed Long-Term Care to Fee-For-Service; and**
- **A Transition (Carveout) of Pharmacy Benefits from Medicaid Managed Care to Fee-For-Service.¹**

These amendments were developed by the State’s Medicaid Redesign Team II (“MRT II”), and are part of a larger, more comprehensive set of reforms that the State is planning to innovate and improve the Medicaid program. MRT II built on the work of the first MRT (and for which New York’s 1115 Waiver was renamed) and brought together a comprehensive set of stakeholders to collectively find solutions that improve the delivery of care and outcomes for Medicaid members and contain spending growth in the Medicaid program.

Although the State began planning for a larger renewal effort for the MRT waiver, these efforts have been *significantly impacted* by the COVID-19 pandemic and associated federally declared public health emergency (“COVID-19”). It is essential for the stability of the State’s Medicaid program that the current MRT waiver be extended without delay to give the State and its stakeholders time to consider the long-term impacts of the pandemic on its health care delivery system and identify redesign efforts that will best position the State to respond effectively to both COVID-19 and future public health emergencies. ***As it is critical for the State to extend the MRT waiver for the continuity and stability of the Managed Care program, the State is willing to entertain a non-programmatic extension should CMS require additional time to consider the programmatic amendments.***

The State intends to follow this extension request with a comprehensive programmatic 1115 demonstration package that supports the evolution of the delivery systems to respond to emergency preparedness needs. Critically, COVID-19 will not be the last pandemic or public health emergency that New York or the country will face, and future diseases, catastrophic weather events, or acts of terrorism, among other potential causes of public health emergencies, may pose an even greater strain to the State’s health care infrastructure.

Historical Context

The State’s goal in implementing the MRT Section 1115(a) demonstration was to improve access to health services and outcomes for low-income New Yorkers by:

- Improving access to health care for the Medicaid population;
- Improving the quality of health services delivered; and

¹ This proposal does not include an extension of the Delivery System Reform Incentive Payment (DSRIP) program, which was the subject of our waiver request dated November 27, 2019 or the Designated State Health Program (DSHP), which has been precluded pursuant to State Medicaid Director Letter #17-005, Phase-out of expenditure authority for Designated State Health Programs (DSHP) in Section 1115 Demonstrations (December 15, 2017).

- Expanding coverage with resources generated through managed care efficiencies to additional low-income New Yorkers.

The demonstration is designed to permit New York to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program, and enable the extension of coverage to certain individuals who need long term care and supports. It was originally approved in 1997 to enroll most Medicaid recipients into a Managed Care Organization (“MCO”). As part of the demonstration’s renewal in 2006, authority to require some disabled and aged populations to enroll in mandatory managed care was transferred to a new demonstration, the Federal-State Health Reform Partnership (“F-SHRP”). Effective April 1, 2014, this authority was restored to this demonstration as F-SHRP was phased out.

In 2001, the Family Health Plus (“FHPlus”) program was implemented as an amendment to the demonstration, providing comprehensive health coverage to low-income uninsured adults, with and without dependent children, who have income greater than Medicaid State Plan eligibility standards. FHPlus was further amended in 2007 to implement an employer sponsored health insurance (“ESHI”) component. Individuals eligible for FHPlus who have access to cost-effective ESHI are required to enroll in that coverage, with FHPlus providing any wrap-around services necessary to ensure that members get all FHPlus benefits. FHPlus expired on December 31, 2013 and became a State-only program, but federal matching funding for State expenditures for FHPlus will continue to be available as a Designated State Health Program through December 31, 2014.

In 2002, the demonstration was expanded to incorporate a family planning benefit under which family planning and family planning related services were provided to women losing Medicaid eligibility and to certain other adults of childbearing age (family planning expansion program). The family planning expansion program expired on December 31, 2013 and became a State plan benefit.

In 2010, the Home and Community Based Services Expansion program (HCBS Expansion program) was added to the demonstration. It covers cost-effective home and community-based services to certain adults with significant medical needs as an alternative to institutional care in a nursing facility. The benefits and program structure mirrors those of existing section 1915(c) waiver programs and aims to cover quality services for individuals in the community, ensure the well-being and safety of the participants and increase opportunities for self-advocacy and self-reliance.

As part of the 2011 extension, the State was authorized to develop and implement two new initiatives designed to improve the quality of care rendered to Partnership Plan recipients. The first, the Hospital-Medical Home (“H-MH”) project, provided funding and performance incentives to hospital teaching programs in order to improve the coordination, continuity and quality of care for individuals receiving primary care in outpatient hospital settings and facilitate certification of such programs by the National Committee for Quality Assurance as patient-centered medical homes. This demonstration initiative ended on December 31, 2014.

Under the second 2011 initiative, the State would have provided funding, on a competitive basis, to hospitals and/or collaborations or hospitals and other providers for the purpose of developing and implementing strategies to reduce the rate of Potentially Preventable Readmissions for the Medicaid population. The demonstration initiative was never implemented.

Finally, in 2011 The Centers for Medicare & Medicaid (“CMS”) began providing matching funding for the State’s program to address clinic uncompensated care through its Indigent Care Pool (“ICP”). This pool expired on December 31, 2014, and as such, these changes are no longer in effect.

In 2012, New York added to the demonstration an initiative to improve service delivery and coordination of long-term care services and supports for individuals through a managed care model. Under the Managed Long-Term Care (“MLTC”) program, eligible individuals in need of more than 120 days of community-based long-term care are enrolled with managed care providers to receive long term services and supports as well as other ancillary services. Other covered services are available on a fee-for-service basis to the extent that New York has not exercised its option to include the individual in the Mainstream Medicaid Managed Care Program (“MMMC”). Enrollment in MLTC was phased in geographically and by group.

The State’s goals specific to MLTC are as follows:

- Expanding access to managed long-term care for Medicaid members who are in need of long-term services and supports (“LTSS”);
- Improving patient safety and quality of care for members in MLTC plans;
- Reducing preventable inpatient and nursing home admissions; and
- Improving satisfaction, safety and quality of life.

In April 2013, New York had three amendments approved. The first amendment was a continuation of the State’s goal for transitioning more Medicaid members into managed care. Under this amendment, the Long-Term Home Health Care Program (“LTHHCP”) participants began transitioning, on a geographic basis, from New York’s 1915(c) waiver into the 1115 demonstration and into managed care. Second, this amendment eliminated the exclusion from MMMC of both foster care children placed by local social service agencies and individuals participating in the Medicaid buy-in program for the working disabled.

Additionally, the April 2013 amendment approved expenditure authority for New York to claim Federal Financial Participation (“FFP”) for expenditures made for certain Designated State Health Programs (“DSHP”) beginning April 1, 2013 through March 31, 2014. These DSHPs were aimed to improve health outcomes for Medicaid and other low-income individuals, and the federal funding was linked to requirements for the State to submit deliverables to demonstrate successful efforts to transform its health system for individuals with developmental disabilities.

A December 2013 amendment was approved to ensure that the demonstration made changes that were necessary in order to coordinate its programs with the Medicaid expansion and other changes made under the Affordable Care Act (“ACA”) implementation beginning January 1, 2014.

Effective April 1, 2014, CMS approved an amendment to extend several authorities that expired in calendar year 2014. As part of the amendment CMS extended authorities related to the transitioning of parents into State Plan coverage and other authorities that provide administrative ease to the State’s programs and continuing to provide services to vulnerable populations, i.e., HCBS Expansion program and individuals moved from institutional settings into community-based settings.

Also, effective April 1, 2014, populations receiving managed care or managed long-term care in the 14 counties that encompassed the F-SHRP demonstration were moved into this demonstration.

An amendment approved on April 14, 2014 allowed New York to take the first steps toward a major delivery system reform through a Delivery System Reform Incentive Payment (“DSRIP”) program. This amendment to the Partnership Plan demonstration provided for an Interim Access Assurance Fund to ensure that sufficient numbers and types of providers were available in the community to participate in the transformation activities contemplated by the DSRIP Program. The DSRIP program incentivized providers through additional payments beginning in 2015. The amendment also included expenditure authority for DSHPs to allow the State to concentrate resources on the investments necessary to implement its DSRIP program. Savings from the DSRIP program were anticipated to exceed the cost of the DSHP program.

On December 31, 2014, CMS amended the demonstration to enable New York to extend long term nursing facility services to members of New York’s MMMC and MLTC populations.

Enrollment in MMMC and MLTC was extended to individuals entering residential health care facilities (“RHCF”) for stays that are classified as permanent. As part of the agreement, the State also instituted an independent LTSS assessment process via an enrollment broker and implemented its Independent Consumer Support Program in areas of the State where services and enrollment were being instituted.

In August 2015, CMS approved New York’s request to implement Health and Recovery Plans (“HARP”) to integrate physical, behavioral health and BH HCBS for Medicaid members with diagnosed severe mental illness (“SMI”) and/or substance use disorder (“SUD”) to receive services in their own homes and communities. Under the demonstration, HARPs are a separate coverage product that is targeted to Medicaid members that meet need-based criteria for SMI and/or SUD established by the State. HIV Special Needs Plan (“SNP”) under MMMC will also offer BH HCBS services to eligible individuals meeting targeting, risk, and functional needs criteria. All MMMC plans will offer BH benefits in integrated plans including four new demonstration services.

The demonstration was also amended to effectuate eligibility flexibilities for the Adult Group, including allowing adults enrolled in TANF to be enrolled as a demonstration population without a MAGI determination, extension of continuous eligibility for members of the Adult Group who turn 65 during their continuous eligibility period and temporary coverage for members of the Adult Group who are determined eligible to receive coverage through the Marketplace.

On November 30, 2016, CMS approved an extension of the demonstration, but in response to comments by the State, that extension was rescinded and superseded by a modified approval effective December 7, 2016. Under the most recent extension, the Partnership Plan was renamed New York Medicaid Redesign Team (“MRT”) and references were changed throughout the Special Terms and Conditions (“STCs”). The extension included time-limited authorization to extend the DSRIP program first authorized in 2014, through March 31, 2020. The extension also included a new time limited DSHP authority to the extent that the State increases its Medicaid expenditures through its DSRIP program and achieves metrics that will result in anticipated cost savings that offset the DSHP expenditures. DSHP funding will be phased down over the demonstration period. The DSRIP and DSHP authorities are intended to be a one-time investment in system transformation that can be sustained through ongoing payment mechanisms and/or State and local initiatives.

The Behavioral Health Self-Direction Pilot was included as part of the renewal. This pilot makes self-direction services available to HARP and HIV SNP members receiving BH HCBS. The program is authorized to be in effect from January 1, 2017 through March 31, 2021.

On April 19, 2019, CMS approved an amendment to allow a waiver of comparability which permits managed care members to only be assessed a drug copay. The State will not assess the non-drug benefit cost sharing described in the Medicaid State Plan.

On August 2, 2019, CMS approved an amendment containing the following changes:

- Allow children with HCBS under the State's 1915(c) Children's Waiver and children placed in foster care through a Voluntary Foster Care Agency to enroll in Mainstream Managed Care or an HIV SNP.
- Continues Medicaid eligibility for Family of One ("Fo1") Non-1915 children who would have been eligible under the Children's Waiver had case management not been moved under the State Plan as a Health Home service or who were in a non-SSI category and receive HCBS or Health Home comprehensive case management.
- Include Children's Waiver HCBS and State Plan behavioral health services in the Medicaid managed care benefit package.
- Include children receiving HCBS under the Children's waiver in the Self Direction Pilot for Individual Directed Goods and Services.

On December 19, 2019, CMS approved an amendment with the following changes for Partially Capitated MLTC plans:

- Implement a lock-in policy for partially capitated MLTC plans, pursuant to which members of Partially Capitated MLTC plans are able to transfer to another Partially Capitated MLTC plan without cause during the first 90 days of a 12-month period and with good cause during the remainder of the period. A member of a Partially Capitated MLTC plan may transfer to another type of MLTC plan at any time.
- Limit the nursing home benefit in the Partially Capitated MLTC plan to three months for those members who have been designated as Long-Term Nursing Home Stays ("LTNHS") in a skilled nursing or residential health care facility, at which time the individual will be involuntarily disenrolled from the Partially Capitated MLTC plan and payment for nursing home services will be covered by Medicaid fee for service for individuals that qualify for institutional Medicaid coverage. Consistent with this Partially Capitated MLTC benefit change, individuals 21 years of age or older who are dually eligible for Medicare and Medicaid and LTNHS in a nursing home will be excluded from enrollment in a Partially Capitated MLTC plan.

Progress to Date

The MRT Waiver to date has realized measurable progress in achieving the following goals:

- 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 State has made significant strides to transform Medicaid delivery systems to meet the myriad and evolving needs of Medicaid members today, while building infrastructure that

supports providers' ability to increase efficiencies in the delivery of care, engage in risk-contracting, and support population health. This transition has resulted in moving Medicaid provider contracts into early risk-based arrangements and testing models of collaboration to support providers and MCOs in addressing the social determinants of health ("SDOH"). Medicaid providers earned incentives for creating integrated, high-performing health care delivery systems that improve quality of care, support population health, and reduce costs. Continuing this critical work while building a transition to even more integrated structures and reward pathways will be important to sustain gains made. Further developing these clinical network partnerships by deepening existing relationships and workflows, adding new partners, and engaging MCOs will further strengthen local continuums of care and increase efficiencies across delivery systems. While the current MRT waiver represented a crucial first step in the State's transition to value-based payment ("VBP") this extension request is the decisive bridge to the larger renewal that the State will pursue in light of COVID-19 and other MRT II reforms, on the State's journey to the full-realization of value-based care ("VBC").

Extending the Existing Waiver

Since New York's Section MRT waiver was approved in 1997, there have been several amendments, including those incorporating changes resulting from the recommendations of Governor Andrew Cuomo's Medicaid Redesign Team ("MRT"). New York remains well-positioned to lead the nation in Medicaid reform. Governor Cuomo's MRT and now the MRT II, which was established in early 2020, has developed an action plan, similar to the first MRT, that will build on the work of the MRT and, when fully implemented, will continue to improve health outcomes for more than six million New Yorkers, increase member satisfaction, and support the long-term fiscal sustainability of the Medicaid program. Significant federal savings were realized through New York's first MRT process and will also accrue from MRT II.

However, as COVID-19 spread across the United States, almost all states have been impacted—New York being no exception—as reflected both by the number of confirmed cases and resulting deaths. COVID-19 has laid bare the necessity for New York's healthcare system to be fundamentally reconfigured for scalability and flexibility, both for the near and long term.

While New York State recognizes this need, the outbreak of COVID-19 has proven that the original mission of ensuring coverage, access and quality health care to low-income New Yorkers, remains as much of an imperative today as it was in 1997. Despite the State's decisive response to the COVID-19 outbreak by providers, local departments of social services ("LDSS"), managed care organizations ("MCOs"), and communities—which has been extraordinary and involves taking swift action to approve private laboratories to test for the virus, standing up drive-through testing centers in outbreak hotspots to increase its testing capacity, and now rapidly building temporary hospital sites—COVID-19 revealed the limitations of the current delivery system to surge and redeploy resources rapidly during times of crisis.

It is with this strain on the system and increase in new members to the program, that the State is requesting a three-year extension. At present, according to the most recent monthly enrollment report, approximately 600,000 new members have been added to the program since the declaration of the Public Health Emergency.² The extension allows the continuation of the essential delivery of services to the Medicaid population in New York—including its authority to operate a comprehensive managed care program inclusive of long-term

² New York State Department of Health Enrollment by County, September 2020
https://www.health.ny.gov/health_care/medicaid/enrollment/docs/by_resident_co/2020/sept-2020.pdf

supports and services to the frail and elderly, support people with behavioral health diagnoses in managed care, and offer essential home and community based services to children, among other authorities—and affords the State sufficient time to comprehensively assess and incorporate into its strategy the impacts of COVID-19 and the systems changes that must occur in order to enhance its response to future public health crises and pandemics.

Goals and Objectives of the Extension

The goals and objectives of this waiver extension remain the same as the current goals and objectives set forth in the MRT Waiver at its onset (at initial approval known as “The Partnership Plan”). Those goals and objectives are:

- 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.

New York State seeks to ensure that the State Medicaid program may continue meeting these goals throughout the COVID-19 pandemic and while the State and its stakeholders collectively develop a waiver renewal.

Eligibility, Benefits and Cost Sharing Requirements of the Extension

The State is not requesting any changes to eligibility, benefits, or cost-sharing requirements as part of this extension. However, the State is requesting to maintain all current eligibility categories, benefits, and co-payment standards that have already received approval from CMS, as outlined in the current STCs of the MRT waiver.

Delivery System Implications of the Extension

This extension application is not requesting any changes to the delivery system or payment rate for services beyond those following two amendments:

- The Transportation Carveout of Managed Long-Term Care to Fee-For-Service
- The Pharmacy Benefit Carveout from Managed Care to Fee-For-Service

For details on the changes proposed in these amendment requests, please see appropriate sections below.

Implementation Timeline of the Extension

This proposal is for a three-year 1115 waiver extension from April 1, 2021 to March 31, 2024, in order for the State to continue the vital programs authorized through the MRT Waiver and provide the necessary time to work with CMS and stakeholders to develop a full renewal in light of the COVID-19 pandemic.

Fiscal Implications of the Extension

This extension request is budget neutral to the federal government and does not impose any additional cost, nor request any additional federal funding. ***The purpose of this extension request is to maintain existing programs and related waiver and expenditure authorities with minor modifications.*** The State does not anticipate that, as a result of this extension proposal, caseload and costs will significantly change. The anticipated total caseload across the extension proposal to be 4.7M members for DY23, inclusive of the recent increases due to COVID-19. The anticipated total computable cost for this caseload is \$54B. These numbers are

subject to change depending on the minimum wage adjustment or other factors. For further details and additional cost and caseload projections, please see the Budget Neutrality section below.

Requested Amendments to the Existing Demonstration

The two requested amendments from the MRT II process seek to further stabilize our Medicaid program, enhancing the oversight and streamlining the administration of these two benefits so they can be provided to beneficiaries more effectively. The State has, and will, assess all elements of the requested changes for alignment with federal performance measurement approaches, programmatic approaches and promising practices, in order to promote better outcomes for the State's Medicaid members. The State seeks to build on the lessons learned from its current waiver and is requesting two concurrent amendments in this waiver extension, which were recommendations advanced by MRT II to improve health outcomes, increase member satisfaction, and support the long-term fiscal sustainability of the Medicaid program:

- A Transition ("Carveout") of MLTC Non-Emergency Medical Transportation Services Fee-For-Service ("FFS"); and
- A Transition ("Carveout") of the Pharmacy Benefit from Managed Care to FFS.

Each amendment is discussed in further detail below.

A Transition (Carveout) of MLTC Non-Emergency Medical Transportation Services to FFS Amendment

Medicaid transportation is a federally required State Plan-approved service managed and administered by the Department of Health ("DOH" or the "Department") to ensure that members have access to approved medical services. The Medicaid Non-Emergency Medical Transportation ("NEMT") benefit is authorized under the Social Security Act § 1902(a)(70) and 42 C.F.R. § 440.170, and requires that a Medicaid program:

- Ensure necessary transportation to and from providers;
- Use the most appropriate form of transportation; and
- Include coverage for transportation and related travel expenses necessary to secure medical examinations and treatment.

Since 2012, the 1115 MRT demonstration authorized MLTC plans to offer NEMT services to its members as part of the benefit package it manages. With the exception of Programs of All-Inclusive Care for the Elderly ("PACE") organizations, the State now seeks to move the authority for provision of NEMT services from the MRT waiver, into a State Plan Amendment ("SPA"). For additional information, CMS may review a forthcoming SPA, which will be submitted before the end of the calendar quarter in which it will take effect.

Goals and Objectives of the MLTC Transportation Carveout Amendment

While assuring access to care for over six million Medicaid members, and using the most medically appropriate, cost-effective level of service, the New York Medicaid Program spending on NEMT services continues to grow disproportionately, particularly at the taxi/livery level of service. Following a recommendation of MRT II, the State enacted a series of actions to help better manage the growth of NEMT spending and

align these benefits to member needs.³ In connection with these actions, this MRT waiver amendment proposal would carve out the Medicaid NEMT benefit from non-PACE, MLTC capitated rates to FFS management. The management of the trips (e.g., scheduling, assignment of the most appropriate mode, prior authorization) will be performed by a professional transportation management broker—either statewide or in certain regions of the State. Such broker(s) will be procured by the State in a risk-based arrangement(s). This change in transportation management streamlines and centralizes the benefit for Medicaid members, and adheres to the principles of value-based care - payment to improve outcomes. Presently, there are approximately 263,000 MLTC members, in 28 plans, whose NEMT transportation cost component of the capitated rates totals over \$400 million annually. The transportation benefit has previously and successfully been carved out of the MMMC benefit package and managed through the FFS program.

The carveout of the NEMT transportation benefit from MLTC enhances efficiencies by leveraging the contracted transportation management broker resources, including the broker's infrastructure and network. Hospitals, medical providers, and managed care organizations will also benefit from the efficiency of a single transportation management point of contact statewide or in their region, rather than multiple transportation organizations that vary by plan. Additional benefits of transportation broker management include:

- Medicaid per member cost savings
- Increased efficiency with limited resources
- Assignment of the most medically appropriate mode of transport
- Greater Medicaid program accountability
- Improved service quality
- Better coordination of services during inclement weather and catastrophes
- Expedited complaint investigation and resolution
- Early identification of transportation access issues
- Increased flexibility and sensitivity to individual member needs
- Improved fraud and abuse identification

The goals of this amendment request are as follows:

- Improve administrative simplification by creating a consistently managed transportation benefit and removing the benefit from the MRT waiver
- Reduce cost-risk by shifting the broker arrangement to a risk-based arrangement.
- Create a larger pool of members by combining all members, except PACE for which the transportation benefit must be managed by the PACE Organization under federal rules, for brokers to provide NEMT service to.

Eligibility, Benefits, and Cost-Sharing Requirements of the MLTC Transportation Carveout Amendment

The proposed amendment does not make any changes to program eligibility, benefits, or cost-sharing requirements. This proposed regulatory amendment should not have an impact on members' access to the transportation benefit; it instead shifts the delivery of

³ <https://www.nysenate.gov/legislation/laws/SOS/365-H>

the benefit from MLTC plans to FFS. Please see the New York Medicaid State Plan for additional eligibility, benefit and cost-sharing details.

Waiver and Expenditure Authorities of the MLTC Transportation Carveout Amendment

This amendment is carving out the management of transportation benefits for MLTC member lives from the MRT waiver, and therefore is not requesting any additional waiver or expenditure authorities.

Delivery System Implications of the MLTC Transportation Carveout Amendment

Member Impact: The MLTC Carveout will be phased-in upon implementation of the NEMT broker and transitions 292,000 enrollees from MLTC plans to a transportation “broker” model. This carveout is shifting the delivery system through which members receive the benefit but does not change the scope, or eligibility of the benefit itself, therefore there will be minimal member impact due to this amendment.

Plan Impact: The Department will transition the Medicaid transportation benefit from the MLTC plans, and its associated capitated premium calculation (excluding PACE), back to the FFS program. This impacts approximately 292,000 MLTC members. This change is intended to promote consistency and improve quality across the management of the transportation benefit and creates alignment with how transportation is already successfully managed for 6 million members enrolled in MMMC and the FFS program.

Broker Impact: Once the transportation benefit is transitioned back into the FFS program, the management of trips (e.g., scheduling, assignment of the most appropriate mode, prior authorization, etc.) will be performed by one or more professional transportation brokers (“Brokers”) either statewide or in certain regions of the State—that will be procured by the State. Brokers will enter into a risk-based arrangement in order to drive value and lessen cost-risk of the NEMT program.

State Impact: The transition of the benefit will have consumer protections in place to ensure for the smoothest possible transition, including State responsibilities such as:

- Transitioning of member transformation information with limited disruptions in member transportation experience;
- Monitoring of member access;
- Developing mandatory corrective actions for any Medicaid enrolled provider who fails to meet quality performance standards; and
- regular auditing and oversight by the Department of Health and other State and federal agencies in order to ensure the quality of the transportation services provided and adequacy of Medicaid member access to medical care and services.

Implementation Timeline of the MLTC Transportation Carveout Amendment

This carveout is intended to take place upon implementation of the NEMT broker with a phased implementation approach over a six-month period.

Fiscal Implications of the MLTC Transportation Carveout Amendment

This amendment is seeking to carveout MLTC members from receiving transportation services under the waiver authority and transition them to receiving the services through FFS under the State Plan. The total caseload affected is approximately 292,000 members, with total computable cost projected to be approximately \$291.6M for DY23. Costs to administering agencies and the State associated with this amendment will be covered by existing State budget appropriations and anticipated federal financial participation. The proposed amendment does not have an impact on the budget neutrality of the MRT waiver. There are no costs imposed on local governments by these regulations because the amendments incorporate Medicaid transportation program changes related to implementation of the transportation management broker. With anticipated member impact is intended to be minimal.

Public Notice Compliance and Documentation of the MLTC Transportation Carveout Amendment

The State scheduled public hearings on January 21, 2021 and January 27, 2021, which were conducted through real-time, audio-visual webinars on WEBEX and recorded and provided an opportunity for the public to offer comment, consistent with flexibilities granted by CMS during the federal public health emergency period. This amendment was further provided to the public as part of the larger extension request on December 16, 2020.

Tribal Notification of the MLTC Transportation Carveout Amendment

The State provided tribal notification of this amendment as part of the larger extension request on December 16, 2020.

A Transition (Carveout) of the Pharmacy Benefit from Managed Care to FFS Amendment

As the policy landscape of providing pharmacy benefits in Medicaid shifts away from the “carve in” model, where pharmacy benefits are included in the managed care benefit package, to a “carve out” model, several large Medicaid programs (e.g., California, West Virginia, Wisconsin, Tennessee⁴) have decided to manage the pharmacy benefit for Medicaid members through the FFS benefit under the State’s control. The State Plan currently authorizes FFS to deliver this benefit, from which MMMC members were carved out of in 2011. The transition *back* to FFS will leverage the existing State Plan authority for all Medicaid members. As such, CMS approval of the State’s 1115 waiver is not a pre-condition to implementation of the pharmacy transition to Medicaid fee-for-service.

Goals and Objectives of the Pharmacy Carveout Amendment

The transition of the pharmacy benefit from MMMC to FFS is a result from growing concerns about the value of “carve-in” model and the ability to of the State to manage pharmacy spending, given the lack of transparency by MCOs and their Pharmacy Benefit Managers (“PBMs”).¹ The use of “spread pricing” where managed care plans contract with PBMs to manage their prescription drug benefits, and the PBMs keep a portion of the amount paid to them by the health plans for prescription drugs has exposed the lack of transparency in managed care pharmacy reimbursement and the

⁴ <https://www.kff.org/report-section/how-state-medicaid-programs-are-managing-prescription-drug-costs-pharmacy-benefit-administration/>

potential for additional expenses borne by the Medicaid program. The pharmacy benefit carveout will address these concerns and achieve the following goals:

- Provide the State with full visibility into prescription drug costs;
- Centralize and leverage negotiation power;
- Realize economies of scale through centralized management and administration;
- Provide a single drug formulary with standardized utilization management protocols; and
- Address the growth of the 340B program and associated reductions in State rebate revenue.

Despite the State's efforts to control rising drug costs, Medicaid spending on prescription drugs has been growing faster than the rate of inflation. By moving the pharmacy benefit for the over 5 million Medicaid Managed Care ("MMC") members back to the FFS system, the State will have greater visibility into the underlying cost of prescription drugs and the ability to centralize the purchasing power for all 6.6 million Medicaid members as a single State purchaser of drugs. In addition to greater transparency and enhanced purchasing power, there will be a single, centralized formulary to ensure consistency in the pharmacy benefit across the Medicaid program. This will simplify the benefit for members and prescribers, easing administrative burden by eliminating multiple formularies and prior authorization contacts, remove conflicts of interest with intermediaries in the pharmaceutical supply chain, and improve the ability of the State to negotiate rebates with drug manufacturers.

This carveout is also intended to address growth in the State's 340B program and associated reductions in State rebate revenues. While 340B is an important program to safety-net providers, its rate of growth (averaging 47% on a compounded annual basis) has become unsustainable. This loss of rebates to the NY Medicaid program has totaled over \$800 million (gross) over the past four years and continues to increase year over year. In recognition of both the importance of the 340B program to safety-net providers in the State, but also the need to address revenue reductions, the State is committed to the reinvestment of \$102M, in State Fiscal Year ("SFY") 2021-22 (subject to federal approval), to directly support covered entities and preserve critical services that are currently funded with 340B revenue. A 340B Advisory Group, composed of key 340B stakeholders was established in State statute, to provide feedback to the State regarding how the \$102M will be distributed. To date, the 340B Advisory Group has not submitted recommendations regarding how the \$102M will be distributed. Therefore, the State has proposed, in the SFY 2021-22 Executive Budget, a methodology for the distribution of these funds. Specifically, the proposed SFY 2021-22 Executive Budget establishes a 340B Reimbursement Fund to offset losses to certain 340B entities as a result of the pharmacy carve out. Eligible 340B providers, which will include non-hospital 340B providers in New York, will receive a proportionate distribution from a methodology that considers each providers 340B revenue and volume of Medicaid members served. The State intentionally limited the provider eligibility to safety net clinics and Medicaid dependent providers to ensure minimal financial disruption for these providers and the Medicaid members they serve. Annual distributions from the 340B Reimbursement Fund will equal the amount of \$102 million for the upcoming fiscal year and continue for each fiscal year thereafter; however, the statutory language allows for additional funding in future years.

After the carveout, 340B covered entities will continue to purchase drugs at reduced prices and receive margin on 340B drugs associated with other payors (e.g., Medicare and Commercial Insurers) and Medicaid covered physician administered drugs. Medicaid members will continue to access their medications regardless of whether 340B drug stock is used. The tagging of a claim as 340B vs. non-340B is not visible to the member and does not result in disruption at the counter when members pick up their medications.

Eligibility, Benefits, and Cost-Sharing Requirements of the Pharmacy Carveout Amendment

There are no changes to eligibility, scope of benefits, or co-payment standards as a result of this carveout. This amendment simply shifts the administration and delivery of the benefits by *carving out* these this benefit from the Medicaid Managed Care delivery systems to Fee-For-Service in the State Plan. This carveout is intended to generate savings, through greater transparency and enhanced purchasing power, with the goal of minimal provider and member disruption. The Pharmacy benefit carveout applies to all MMMCs, including HARP and HIV-SNP plans; however, this carveout does *not* apply to MLTC plans (e.g., PACE, MAP, partial capitation MLTC), the Essential Plan, or Child Health Plus (“CHP”).

The State provided continuously updated charts on both an overview and detailed scope of benefits chart of which services are and are not subject to the carveout, as well as how these services will be handled in the post-transition phase of the carveout. These documents are as follows:

- The Overview of the Scope of Benefits provides a snapshot of what is changing and what is not in relation to pharmacy services in New York Medicaid’s two delivery systems, managed care and FFS, in the current state (pre-transition) and future state (post-transition).
- The Detailed Scope of Benefits provides a comprehensive inventory of the NYS Medicaid’s outpatient pharmacy benefit, and whether the benefit is subject to the carveout and whether the managed care plans are required to continue to provide the benefit available when provided by a non-pharmacy provider.

The Overview and Detailed Scope of Benefits documents can be accessed on the MRT website via this website:

https://health.ny.gov/health_care/medicaid/redesign/mrt2/pharmacy_carve_out/docs/rx_carve_out_scope.pdf.

A full list of Durable Medical Equipment (“DME”) that are not subject to the carveout and are found within the Durable Medical Equipment, Prosthetics, Orthotics, Supplies and Procedure Codes and Coverage Guidelines can be accessed on the MRT website via this link

https://health.ny.gov/health_care/medicaid/redesign/mrt2/pharmacy_carve_out/docs/rx_carve_out_scope.pdf.

Waiver and Expenditure Authorities of the Pharmacy Carveout Amendment

New York State’s MRT Waiver demonstration provides the current authority under which the pharmacy benefit is delivered by MCOs. This amendment is removing the pharmacy benefit for managed care plan enrolled members from the MRT Waiver and moving it

into the existing benefit structure vested by the State Plan. Therefore, the State is not requesting any additional waiver or expenditure authorities in regard to this amendment.

Delivery System Implications of the Pharmacy Carveout Amendment

A large consideration when comparing the impact of the current model (under MCOs) to an FFS model is the administrative costs associated with the delivery of prescription drug benefits. Under the MCO model, these costs are incurred by the MCO and their associated PBM, and reimbursed by the State through managed care premiums, and include services such as pharmacy network management, eligibility management, claims processing, preferred drug list (“PDL”) development and maintenance, and drug utilization review and health plan surplus.

Under the FFS model, New York State Medicaid would bear these responsibilities and the associated costs directly, in addition to overhead for State staff, expenses for pharmacy claims and rebate processing vendors, PDL maintenance, as well as other consulting and administrative services costs. Other impacts on specific stakeholders and systems are listed below:

Member Impact: The intent of the previously mentioned transition period is to limit service disruption to the fullest extent possible. The communication of the benefit transition will be done so through use of social media, the distribution of easy-to-read tip sheets for members that provide them with key information and links to guide them through the transition. Additionally, updates to providers and pharmacies will be done via *Medicaid Update* articles and targeted prescriber outreach to address member specific issues (e.g., use of non-preferred medications), through mail, email and other electronic methods. All members who upon transition are receiving non-preferred medications will be allowed a one-time fill within 90 days of the implementation, slated on or after April 1, 2021. Prescribers will also be alerted that their patients are on non-preferred medications so that they can switch to a preferred medication or request prior authorization, for fills beyond the transition fill. Medicaid members will continue to obtain their medications, regardless of whether 340B drug stock is used to fill their prescriptions.

Managed Care members without their Medicaid card will not experience disruption at the counter when picking up their medications at the pharmacy, as there will be a variety of methods in which pharmacies will be able to verify enrollment and process prescriptions including accessing the Medicaid Client Identification (“CIN”) number from either the Medicaid Card or the MCO card, using the State’s ePACES system or the pharmacy claim standard (“NCPDP”) E1 eligibility transaction.

Children in foster care that are already enrolled in MCOs will begin to receive their outpatient pharmacy benefit through the FFS program effective on or after April 1, 2021. Foster care children that transition from FFS into an MCO July 1, 2021 will continue to receive their pharmacy benefit through the FFS program, resulting in a consistent pharmacy benefit for all children in foster care.

Additional information about the communication activities, strategy, and timeline to notify members, providers, and plans can be found on the New York MRT Website regarding the Pharmacy Carveout can be found at this website:

https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/pharmacy_carve_out/docs/rx_carve_out_activities_timeline.pdf.

Provider Impact: Providers that are prescribing outpatient drugs (or other products covered under the outpatient pharmacy benefit), for MCO members, will access a single FFS formulary and the PDL to determine coverage parameters. Pharmacies that are billing for outpatient drugs for MCO members will submit claims to the eMedNY system. In doing so, this significantly reduces the burden on providers to check multiple formularies in order to determine preferred or non-preferred status of a drug, and instead streamlines this process by using the established FFS formulary.

The Pharmacy Carveout will have no impact to 340B Covered Entities' ability to use the 340B program for practitioner administered drugs provided to Medicaid members and non-Medicaid members (e.g., Medicare and Commercial Insurers). It also is important to note that the Pharmacy Carveout will not change the ability of a 340B Covered Entity to purchase medications at reduced 340B prices.

MCO Impact: MCOs will continue to be responsible for maintaining all activities necessary for their enrolled members' care coordination and claims payment for non-outpatient pharmacy services and related activities, consistent with contractual obligations. The MCOs will determine the personnel and resources that they need in order to continue to perform these functions in order and effectively transition the pharmacy benefit out of their scope.

DOH has worked closely with the MCOs to ensure that they receive timely pharmacy data and reports that will enable continued care management, pharmacy compliance programs and support value-based program (VBP) activities. As such, DOH will be providing the MCOs with a daily pharmacy claims file that includes pharmacy claims activity for the prior day. Furthermore, DOH will be providing a set of on-demand reports that support integrated care management and disease management activities, including but not limited to managing members' chronic diseases, promoting medication adherence, and monitoring adverse reactions. These reports will provide for more timely access to critical data, given that there is a lag for some of the MCOs when loading the daily pharmacy claims file to their data warehouse, and ensure that existing VBP arrangements between MCO's and providers continue post transition.

POS Pharmacy Impact: The impact to pharmacies underwent an extensive stakeholder engagement and feedback process throughout the development of this amendment during which they provided key input into the transition strategy. Upon transition of the pharmacy benefit to the FFS program, DOH will use the eMedNY system for point-of-sale claims adjudication. This is the claims adjudication system which is currently used for Medicaid members that access all their benefits through the FFS program. A comprehensive evaluation of the eMedNY system has been conducted, to ensure that the system contains adequate capacity for the increased claims volume. Pharmacies will have multiple modalities to quickly obtain member ID including accessing the CIN number from either the Medicaid Card or the MCO card, as well as the State's ePACES system, and finally the pharmacy claim standard (i.e., NCPDP) E1 eligibility transaction. Additionally, monitoring processes and reports have been refined to more quickly identify potential claim processing variances (e.g., monitoring of expected claim transactions vs. actual transactions, # of claim denials by reason vs. actual claim denials by reason). Lastly, post implementation monitoring will include recurring calls with call centers and

stakeholders to further identify and resolve questions and/or issues related to claims processing.

Drugs and Supplies Covered by the Carveout: The carveout will include covered outpatient drugs and other products covered under the Outpatient Pharmacy Program. This includes outpatient prescription and over-the-counter drugs, diabetic, incontinence and other supplies. It does not include physician administered (J-Code) drugs. The Scope of Benefits chart which can be found on the NY MRT website lists what drugs and products are included in the Outpatient Pharmacy Program, https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/pharmacy_carve_out/rx_carve_out_scope.htm

Preferred Drug Program: The Medicaid FFS Preferred Drug Program (“PDP”) promotes the use of less expensive, equally effective prescription drugs when medically appropriate. The determination of whether a drug is preferred or non-preferred drugs within the PDP, does not prohibit a prescriber from obtaining any of the drugs. To ensure a smooth transition, DOH conducted an analysis comparing the drugs currently being used by managed care members to the drugs in the PDP and determined that there is a 90% match to drugs that are preferred under the PDP. Furthermore, for the 10% that didn’t match, half are for acute drugs, that would most likely, not be continued on or after April 1, 2021. The *one-time fill* and transition period in concert with the targeted communications to prescribers and members, as previously described, will mitigate transition issues.

State Program and Policy Staff: The Office of Health Insurance Programs (“OHIP”) within DOH is responsible for policy and program management for the Medicaid pharmacy program. With the transition of the pharmacy benefit into the FFS program, there will be significant volume increases, as outlined in Table 1, for which additional capacity in distinct pharmacy roles, including pharmacist supervisors, pharmacy managers, and data analysts, are necessary for clinically based operations and processes within the program.

Clinical and subject matter expertise are essential to mitigate the risks associated with added claims and prior authorization volumes as well as critical transition activities including, but not limited to evaluating pharmacy claims data, drug utilization patterns, and comparing plan formularies to the FFS formulary to inform the development of transition strategies that ensure that members continue to get access to needed medications. As such, thirteen state positions have been added to support these activities.

A detailed overview of the extent of the pharmacy benefit categories that OHIP will be responsible for are outlined in the aforementioned Scope of Benefits Charts. Please note that all pharmacy categories except for one (physician administered drugs) will be under the responsibility of FFS effective on or after April 1, 2021.

Systems and Operations: In order to ensure a successful implementation and ongoing management of the pharmacy program additional infrastructure, staff and supports are necessary to facilitate and support such a transition. The OHIP systems role in the Pharmacy Carveout is arguably among the most crucial as the systems team within OHIP is responsible for paying all FFS claims through the eMedNY system, storing and managing all adjudicated claims data in the Medicaid Data Warehouse, and staff are

responsible for the prior approval for DME & Supplies that are subject to the carveout, all of which are integral to the ability to manage the additional pharmacy volume. Currently, OHIP systems staff is responsible for the oversight of information systems that support the New York Medicaid Program and DOH initiatives including the Medicaid Management Information System, Healthcare Benefit Exchange, and Medicaid Data Warehouse.

The increased volume that the FFS program will incur as a result of the transition from managed care is significant – there will be a 600% increase in the claims volume, \$7 billion dollars of additional payments made through the claims payment system (i.e., eMedNY), an additional 700,000 prior authorizations – and several system and operational enhancements are underway to ensure the appropriate application of clinical criteria and standards are embedded into the claims payment system to appropriately pay claims accordingly.

OHIP (and the contractors it directs and oversees) are effectively replacing all the functions that plans currently contract out to PBMs. Absent adequate system enhancements and additional State personnel with relevant expertise the risk of denied claims and/or inaccurate payment of approved claims is significant. The impact of these risks would be realized at the point of sale when a pharmacy submits a claim to the eMedNY system. Eliminating unnecessary claim rejections and ensuring that questions regarding claim denials are handled in an expeditious manner ensure that Medicaid members receive medications in a timely manner. Issues regarding coding logic specific to a drug with high utilization could impact thousands of times for Medicaid members. In addition, if claims are paid inaccurately due to a failure in coding, reimbursement logic, or payment edits, the Medicaid program would be liable for overpayment until such a time that issue was identified and corrected, both of which would be less likely to occur with the appropriate resources for claims, monitoring, quality assurance and oversight.

Furthermore, the additional staff will be responsible for the development of systems capability to monitor claims flow, logic, timeliness of payment, variations in submissions and related 'operational health of the program' activities. In addition, the staff will build system tools that support all areas of the pharmacy benefit in managing the program. This includes developing analytic dashboard, system views, supporting programmers and analysis with visibility into the claims adjudication system, conducting detailed reimbursement logic to support pricing efficiencies, thereby reducing waste and improving service delivery to providers and recipients. In addition, OHIP will be required to build out infrastructure so support data sharing with the MCOs so that they can continue to provide effective care management for their Medicaid members. As such twelve State positions have been added to support the Medicaid FFS Pharmacy systems and operational activities.

Finance and Rate Setting: Finance and Rate Setting within OHIP is responsible for projecting and monitoring the Medicaid Drug Cap. In addition, and important to the fiscal management of the pharmacy benefit, DFRS is responsible for administering the Pharmacy Rebate Program through which Medicaid currently receives over \$2 billion dollars in manufacturer rebates to offset program costs, an amount that is expected to increase with the Carveout as detailed in Table 1 below.

The transition of the pharmacy benefit to FFS means that the State, as opposed to the managed care plans, will bear full responsibility for the financial management of the

Medicaid pharmacy program. As such, four positions will be added to DFRS and a dedicated unit will be created, charged with overseeing and leading financially based operations and processes within the Medicaid Pharmacy program. This will ensure adequate resources are in place to conduct timely analyses of spending and rebates.

Implementation Timeline of the Pharmacy Carveout Amendment

Communication about the transition of the pharmacy benefit to FFS will be done by both NYS DOH and the MCOs and will be accomplished through a variety of methods including recurring stakeholder meetings letters and [Medicaid Update](#) articles. Additional details regarding the stakeholder meetings can be found in the "[Public Notice, Compliance and Documentation Section](#)" of this document.

The State has provided detailed and continuously updated charts to give additional context and information related to the New York State Department of Health's (NYS DOH) transition and communication activities of the Pharmacy Carveout from Managed Care to Fee-For-Service as well as the roles and responsibilities of the State (Department of Health, Office of Health Insurance Programs), MCOs, and FFS Pharmacy Contractors in the post-transition phase of the carveout. These transition and communication activities and roles and responsibilities can be found at https://health.ny.gov/health_care/medicaid/redesign/mrt2/pharmacy_carve_out/docs/rx_carve_out_activities_timeline.pdf and https://health.ny.gov/health_care/medicaid/redesign/mrt2/pharmacy_carve_out/docs/rx_carve_out_roles.pdf, respectively.

Transition Strategy: SFY 2019-20 has been established as the year for planning and implementation, guided by the following principles:

- **Continuity:** Ensure members are provided with continued access to needed medications and supplies with minimal impact. Comparison of FFS pharmacy claims and Medicaid Managed Care pharmacy claim encounters will inform transition strategy.
- **Communication:** Maintain communication with stakeholders (e.g. providers, patient advocates, and MCOs) through recurring stakeholder meetings and the posting of pertinent information on the Carveout on the DOH website, which may be accessed at the following website: https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/pharmacy_carve_out/
- **Oversight:** Utilize post-implementation processes that ensure appropriate oversight, issue identification, tracking and resolution.

DOH has worked closely with MCOs and other stakeholders including agencies such as the Office of the Medicaid Inspector General (OMIG) concerning implementation-related decisions and activities such as provider and pharmacy communications and data sharing specifications for health plans so that they can continue to maintain all activities necessary for their members' care coordination as well as activities to identify Fraud Waste and Abuse. The focus has been to limit member and provider impact through a comprehensive analysis of current utilization of pharmacy services and the implementation of transition and communication strategies that will smooth the transition. DOH has established several stakeholder groups including Managed Care Plans, a

340B advisory group, and all-stakeholder meetings, that meet on a recurring basis (further discussed below), and whose feedback has informed the implementation.

All individuals currently receiving pharmacy benefits provided by 16 managed care organizations will continue to have access to needed medications when the benefit is transitioned to FFS on or after April 1, 2021. This will be accomplished through a data driven transition strategy that addresses formulary differences ahead of the effective date through targeted communication and outreach activities. There will also be a transition period from on or after April 1, 2021 through June 30, 2021. During this period, members will be provided with a one-time, temporary fill for medications that would normally require prior authorization under the FFS Preferred Drug Program (PDP). This allows additional time for prescription-related alerts and communication to prescribers to either seek prior authorization or change to a drug, which does not require prior authorization. Additionally, NY State will honor prior authorizations already provided by the MCOs.

Fiscal Implications of the Pharmacy Carveout Amendment

The approximate caseload impact is 4.4 million members currently receiving this benefit through Managed Care that will be carved out to Fee-For-Service. The projected impact of this carveout for DY23 is approximately \$6.3B. The transition of the pharmacy benefit from managed care to FFS is projected to save the State approximately \$87.3M annually beginning in State Fiscal Year (SFY) 2021-22. The elements of the projected savings in SFY 2021-22, include but are not limited to the following factors:

- Additional federal and State supplemental drug rebates resulting from a shift of drug utilization from the Managed Care (MC) delivery system to the Fee-For-Service (FFS) delivery system under a uniform preferred drug list, which will increase leverage when negotiating with drug manufacturers.
- Reduction of administrative costs and non-claim components of spending, including the costs associated to administrative functions of multiple pharmacy benefits managers used by MCOs as well as taxes and surplus funded in MC premiums; and
- Savings on 340B drugs from reimbursement of actual acquisition cost, which is the federally required reimbursement for 340B drugs in FFS. The \$87.3M in State share savings assumes that less than 50% of the 340B savings will be realized in the SFY 2021-22.
- In addition, the State share savings projection is based on current FFS reimbursement methodology, which includes a \$10.08 professional dispensing fee.

OHIP required one year (that being the current state fiscal year) to prepare for the transition due to the scope of the programmatic and operational activities that need to take place to transition the pharmacy benefits for over 5 million Medicaid Managed Care members to FFS. Investments in staffing and systems as previously explained, are necessary to accommodate the influx of managed care pharmacy utilization, which is five times the size of the current FFS utilization. Table 1 below illustrates the expected volume increases associated with the transition to FFS that will occur on or after April 1, 2021, Table 2 depicts the fiscal summary of the carveout, and savings generated, which are the results of net investments in staffing and systems.

Additionally, administrative costs are a critical component to financial plan budget savings. Administrative costs that are included within the current managed care capitation rates along with the level of spread pricing included within the managed care reimbursement allows for MCOs and PBMs to realize a profit when administering the pharmacy benefit. Administrative costs paid to managed care plans to administer the Medicaid pharmacy benefit were \$285 million in 2019. By comparison, the Department administration of the functions, including the cost of the additional staff, is \$43 million (of which \$22.5M are State only costs) Although the number of Medicaid members currently served by the Medicaid FFS pharmacy program is relatively small compared to the number of members receiving their pharmacy benefits through a managed care plan, some portion of the administrative overhead cost associated with running the FFS program are already being incurred by the Medicaid program, which enables DOH to replicate this function and manage this benefit for over 6 million additional Medicaid beneficiaries at a relatively minimal marginal cost. Details on the administrative savings associated with the FFS Pharmacy Carveout are shown in the table below.

Table 1: Projected Volume Increases – Pharmacy Transition to FFS

Projected Volume Increases – Pharmacy Transition from Managed Care to FFS	FFS Today	FFS 4/1/2021	Percentage Increase
Members	1.5M	6.6M ¹	340%
Total Annual Gross Spend	\$785M	\$7.4B	843%
Annual Claims Transactions	26.6M	150M	464%
Annual Paid Claims	12M	90M	650%
Annual Prior Authorizations	120,876	906,570 ²	650%
Federal and Supplemental Rebates	\$700M	\$3.6B	429%
Rebates as a % of Total Pharmacy Spend	50.92%	57.92% ³	7%
<p><u>Notes:</u></p> <p>1: Source: September 2020 NYS OHIP Medicaid Monthly Enrollment Report</p> <p>2: Based on current ratio of prior authorizations to paid claims</p> <p>3: Based on SFY 2021-22 Savings Target of \$87.3M (State Share)</p>			

Table 2: Pharmacy Carveout Fiscal Summary (SFY 2020-21 Enacted Budget)

Key Drivers / Component	Managed Care	FFS	Cost/(Savings)
<u>Claims Repricing (includes rebates)</u>			

Key Drivers / Component	Managed Care	FFS	Cost/(Savings)
Ingredient Cost ⁵	\$6,066M	\$5,558M	(\$508M)
Dispensing Fee ⁶	\$32M	\$637M	\$605M
Net Change in Reimbursement Cost	\$6,098M	\$6,195M	\$97M
Administrative Costs			
Current Admin (Including Taxes & Surplus) ⁷	\$285M	-	(\$285M)
New Admin (Including New Staff & Contract Costs) ⁸	-	\$43M	\$43M
Net Change in Admin Spend	\$285M	\$43M	(\$242M)
Rebates			
Current Federal & Supplemental Rebates ⁹	(\$3,357M)	(\$3,219M)	\$138M
New Federal & Supplemental Rebates ¹⁰	-	(\$419M)	(\$419M)
Net Change in Rebates	(\$3,357M)	(\$3,638M)	(\$281M)
Other Adjustments			
340B Reinvestment ¹¹	-	\$102M	\$102M
Risk Margin ¹²	-	\$89M	\$89M

⁵ Assumes FFS Reimbursement logic to reprice ingredient cost for managed care claims (Source: MDW SFY 2018-19 claims). Incremental trend of 4% applied to both MC and FFS spend to account for SFY 2020-21 Benefit Period (Source: Deloitte). The repricing of Managed Care claims using the FFS reimbursement logic includes \$166 million in savings (gross) associated with 340B reimbursement. In addition, the repricing assumes increased FFS utilization of non-preferred drugs due to the impact of prescriber prevails; and applies the savings from the SFY 2019-20 budget action to eliminate spread pricing in MC as a cost to FFS (because these savings were achieved prior to 4/1/21 carveout).

⁶ Assumes \$.50 Dispensing Fee for Managed Care claims (Source: Plan Contracts); and the current \$10.08 Dispensing for FFS. Includes dispensing fee associated with 340B claims.

⁷ Assumes MMC Admin reduction (3.07%), as well as relevant taxes (.84%) and surplus (1%) in managed care premiums. Does not include the ACA tax. (Source: Deloitte)

⁸ New FFS Admin costs assumes 29 new FTE's (\$4M) and additional funding for existing pharmacy vendor contracts (\$39M) (Source: DOH).

⁹ Assumes the same federal rebate dollars for Managed Care and FFS; Also, assumes reduced supplemental rebates in FFS compared to MC due to drug mix of current FFS SR agreements. These rebates assumptions do not factor drug mix or rebate changes associated with a Statewide PDL.

¹⁰ Includes a 6% increase in federal rebates due to drug mix changes under the FFS Preferred Drug List (PDL). Also assumes that FFS can achieve a 1% increase in supplemental rebates due to additional negotiating leverage under the NPMI and Medicaid Drug Cap. (Source: Magellan)

¹¹ The value of the 340B reinvestment will be permanently reinvested to 340B Covered Entities beginning in SFY 2021-22 and each year thereafter.

¹² Assumes a 1.5% risk margin (on repriced FFS spend) to account for the transfer of risk from Managed Care to FFS where the State would bear the risk for blockbuster drugs in the pipeline.

Key Drivers / Component	Managed Care	FFS	Cost/(Savings)
Net Change in Other Adjustments	-	\$201M	\$201M
Net Spend (Gross)	\$3,026M	\$2,792M	(\$235M)
Net Spend (State Share) ¹³	\$1,123M	\$1,036M	(\$87M)

Public Notice Compliance and Documentation of the Pharmacy Carveout Amendment

The State scheduled public hearings on January 21, 2021 and January 27, 2021, which were conducted through real-time, audio-visual webinars on WEBEX and recorded and provided an opportunity for the public to offer comment, consistent with flexibilities granted by CMS during the COVID-19 federal public health emergency period. This amendment was further provided to the public as part of the larger extension request on December 16, 2020.

The State has also conducted extensive stakeholder engagement efforts throughout the amendment process across three different groups. First, monthly stakeholder meetings were held in service of providing all interested stakeholders with updates, facilitate a Q&A session, and incorporate feedback into the workplan as needed. Second, bi-weekly meetings with the MCOs were held to provide a recurring forum for DOH and the Medicaid Managed Care plans to address specific topics that require consensus or clarification, in order to progress with the transition. Finally, as part of the legislation to transition the pharmacy benefit out of MMMC to FFS, the State convened a 340B Advisory Group in order to develop non-binding recommendations to achieve savings and align with the goals of the carveout amendment.

In addition, the State has established a [web page](#) specific to the Pharmacy Carveout, to keep stakeholders informed of the discussion topics at the various stakeholder meetings, and it also contains a comprehensive FAQ document which can be accessed using this link

https://health.ny.gov/health_care/medicaid/redesign/mrt2/pharmacy_carve_out/docs/pharm_carve_out_faq.pdf.

Tribal Notification of the Pharmacy Carveout Amendment

The State provided tribal notification of this amendment as part of the larger extension request on December 16, 2020.

Waiver and Expenditure Authorities

The State requests to continue following waivers and expenditure authorities to operate the demonstration, as outlined below.

Waiver Authorities Requested

¹³ Assumes State Share costs @ 37.10% of Gross costs.

Waiver Authority	Reason and Use of Waiver Authority
1. Extension of Existing Demonstration Section 1115(a)	a. To the extent necessary to enable the State to extend the existing waiver for an additional three years.
2. Statewide Section 1902(a)(1)	a. To permit New York to geographically phase in the Managed Long-Term Care (MLTC) program and the Health and Recovery Plans (HARP) and to phase in Behavioral Health (BH) Home and Community Based Services (HCBS) into HIV Special Needs Plans (HIV SNP).
3. Comparability Section 1902(a)(10), section 1902(a)(17)	a. To enable New York to apply a more liberal income standard for individuals who are deinstitutionalized and receive HCBS through the managed long-term care program than for other individuals receiving community-based long-term care. b. To the extent necessary to permit New York to waive cost sharing for non-drug benefit cost sharing imposed under the Medicaid State Plan for members enrolled in the Mainstream Medicaid Managed Care Plan (MMMC) – including Health and Recovery Plans (HARP) and HIV SNPs – and who are not otherwise exempt from cost sharing in §447.56(a)(1). c. Family of One Non-1915 Children, or “Fo1 Children” – To allow the State to target eligibility to, and impose a participation capacity limit on, medically needy children under age 21 who are otherwise described in 42 CFR §435.308 of the regulations who: 1) receive Health Home Comprehensive Care Management under the State Plan in replacement of the case management services such individuals formerly received through participation in New York’s NY #.4125 1915(c) waiver and who no longer participate in such waiver due to the elimination of the case management services, but who continue to meet the targeting criteria, risk factors, and clinical eligibility standard for such waiver; and 2) receive HCBS 1915(c) services who meet the risk factors, targeting criteria, and clinical eligibility standard for the above-identified 1915(c) waiver. Individuals who meet either targeting classification will have excluded from their financial eligibility determination the income and resources of third parties whose income and resources could otherwise be deemed available under 42 CFR § 435.602(a)(2)(i). Such individuals will also have their income and resources compared to the medically needy income level (MNIL) and resource standard for a single individual, as described in New York’s State Medicaid Plan.

Waiver Authority	Reason and Use of Waiver Authority
4. Amount, Duration & Scope Section 1902(a)(10)(B)	a. To enable New York to provide behavioral health (BH) HCBS services, whether furnished as a State Plan benefit or as a demonstration benefit to targeted populations that may not be consistent with the targeting authorized under the approved State Plan, in amount, duration and scope that exceeds those available to eligible individuals not in those targeted populations.
5. Freedom of Choice Section 1902(a)(23)(A)	a. To the extent necessary to enable New York to require members to enroll in Managed Care Organizations, including the Mainstream Medicaid Managed Care (MMMC), and MLTC (excluding individuals designated as “Long-Term Nursing Home Stays”) and HARPs programs in order to obtain benefits offered by those plans. Members shall retain freedom of choice of family planning providers.
6. Reasonable Promptness Section 1902(a)(8)	a. To enable the State to limit the number of medically needy Fo1 Children not otherwise enrolled in the Children’s 1915(c) waiver.
<i>Title XIX Requirements Not Applicable to Self-Direction Pilot Program (see Expenditure Authority 6, “Self-Direction Pilot”)</i>	
7. Direct Payment to Providers Section 1902(a)(32)	a. To the extent necessary to permit the State to make payments to members enrolled in the Self Direction Pilot Program to the extent that such funds are used to obtain self-directed HCBS LTC services and supports.

The State is also requesting the use of the same expenditure authorities as approved in the existing 1115 demonstration, except for expenditure authority to provide incentive payments and planning grants for the previously numbered Expenditure Authority 7, Delivery System Incentive Reform Payment (DSRIP) program, which are expiring in March of 2020, or previously numbered Expenditure Authority 6, Designated State Health Program Funding, which expired in 2020.

While the State is not requesting the use of the DSRIP Expenditure Authority, CMS provided additional authority to provide DSRIP administration and a schedule of PPS payments until 2021. This additional authority is not part of this extension request.

The State requests the continuation of the remaining expenditure authorities and are as follows:

Expenditure Authorities Requested

Expenditure Authority	Reason and Use of Expenditure Authority
<p>1. Demonstration-Eligible Populations.</p>	<p>Expenditures for healthcare related costs for the following populations that are not otherwise eligible under the Medicaid State Plan:</p> <ul style="list-style-type: none"> a. Demonstration Population 2 (TANF Adult). Temporary Assistance for Needy Families (TANF) Recipients. Expenditures for health care related costs for low- income adults enrolled in TANF. These individuals are exempt from receiving a MAGI determination in accordance with §1902(e)(14)(D)(i)(I) of the Act. b. Demonstration Population 9 (HCBS Expansion). Individuals who are not otherwise eligible, are receiving HCBS, and who are determined to be medically needy based on New York’s medically needy income level, after application of community spouse and spousal impoverishment eligibility and post-eligibility rules consistent with section 1924 of the Act. c. Demonstration Population 10 (Institution to Community). Expenditures for health care related costs for individuals moved from institutional nursing facility settings to community settings for long term services and supports who would not otherwise be eligible based on income, but whose income does not exceed the income standard described in STC 4(c) of section IV, and who receive services through the managed long term care program under the demonstration. d. Included in Demonstration Population 12 (Fo1 Children)- Medically needy children Fo1 Demonstration children under age 21 with a waiver of 1902(a)(10)(C)(i)(III) who meet the targeting criteria, risk factors, and clinical eligibility standard for #NY.4125 waiver including ICF, NF, or Hospital Level of Care (LOC) who are not otherwise enrolled in the Children’s 1915(c).
<p>2. Twelve-Month Continuous Eligibility Period.</p>	<ul style="list-style-type: none"> a. Expenditures for health care related costs for individuals who have been determined eligible under groups specified in Table 1 of STC 3 in Section IV for continued benefits during any periods within a twelve-month eligibility period when these individuals would be found ineligible if subject to redetermination. This authority includes providing continuous coverage for the Adult Group determined financially eligible using Modified Adjusted Gross Income (MAGI) based eligibility methods. For expenditures related to the Adult Group, specifically, the State shall make a downward adjustment of 2.6 percent in claimed expenditures for federal matching at the enhanced federal matching rate and will instead claim those expenditures at the regular matching rate.

Expenditure Authority	Reason and Use of Expenditure Authority
3. Facilitated Enrollment Services.	a. Expenditures for enrollment assistance services provided by managed care organizations (MCO), the costs for which are included in the claimed MCO capitation rates.
4. Demonstration Services for Behavioral Health Provided under Mainstream Medicaid Managed Care (MMMC).	a. Expenditures for provision of residential addiction services, crisis intervention and licensed behavioral health practitioner services to MMMC members only and are not provided under the State Plan [Demonstration Services 9].
5. Targeted Behavioral Health (BH) HCBS Services.	a. Expenditures for the provision of BH HCBS services under Health and Recovery Plans (HARP) and HIV Special Needs Plans (SNP) that are not otherwise available under the approved State Plan [Demonstration Services 8].
6. Self-Direction Pilot.	a. Expenditures to allow the State to make self-direction services available to HARP and HIV/SNP members receiving BH HCBS or children meeting targeting criteria for the Children’s 1915(c) Waiver and in MMMC receiving HCBS under the Children’s Waiver. The program will be in effect from January 1, 2017 through March 31, 2021 [Demonstration Services 8].

Budget Neutrality

The State is seeking CMS approval to extend the vital programs authorized under its existing 1115 waiver authority for a period of three years to allow the State and its stakeholders to develop a renewal proposal that addresses existing and emerging needs identified through the State’s MRT II process and from the collective experiences gained from addressing COVID-19. In addition, this proposal includes two carveouts: 1) moving the NEMT benefit for MLTC plan members from Managed Care into FFS, and 2) moving the pharmacy benefit from Managed Care to FFS.

As required for all 1115 waiver amendment applications, the State has prepared the necessary Budget Neutrality documentation in this section. We also identified in the above sections, the fiscal and programmatic implications of the two proposed amendments as well as the overall underlying extension proposal. Through this exercise, the State has identified several considerations for discussion with CMS as part of the review process.

Considerations Impacting Caseloads & Costs

The purpose of this extension request was to maintain existing programs with minor modifications. **Accordingly, we do not expect caseloads and costs to significantly change due to this extension proposal.** However, the State anticipates caseloads and costs may be impacted by the following factors outside of the State’s control;

COVID-19: The pandemic has been challenging for many New Yorkers and New York businesses. According to a September 2020 report from the New York State Comptroller, 1.9 million jobs were lost in March-April 2020, with only 28% of those jobs regained statewide.¹⁴

¹⁴ Office of New York State Comptroller. “New York’s Economy and Finances in the COVID-19 Era”, September 2, 2020. Available online at: <https://www.osc.state.ny.us/reports/covid-19-september-2-2020#prior>

Small businesses were hit especially hard, and New York currently ranks second nationally in jobs lost behind California.¹⁵ While not everyone will lose employer-sponsored coverage and choose to seek Medicaid coverage, even a small percentage of 1.9 million would increase projected caseloads substantially. While we do not anticipate caseloads to change significantly due to this proposal, due to COVID-19, a September 2020 report reported that the State has seen total caseloads increase by approximately 600,000 beneficiaries since the declaration of the Public Health Emergency in March.¹⁶

Minimum Wage Increase: The State passed legislation in 2016 seeking to increase the State's minimum wage to \$15 per hour by December 31, 2021, using a phased regional approach.¹⁷ This increase impacts a number of health care providers, resulting in increases in Home Care MLTC and MMMC cost, as well as MLTC Reconciliation. The projected total computable dollars for DY23 do not currently include an adjustment for future minimum wage increases that are not in the historical base experience.

In addition to these considerations to the budget neutrality calculations of the State's extension proposal, the anticipated caseloads and projected impacts for both amendments can be seen below.

Anticipated Waiver Cost & Caseloads

This extension proposal is budget neutral and does not request any additional federal funding. It instead seeks to extend existing waiver authorities and programs and does not include a funding request. This 1115 extension proposal is expected to have no or nominal impact on annual Medicaid enrollment.

Based on an analysis of available Budget Neutrality quarterly reporting data that is currently available and previously submitted to CMS, the NYS 1115 MRT Waiver has met requirements for Budget Neutrality as detailed in the STCs Section IX. General Financial Requirements.

Projected waiver expenditures for the renewal period were calculated in adherence with CMS Budget Neutrality and Rebasing guidance as detailed in SMD # 18-009 issued August 22, 2018. Estimated Without Waiver baseline PMPMs were calculated based on claims data from the five-year period 4/1/15 - 3/31/20. The programmatic aspects of the demonstration as detailed in this extension application remain unchanged apart from the proposed Pharmacy and MLTC Transportation benefits carveouts. Therefore, as neither carveout has an impact on eligibility criteria, the State projects no change to enrollment in this renewal.

The State anticipates a total caseload across the extension proposal to be 4.9M members for DY23, inclusive of the recent increases due to COVID-19. The anticipated total computable cost for this caseload is \$53.9B. The historical caseloads and costs for the current demonstration period are detailed below in Exhibit 1, and the projected caseloads and costs are provided below in Exhibit 2. The full budget neutrality workbooks can be found in Attachment E.

¹⁵ Office of New York State Comptroller. "New York's Economy and Finances in the COVID-19 Era", October 14, 2020. Available online at: <https://www.osc.state.ny.us/reports/covid-19-october-14-2020>

¹⁶ New York State Department of Health Enrollment by County, September 2020
https://www.health.ny.gov/health_care/medicaid/enrollment/docs/by_resident_co/2020/sept-2020.pdf

¹⁷ <https://labor.ny.gov/workerprotection/laborstandards/workprot/minwage.shtm>

Exhibit 1: Historical Caseloads and Costs (in total computable dollars) *

Demonstration Year	DY18	DY19	DY20	DY21*	DY22*
Historical Caseload	5,883,962	5,860,033	6,202,557	5,051,990	5,296,895
Historical Cost	\$47,739,999,038	\$44,488,018,228	\$50,916,108,128	\$52,379,623,963	\$47,970,320,886

*Includes projected data.

**Caseload is based on total Member Months reported (CY2020 Q4 submission of the Budget Neutrality Reporting Tool, MemMon Total Tab).

**Total historical cost figures as reported in the CY2020 Q4 submission of the Budget Neutrality Reporting Tool, WW Spending Total Tab.

Exhibit 2: Projected Caseloads and Costs (in total computable dollars) *

Demonstration Year	DY23	DY24	DY25
Projected Caseload of the Demonstration	4.7 million	4.7 million	4.7 million
<i>MLTC Transportation Carveout Only</i>	0	n/a	n/a
<i>Pharmacy Carveout Only</i>	0	n/a	n/a
Projected Cost	\$53.9 billion	\$56.2 billion	\$ 58.5 billion
<i>MLTC Transportation Carveout Only</i>	\$0.292 billion	n/a	n/a
<i>Pharmacy Carveout Only**</i>	\$6.282 billion	n/a	n/a

*The numbers above represent projected caseload and costs for the entire waiver proposal, as well as specific details related to the two proposed amendments.

**MLTC Transportation and Pharmacy Carveouts will not impact membership as neither carveout affects member eligibility.

Demonstration Evaluations To-Date

Below is a summary of waiver evaluation efforts to date. While the pandemic has severely impacted evaluation timelines, the State has worked with its evaluators across the various programs to develop preliminary evaluation reports, as well as summarized reports from external quality review organizations.

Summaries of External Quality Review Organization Reports (EQROs)

In compliance with federal regulations, the State contracts with IPRO to conduct the annual External Quality Review (“EQR”) of the MCOs certified to provide Medicaid coverage in the State. The State is dedicated to providing and maintaining the highest quality of care for enrollees in managed care organizations, The NYSDOH’s OHIP and Office of Quality and Patient Safety (“OQPS”) collaboratively employ an ongoing strategy to improve the quality of care provided to plan enrollees, to ensure the accountability of these plans, and to maintain the continuity of care to the public.

This report serves as an aggregate of the detailed information included in the MCO-specific technical reports. In accordance with federal regulations, these reports summarize the results of the 2017 EQR to evaluate access to, timeliness of, and quality of care provided to NYS Medicaid beneficiaries. Mandatory EQR-related activities (as per Federal Regulation 42 CFR § 438.358) reported include validation of performance improvement projects (“PIPs”), validation of MCO-reported and NYSDOH-calculated performance measures, and review for MCO compliance with NYSDOH structure and operation standards. Optional EQR-related activities (as per Federal Regulation 42 CFR § 438.358) reported include administration of a consumer survey of quality of care (“CAHPS®”) by an NCQA-certified survey vendor and technical

assistance by the NYS EQRO to MCOs regarding PIPs and reporting performance measures. Other data incorporated to provide additional background on the MCOs include the following: MCO corporate profiles, enrollment data, provider network information, encounter data summaries, PQI/compliance/satisfaction/quality points and incentive, and deficiencies and citations summaries.¹⁸

The report is organized into the following domains: MCO Corporate Profiles, Enrollment and Provider Network, Utilization, Performance Indicators, and Structure and Operation Standards. Although the technical reports focus primarily on Medicaid data, selected sections of the individual, MCO-specific reports also include data from the MCOs' Child Health Plus ("CHP") and Commercial product lines. The CHP product line is the NYS version of the federal Child Health Insurance Program ("CHIP"), which provides health coverage to eligible children in families with incomes too high to qualify for Medicaid, but who cannot afford private coverage. CHP data are part of the Medicaid managed care data sets used in this report. For some measures, including QARR 2018 (MY 2017), aggregate rates are used, which represent the combined population of the Medicaid and CHP product lines. These measures are noted as such. Additionally, when available and appropriate, the MCOs' data are compared with statewide benchmarks. Unless otherwise noted, when benchmarks are utilized for rates other than HEDIS®/QARR or CAHPS®, comparative statements are based on differences determined by standard deviations: a difference of one standard deviation is used to determine rates that are higher or lower than the statewide average.

Section VII of the individual, MCO-specific technical reports provides an assessment of the MCOs' strengths and opportunities for improvement in the areas of accessibility, timeliness, and quality of services. For areas in which the MCOs have opportunities for improvement, recommendations for improving the quality of the MCOs' health care services are provided. To achieve full compliance with federal regulations, this section also includes an assessment of the degree to which the MCOs effectively addressed the recommendations for quality improvement made by the NYS EQRO in the previous year's EQR report. The MCOs were given the opportunity to describe current or proposed interventions that address areas of concern, as well as an opportunity to explain areas that the MCOs did not feel were within their ability to improve. The responses by the MCOs are appended to this section of the individual, MCO-specific reports.

In an effort to provide the most consistent presentation of this varied information, the technical reports are prepared based on data for the most current calendar year available. This report includes data from Reporting Year 2017. The entirety of the report can be found on the New York MRT website by accessing this link: https://www.health.ny.gov/statistics/health_care/managed_care/plans/reports/docs/all_plan_summary.pdf.

Preliminary Interim Evaluation Reports

As required under the terms and conditions of the current MRT waiver, New York engaged independent research organizations to evaluate the performance of the Children's Design, the Self-Directed Care Pilot, HARP program, and evaluation of components of the MRT waiver. The State contracted the RAND Corporation to conduct independent evaluations for the aforementioned components of the demonstration which can be found as attachments A-D.

¹⁸ External Appeals data are reported in the Full EQR Technical Report prepared every third year.

Where preliminary results are available in the 1115 evaluation, results show encouraging signs of progress towards achieving the State's goals. Because of significant delays borne out of the State's need to pivot towards COVID-19 emergency response, subsequent findings and data will provide a fuller picture of the demonstration's progress towards achieving success for its goals. Per written guidance from CMS provided to the State on July 23, 2020 concerning the interference of COVID-19 with delivering full interim reports, the State has provided an explanation of the resultant gaps and the evaluation efforts the State has made thus far, as well as a timeline to complete the full interim evaluation for each of the reports attached. The preliminary interim evaluation reports can be found as Attachments A-D.

Children's Design Preliminary Interim Evaluation

As part of the ongoing redesign efforts, the State has developed amendments to the 1115 MRT waiver and the 1915(c) Children's Waiver (collectively known as the "Children's Redesign" that aims to consolidate and streamline care for children and youth under the age of 21 who have needs of Behavioral Health (BH) and Home and Community Based Services ("HCBS"). This preliminary report provides an overview of the approved and planned evaluation, that was significantly impacted by COVID-19, which required not only the State DOH personnel to shift attention, resources and priorities, but also the entire health care system in New York. This shift caused contract execution and data access delays which prevented adequate time for analysis and development of findings. As a result of these delays, the Children's independent evaluation timeline was significantly impacted and therefore no preliminary interim findings are available at this time. New York State contracted with the RAND Corporation in 2020 to conduct the Children's independent evaluation. The preliminary Children's independent evaluation report, which can be found in Attachment A, contains an explanation of progress towards findings to date, as well as a timeline for analysis and presentation of these findings, with an anticipated date of Spring 2021.

Health and Recovery Plan Preliminary Interim Evaluation

With the goal of improving access to and quality of health care for the Medicaid population through a managed care delivery system, this Demonstration included reforms specifically targeted to beneficiaries with behavioral health ("BH") needs (hereafter, BH Demonstration); one of them is the Health and Recovery Plans ("HARP") program. New York State contracted with the RAND Corporation in 2019 to conduct an independent evaluation of the BH Demonstration programs, including a HARP program evaluation (New York State Department of Health, 2019). Similarly, to the Children's evaluation, this HARP preliminary report provides an overview of the approved and planned evaluation that was significantly impacted by COVID-19, requiring DOH to shift personnel, resources and priorities to respond the pandemic therefore delaying the timeline for completion of this evaluation. As a result of this shift, the independent evaluation timeline was significantly impacted and therefore no preliminary interim findings are available at this time. The preliminary independent evaluation report can be found in Attachment B with an explanation of progress towards findings to date, as well as a timeline for analysis and presentation of these findings, with an anticipated date of Spring 2021 for completion.

Self-Directed Care Preliminary Interim Evaluation

The Self-Directed Care ("SDC") pilot program was implemented as part of the behavioral health (BH) reforms included in the larger Section 1115 Demonstration. In 2019 NYS contracted with the RAND Corporation to conduct an independent evaluation of the SDC pilot program. As with all evaluations, this preliminary report provides an overview of the approved and planned evaluation that was significantly impacted by COVID-19, requiring DOH to shift personnel, resources and priorities to respond the pandemic therefore delaying the timeline for completion

of this evaluation. As a result of this shift, the independent evaluation timeline was significantly impacted and therefore no preliminary interim findings are available at this time. The SDC preliminary independent evaluation report can be found in Attachment C with an explanation of progress towards findings to date, as well as a timeline for analysis and presentation of these findings, with an anticipated date of Spring 2021 for completion.

1115 Preliminary Interim Evaluation

To meet the special terms and conditions specified by the Centers for Medicare and Medicaid Services for the waiver renewal, RAND Corporation was competitively selected as the independent evaluator to assess two components under this 1115 Demonstration Waiver: The Managed Long-Term Care (MLTC) program and the 12-month continuous eligibility and enrollment. This interim evaluation aims to examine if these two programs have achieved the following two goals:

- MLTC: expanding access to long-term services and supports and improving patient safety, quality of care, and consumer satisfaction
- Twelve-month continuous eligibility: reducing enrollment gaps and increasing Medicaid enrollment duration

As with all evaluations, this preliminary report provides an overview of the approved and planned evaluation that was significantly impacted by COVID-19, requiring DOH to shift personnel, resources and priorities to respond the pandemic therefore delaying the timeline for completion of this evaluation. As a result of this shift, 11 out of the 23 research questions in this preliminary report were able to be evaluated or responded to. The 1115 Demonstration preliminary independent evaluation report can be found in Attachment D with an explanation of progress towards findings to date, as well as a timeline for analysis and presentation of these findings, with an anticipated date of Spring 2021 for completion.

Public Notice Compliance and Documentation

In compliance with 42 CFR § 431.408(a), the final rule regarding Review and Approval Process for Section 1115 Demonstrations; Application, Review, and Reporting Process for Waivers for State Innovation, as well as the current STCs regarding the Public Forum requirement, the State certifies that the abbreviated and full public notices for the formal waiver extension were published in the New York State Register on December 16, 2020 with written comments to be received by electronic or written mail by January 15, 2021. A copy of the State Register with the highlighted abbreviated and full public notices can be found in Appendix A.

Due to in-person limitations that social distancing requires, the State did not hold in-person hearings and instead scheduled two virtual public hearings to be held on two separate occasions, on January 21, 2021, and January 27, 2021. The public hearings were broadcast live via WEBEX (accessible via the New York MRT website) and were scheduled to gather feedback and public input on the waiver extension request, as well as afford the public opportunity to comment on the waiver writ large in compliance with Public Forum requirements. All interested speakers were given an opportunity to express their views which were documented and incorporated into the final waiver extension application. All commenters were advised of a five-minute limit per comment to ensure that all public comments were able to be heard. Public comment transcripts, slides, and a recording of the hearings, as well as supporting materials are publicly available on the New York MRT website, which can be accessed using the following link: https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/ext_request/index.htm

Both comment sessions included a current overview of current MRT waiver initiatives as well as a brief summary of New York's Medicaid Redesign Team (MRT) extension application request. After the presentation by NYS DOH staff, commenters, both registered and unregistered were afforded the opportunity to present oral comments, questions, or recommendations to the panel of NYS DOH staff. All comments that were presented during these sessions were made available in a taped recording and transcripts that were posted on the NY MRT website.

The State confirms that it used an electronic mailing list to notify the public of the State's intent to seek a waiver extension on December 16, 2020. The State created a Medicaid Redesign Team Listserv (MRT Listserv) in order to notify interested parties that new information was posted on the MRT website. The notices alerted subscribers to new information available on the MRT website which included: meeting announcements, access to webcasts, meeting materials, updated timelines, press releases and any other information of interest. This listserv was available to the public for email sign-up. Individuals who wished to submit written comments during the aforementioned periods were able to do so by writing an email to 1115waivers@health.ny.gov by including "1115 waiver extension comment" in the subject line.

Public Comment Overview

The State received 721 written comments regarding the extension application, as well as an additional 41 comments received verbally from the virtual hearings from individuals, advocacy groups, community providers, and other stakeholders. Of the 721 written comments received, 702 focused solely on the Pharmacy Carveout, 8 comments addressed the general waiver extension, 6 comments addressed the MLTC Transportation Carveout, and 5 comments were received that addressed multiple subject areas (e.g., a combination of comments related to the Carveouts and the general waiver extension). The majority of comments received regarding the extension application were concerning Pharmacy Carveout amendment, with specific regard to the impact on the 340B program and the impact to 340B "Covered Entities." The State appreciates all of the comments and feedback shared by its stakeholders regarding this waiver extension application. These comments informed the content and approach of the waiver extension and will continue to help shape the State's pursuit of future programmatic initiatives that go beyond this extension and carveout amendments and will be taken under advisement as the State works with CMS to design a larger extension. The current application reflects the importance of stakeholder public comment and the responsiveness of the State to these suggestions. In response to stakeholder comments and questions, the State developed FAQs regarding the overall extension and both the Pharmacy and MLTC Transportation Carveouts. The FAQs can be accessed through the following link:

https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/ext_request/index.htm

Public Comment Themes and State Responses

General Waiver Extension Comments

Regarding the waiver extension proposal (exclusive of the two amendments, whose comments are summarized below), the State received several comments regarding future programmatic initiatives as well as comments supporting the continuation of DSRIP. The State appreciates these comments and recognition of the need to continue systems transformation particularly in light of the COVID-19 pandemic, improving health equity and increasing Community-Based Organization ("CBO") support. Furthermore, the State looks forward to pursuing larger

programmatic initiatives in the future upon approval of this waiver extension application and designing a renewal package that is inclusive of broader transformation needs of the state and its stakeholders. Comments that were not germane and outside of the scope of this waiver extension and the related carveout amendments were not included in this summary.

Pharmacy Carveout Amendment Comments

Over 98% of all comments received during the public comment period on the extension application were regarding the Pharmacy Carveout amendment. While many of these comments supported the overarching goals of the extension application, the majority of comments regarding the Pharmacy Carveout amendment expressed concern regarding the potential for a negative impact on safety-net providers such as Federally Qualified Health Centers (“FQHCs”), Ryan White and Disproportionate Share Hospitals (“DSH”) to use savings from the 340B program to fund gaps in services or care. The State recognizes the importance of the 340B program to safety-net providers, which is reflected in the State’s commitment to reinvest \$102M, in State Fiscal Year (“SFY”) 2021-22 and subsequent years thereafter (subject to federal approval), to directly support covered entities and preserve critical services that are currently funded with 340B revenue. After the Carveout, 340B covered entities will continue to be able to purchase drugs at reduced prices and receive margin on 340B drugs associated with other payors (e.g., Medicare and Commercial Insurers) and Medicaid covered physician administered drugs.

Additional comments regarding the Pharmacy Carveout amendment received were concerned with the State’s ability to accurately capture real-time pharmacy data, which could have a negative impact on care management. The State is providing the MCOs with a daily pharmacy claims file that includes pharmacy claims activity for the prior day. Furthermore, DOH will be providing a set of on-demand reports that support integrated care management and disease management activities, including but not limited to managing members’ chronic diseases, promoting medication adherence, and monitoring adverse reactions. These reports will provide for more timely access to critical data, given that there is a lag for some of the MCOs when loading the daily pharmacy claims file to their data warehouse, and ensure that existing VBP arrangements between MCO’s and providers continue post transition.

The State also received a comment regarding the Pharmacy Carveout amendment’s impact on budget neutrality calculations and that the cost projections may not have captured accurately the savings that would be generated from the Carveout. In developing the fiscal implications and savings assumptions for the Carveout, the State took the following factors into account to ensure accurate capture of Carveout savings:

- Additional federal and State supplemental drug rebates resulting from a shift of drug utilization from the managed care delivery system to the FFS delivery system under a uniform preferred drug list, which will increase leverage when negotiating with drug manufacturers.
- Reduction of administrative costs and non-claim components of spending, including the costs associated to administrative functions of multiple pharmacy benefits managers used by MCOs as well as taxes and surplus funded in managed care premiums; and
- Savings on 340B drugs from reimbursement of actual acquisition cost, which is the federally required reimbursement for 340B drugs in FFS. The \$87.3M in State share savings assumes that approximately 60% of the 340B savings will be realized in the SFY 2021-22.

- In addition, the State share savings projection is based on current FFS reimbursement methodology, which includes a \$10.08 professional dispensing fee.

In response to stakeholder feedback, the State has largely retained the Pharmacy Carveout amendment as written and has clarified that the amendment is pursuing technical corrections to the STCs to reflect the shift in authority from the 1115 waiver to the State Plan in how the benefit is administered and how federal match is claimed.

MLTC Transportation Carveout Amendment Comments

Comments provided regarding the MLTC Transportation Carveout amendment were primarily focused on the State's transition to a broker model as well as concerns regarding this shift to a single broker and away from health plans. The State developed this amendment based on MRT II recommendations through its stakeholder process, and appreciates the concern raised regarding the shift to a broker model. Through this amendment, the management of the trips (e.g., scheduling, assignment of the most appropriate mode, prior authorization) will be performed by a professional transportation management broker—either statewide or in certain regions of the State. Such broker(s) will be procured by the State in a risk-based arrangement(s). This change in transportation management streamlines and centralizes the benefit for Medicaid members, and adheres to the principles of value-based care - payment to improve outcomes.

Some commenters further expressed concern about potential benefit disruption and confusion among members as a result of this carveout. This carveout is intended to shift the delivery system of the benefit from MLTC to FFS with minimal to no disruptive effects on the provision of NEMT transportation services to members.

Tribal Notification

New York State is home to nine federally recognized Tribal Nations: Tonawanda, Tuscarora, Seneca, Onondaga, St. Regis Mohawk, Oneida, Cayuga, Shinnecock, Unkechaug (Poospatuck).¹⁹

In accordance with 42 CFR § 431.408(b), on December 16, 2020 Tribal letters were sent out. Tribes were provided at least 30 days to comment. The Department of Health advised the above-mentioned tribes and associated tribal health centers by letter of the intent to request a three-year extension request (refer to Appendix B, Tribal Letter). During this notice period, no comments were received from any of the aforementioned tribes.

¹⁹ https://www.health.ny.gov/community/american_indian_nation/

Appendix A– Compliance with Public Comment Circulation Requirements

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

PUBLIC NOTICE

GreenNY Interagency Committee on Sustainability and Green Procurement

Pursuant to Executive Order No. 4: Establishing a State Green Procurement and Agency Sustainability Program, April 24, 2008 ("EO 4"), the Interagency Committee on Sustainability and Green Procurement hereby gives public notice of the following:

Four green specifications were tentatively approved by the Interagency Committee on Sustainability and Green Procurement and have been posted for public comment.

These include new or amended specifications on the following topics:

Apparel and Textile Materials, Coating Removal Products, Garment Cleaning, and Laundry Detergent.

All of the above specifications are available for viewing at: <https://ogs.ny.gov/greeny/executive-order-4-tentatively-approved-specifications>

Information regarding the green specification approval process is also available at the above link.

Comments may be submitted electronically to: GreenEO4@ogs.ny.gov

Comments from the public regarding the tentatively approved specifications will be accepted until Friday, March 19, 2021.

PUBLIC NOTICE

Department of Health

MRT 1115 Waiver Extension Request

In compliance with 42 CFR 431.408(a)(2)(ii) as well as the current MRT Waiver Special Terms and Conditions regarding the annual Public Forum requirement, the Department of Health is pleased to announce that it will conduct two virtual public hearings/public forums, to provide an overview of the State's 1115 waiver extension request and allow members of the public to provide comments. This notice

further serves to open the 30-day public comment period which will close on Friday, January 15, 2021. In addition to this 30-day comment period where the public will be afforded the opportunity to provide written comments, the Department of Health will be hosting two virtual public hearings during which the public may provide oral comments. Any updates related to the public hearings and forum will be sent via the MRT ListServ.

The New York State Department of Health ("NYSDOH") is requesting a three-year extension of the existing Section 1115 Medicaid Redesign Team ("MRT") waiver demonstration, which is set to expire on March 31, 2021. This extension proposal seeks an extension of all current programs and authorities in the State's current waiver demonstration, with the following two programmatic amendments:

- Carveout of the Non-Emergency Medical Transportation (NEMT) Benefit for Managed Long-Term Care Members to Fee-For-Service: The goals of this amendment request are as follows:

- Improve administrative simplification by creating a consistently managed transportation benefit and removing the benefit from the MRT Waiver;

- Reduce cost-risk by shifting the broker arrangement to a risk-based arrangement; and

- Create a larger pool of members by combining all members, except PACE for which the transportation benefit must be managed by the PACE Organization under federal rules, for brokers to provide NEMT service to.

- Carveout of Pharmacy Benefits from Medicaid Managed Care to Fee-For-Service. The goals of this amendment request are as follows:

- Provide the State with full visibility into prescription drug costs;

- Centralize and leverage negotiation power;

- Provide a single drug formulary with standardized utilization management protocols; and

- Address the growth of the 340B program and associated reductions in State rebate revenue.

These amendments were developed by the State's Medicaid Redesign Team II (MRT II), and are part of a larger, more comprehensive set of reforms that the State is planning to innovate and improve the Medicaid program. MRT II brought together a comprehensive set of stakeholders to collectively find solutions that improve the delivery of care and outcomes for Medicaid members and contain spending growth in the Medicaid program.

The two virtual public hearing/public forum meetings will be held as follows:

1. First Public Hearing/Public Forum

a. Thursday, January 21, 2021 from 1-4pm.

b. Pre-registration is required for anyone wishing to provide oral comment using this link: <https://meetny.webex.com/meetny/onstage/g.php?MTID=eafaac7a7545ec85e7a621bdc99cdb98d>.

c. Individuals who wish to provide comment will need to register with an "SP" in front of their name (ex: SP Jane Doe) and must email 1115waivers@health.ny.gov no later than Wednesday, January 20, 2021 at 4pm to confirm registration.

d. Individuals will speak in their order of registration. We kindly request that all comments be limited to five minutes per presenter to ensure that all public comments may be heard.

2. Second Public Hearing/Public Forum

a. Wednesday, January 27, 2021 from 1-4pm.

b. Pre-registration is required for anyone wishing to provide oral comment using this link: <https://meetny.webex.com/meetny/onstage/g.php?MTID=eb77f943a1d8bfd61a0caba29cf338bf>

c. Individuals who wish to provide comment will need to register with an "SP" in front of their name (ex: SP Jane Doe) and must email 1115waivers@health.ny.gov no later than Tuesday, January 26, 2021 at 4pm to confirm registration.

d. Individuals will speak in their order of registration. We kindly request that all comments be limited to five minutes per presenter to ensure that all public comments may be heard.

A draft of the proposed MRT Waiver extension request available for review at: https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/ext_request/index.htm.

Due to COVID-19 pandemic, the Department of Health offices are operating at a reduced in-person capacity. For individuals with limited online access and require special accommodation to access paper copies, please call (518) 473-0919. While the State will be accepting physical written comments due to COVID-19, comments submitted electronically by email is preferred.

Prior to finalizing the proposed MRT Waiver extension application, the Department of Health will consider all written and verbal comments received. These comments will be summarized and addressed in the final version that is submitted to CMS. The Department will post a transcript of the public hearings, as well as any submitted written public comments, on the following website: https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/ext_request/index.htm.

Please direct all questions to 1115waivers@health.ny.gov.

Written comments will be accepted by email at 1115waivers@health.ny.gov or by mail at Department of Health, Office of Health Insurance Programs, Waiver Management Unit, 99 Washington Ave., 7th Fl., Suite 720, Albany, NY 12210.

All comments must be postmarked or emailed by 30 days of the date of this notice.

PUBLIC NOTICE

Department of Health

MRT 1115 Waiver Extension Request

In compliance with 42 CFR 431.408(a)(1) as well as the current MRT Waiver Special Terms and Conditions regarding the annual Public Forum requirement, the New York State Department of Health is pleased to announce that it will conduct two virtual public hearings/public forums, to provide an overview of the State's 1115 waiver extension request and allow members of the public to provide comments. This notice further serves to open the 30-day public comment period which will close on Friday, January 15, 2021. In addition to this 30-day comment period where the public will be afforded the opportunity to provide written comments, the Department of Health will be hosting two virtual public hearings during which the public may provide oral comments. Any updates related to the public hearings and forum will be sent via the MRT ListServ.

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2. Second Public Hearing/Public Forum

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c. Individuals who wish to provide comment will need to register with an "SP" in front of their name (ex: SP Jane Doe) and must email 1115waivers@health.ny.gov no later than Tuesday, January 26, 2021 at 4pm to confirm registration.

d. Individuals will speak in their order of registration. We kindly request that all comments be limited to five minutes per presenter to ensure that all public comments may be heard.

Prior to finalizing the proposed MRT Waiver extension application, the Department of Health will consider all written and verbal comments received. These comments will be summarized and addressed in the final version that is submitted to CMS.

Extension Proposal Summary and Objectives

The New York State Department of Health ("NYSDOH") is requesting a three-year extension of the existing Section 1115 Medicaid Redesign Team ("MRT") waiver demonstration, which is set to expire on March 31, 2021. This extension proposal seeks an extension of all current programs and authorities in the State's current waiver demonstration, with the following two programmatic amendments:

- Carveout of the Non-Emergency Medical Transportation (NEMT) Benefit for Managed Long-Term Care Members to Fee-For-Service: The goals of this amendment request are as follows:

- o Improve administrative simplification by creating a consistently managed transportation benefit and removing the benefit from the MRT Waiver;

- o Reduce cost-risk by shifting the broker arrangement to a risk-based arrangement; and

- o Create a larger pool of members by combining all members, except PACE for which the transportation benefit must be managed by the PACE Organization under federal rules, for brokers to provide NEMT service to.

- Carveout of Pharmacy Benefits from Medicaid Managed Care to Fee-For-Service. The goals of this amendment request are as follows:

- o Provide the State with full visibility into prescription drug costs;

- o Centralize and leverage negotiation power;

- o Provide a single drug formulary with standardized utilization management protocols; and

- o Address the growth of the 340B program and associated reductions in State rebate revenue.

These amendments were developed by the State's Medicaid Redesign Team II (MRT II), and are part of a larger, more comprehensive set of reforms that the State is planning to innovate and improve the Medicaid program. MRT II brought together a comprehensive set of stakeholders to collectively find solutions that improve the delivery of care and outcomes for Medicaid members and contain spending growth in the Medicaid program.

Eligibility, Benefits, and Cost-Sharing Changes

This extension proposal, inclusive of the two proposed amendments, contains no changes to eligibility, scope of benefits, or cost-sharing requirements. The two proposed amendments simply shift the administration and delivery of the two identified benefits by carving out these two benefits from the Medicaid Managed Care delivery systems to Fee-For-Service in the State Plan.

Enrollment and Fiscal Projections

Please see the Appendix at the end of this Issue for the Enrollment and Fiscal Projections.

Hypotheses and Evaluation

In July 1997, New York State (the "State") received approval from the Centers for Medicare and Medicaid Services ("CMS") for its "Partnership Plan" Medicaid Section 1115 Demonstration (the "1115 Demonstration"). In implementing the 1115 Demonstration, the State sought to achieve the following goals:

- Improve access to health care for the Medicaid population;

- Improve the quality of health services delivered;
- Expand access to family planning services; and
- Expand coverage to additional low-income New Yorkers with resources generated through managed care efficiencies.

The primary purpose of the Demonstration was to enroll a majority of the State’s Medicaid population into managed care; to use a managed care delivery system to deliver benefits to Medicaid recipients; to create efficiencies in the Medicaid program, and enable the extension of coverage to certain individuals who would otherwise be without health insurance. The MRT Waiver continues to meet the goals and objectives that were established at the initial approval of the demonstration.

The current hypotheses for the aforementioned goals are:

- The MRT Waiver will improve access to health care for the Medicaid population;
- The MRT Waiver will improve the quality of health services delivered;
- The MRT Waiver will expand access to family planning services; and
- The MRT Waiver will expand coverage to additional low-income New Yorkers with resources generated through managed care efficiencies.

Waiver and Expenditure Authorities

As specified in the MRT Waiver extension application, the State requests a continuation of the following waiver and expenditure authorities to operate the demonstration:

Waiver Authority	Reason and Use of Waiver Authority
1. Extension of Existing Demonstration Section 1115(a)	a. To the extent necessary to enable the State to extend the existing waiver for an additional three years.
2. Statewide Section 1902(a)(1)	a. To permit New York to geographically phase in the Managed Long-Term Care (MLTC) program and the Health and Recovery Plans (HARP) and to phase in Behavioral Health (BH) Home and Community Based Services (HCBS) into HIV Special Needs Plans (HIV SNP).
3. Comparability Section 1902(a)(10), section 1902(a)(17)	a. To enable New York to apply a more liberal income standard for individuals who are deinstitutionalized and receive HCBS through the managed long-term care program than for other individuals receiving community-based long-term care. b. To the extent necessary to permit New York to waive cost sharing for non-drug benefit cost sharing imposed under the Medicaid State Plan for members enrolled in the Mainstream Medicaid Managed Care Plan (MMMC) – including Health and Recovery Plans (HARP) and HIV SNPs – and who are not otherwise exempt from cost sharing in § 447.56(a)(1).

Waiver Authority

Reason and Use of Waiver Authority

c. Family of One Non-1915 Children, or “Fo1 Children” – To allow the State to target eligibility to, and impose a participation capacity limit on, medically needy children under age 21 who are otherwise described in 42 CFR § 435.308 of the regulations who: 1) receive Health Home Comprehensive Care Management under the State Plan in replacement of the case management services such individuals formerly received through participation in New York’s NY #4125 1915(c) waiver and who no longer participate in such waiver due to the elimination of the case management services, but who continue to meet the targeting criteria, risk factors, and clinical eligibility standard for such waiver; and 2) receive HCBS 1915(c) services who meet the risk factors, targeting criteria, and clinical eligibility standard for the above-identified 1915(c) waiver. Individuals who meet either targeting classification will have excluded from their financial eligibility determination the income and resources of third parties whose income and resources could otherwise be deemed available under 42 CFR § 435.602(a)(2)(i). Such individuals will also have their income and resources compared to the medically needy income level (MNIL) and resource standard for a single individual, as described in New York’s State Medicaid Plan.

4. Amount, Duration & Scope Section 1902(a)(10)(B)

a. To enable New York to provide behavioral health (BH) HCBS services, whether furnished as a State Plan benefit or as a demonstration benefit to targeted populations that may not be consistent with the targeting authorized under the approved State Plan, in amount, duration and scope that exceeds those available to eligible individuals not in those targeted populations.

5. Freedom of Choice Section 1902(a)(23)(A)

a. To the extent necessary to enable New York to require members to enroll in Managed Care Organizations, including the Mainstream Medicaid Managed Care (MMMC), and MLTC (excluding individuals designated as “Long-Term Nursing Home Stays”) and HARPs programs in order to obtain benefits offered by those plans. Members shall retain freedom of choice of family planning providers.

6. Reasonable Promptness Section 1902(a)(8)

a. To enable the State to limit the number of medically needy Fo1 Children not otherwise enrolled in the Children’s 1915(c) waiver.

Title XIX Requirements Not Applicable to Self-Direction Pilot Program (see Expenditure Authority 6, “Self-Direction Pilot”)

7. Direct Payment to Providers Section 1902(a)(32)

a. To the extent necessary to permit the State to make payments to members enrolled in the Self-Direction Pilot Program to the extent that such funds are used to obtain self-directed HCBS LTC services and supports.

The State is requesting the use of the same expenditure authorities as approved in the existing 1115 demonstration, except for expenditure authority to provide incentive payments and planning grants for the previously numbered Expenditure Authority 7, Delivery System Incentive Reform Payment (DSRIP) program, which are expiring in March of 2020, or previously numbered Expenditure Authority 6, Designated State Health Program Funding, which expired in 2020.

APPENDIX

The following Appendix was filed with a Public Notice for the Department of Health published in this issue of the State Register.

Enrollment and Fiscal Projections

This 1115 extension proposal is expected to have no or nominal impact on annual Medicaid enrollment, and is further expected to be budget neutral. The tables below illustrate historical caseloads and costs of the current waiver (Exhibit 1), as well as projected caseloads and costs of the demonstration as proposed (Exhibit 2).

Exhibit 1: Historical Caseloads and Costs (in total computable dollars) *

Demonstration Year	DY18	DY19	DY20	DY21*	DY22*
Historical Caseload**	4,903,302	4,883,361	5,170,656	5,472,989	5,738,303
Historical Cost	\$47,739,999,038	\$47,739,999,038	\$47,739,999,038	\$47,739,999,038	\$47,739,999,038

*Includes projected data.

**Total historical cost figures as reported in the CY2020 Q3 submission of the Budget Neutrality Reporting Tool, WW Spending Total Tab.

**Caseload is based on total Member Months reported /12 (CY2020 Q3 submission of the Budget Neutrality Reporting Tool, MemMon Total Tab).

Exhibit 2: Projected Caseloads and Costs (in total computable dollars) *

Demonstration Year	DY23	DY24	DY25
Projected Caseload of the Demonstration	4.9 million	4.9 million	4.9 million
<i>MLTC Transportation Carveout Only</i>	0	n/a	n/a
<i>Pharmacy Carveout Only</i>	0	n/a	n/a
Projected Cost	\$51.2 billion	\$53.5 billion	\$ 56.0 billion
<i>MLTC Transportation Carveout Only</i>	\$16.6 million	n/a	n/a
<i>Pharmacy Carveout Only**</i>	\$698.1 million	n/a	n/a

*The numbers above represent projected caseload and costs for the entire waiver proposal, as well as specific details related to the two proposed amendments.

**MLTC Transportation and Pharmacy Carveouts will not impact membership as neither carveout affects member eligibility.

***The costs below do not include a projection for MEG 9 (HCBS Expansion) and MEG 10 (Institute to Community).

Appendix B– Tribal Letter



ANDREW M. CUOMO
Governor

Department
of Health

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

December 16, 2020

Re: MRT 1115 Waiver Extension Request

Dear Colleague:

The New York State Department of Health (“NYSDOH”) is requesting a three-year extension of the existing Section 1115 Medicaid Redesign Team (“MRT”) waiver demonstration, which is set to expire on March 31, 2021. ***This extension proposal seeks an extension of all current programs and authorities in the State’s current waiver demonstration, with the following two programmatic amendments:***

- **Carveout of the Non-Emergency Medical Transportation (NEMT) Benefit for Managed Long-Term Care Members to Fee-For-Service:** The goals of this amendment request are as follows:
 - Improve administrative simplification by creating a consistently managed transportation benefit and removing the benefit from the MRT Waiver;
 - Reduce cost-risk by shifting the broker arrangement to a risk-based arrangement; and
 - Create a larger pool of members by combining all members, except PACE for which the transportation benefit must be managed by the PACE Organization under federal rules, for brokers to provide NEMT service to.

- **Carveout of Pharmacy Benefits from Medicaid Managed Care to Fee-For-Service.** The goals of this amendment request are as follows:
 - Provide the State with full visibility into prescription drug costs;
 - Centralize and leverage negotiation power;
 - Provide a single drug formulary with standardized utilization management protocols; and
 - Address the growth of the 340B program and associated reductions in State rebate revenue.

These amendments were developed by the State’s Medicaid Redesign Team II (MRT II), and are part of a larger, more comprehensive set of reforms that the State is planning to innovate and improve the Medicaid program. MRT II brought together a comprehensive set of stakeholders to collectively find solutions that improve the delivery of care and outcomes for Medicaid members and contain spending growth in the Medicaid program.

Eligibility, Benefits, and Cost-Sharing Changes

This extension proposal, inclusive of the two proposed amendments, contains ***no changes to eligibility, scope of benefits, or cost-sharing requirements***. The two proposed amendments simply shift the administration and delivery of the two identified benefits by carving out these two benefits from the Medicaid Managed Care delivery systems to Fee-For-Service in the State Plan. The State does not anticipate any additional or unique impact on Tribes.

Enrollment and Fiscal Projections

This 1115 extension proposal is expected to have no or nominal impact on annual Medicaid enrollment, and is further expected to be budget neutral. The tables below illustrate historical caseloads and costs of the current waiver (Exhibit 1), as well as projected caseloads and costs of the demonstration as proposed (Exhibit 2).

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*The numbers above represent projected caseload and costs for the entire waiver proposal, as well as specific details related to the two proposed amendments.

**MLTC Transportation and Pharmacy Carveouts will not impact membership as neither carveout affects member eligibility.

***The costs below do not include a projection for MEG 9 (HCBS Expansion) and MEG 10 (Institute to Community).

Hypotheses and Evaluation

In July 1997, New York State (the "State") received approval from the Centers for Medicare and Medicaid Services ("CMS") for its "Partnership Plan" Medicaid Section 1115 Demonstration (the "1115 Demonstration"). In implementing the 1115 Demonstration, the State sought to achieve the following goals:

- Improve access to health care for the Medicaid population;
- Improve the quality of health services delivered;
- Expand access to family planning services; and
- Expand coverage to additional low-income New Yorkers with resources generated through managed care efficiencies.

The primary purpose of the Demonstration was to enroll a majority of the State's Medicaid population into managed care; to use a managed care delivery system to deliver benefits to Medicaid recipients; to create efficiencies in the Medicaid program, and enable the extension of coverage to certain individuals who would otherwise be without health insurance. The MRT Waiver continues to meet the goals and objectives that were established at the initial approval of the demonstration.

The current hypotheses for the aforementioned goals are:

- The MRT Waiver will improve access to health care for the Medicaid population;
- The MRT Waiver will improve the quality of health services delivered;
- The MRT Waiver will expand access to family planning services; and
- The MRT Waiver will expand coverage to additional low-income New Yorkers with resources generated through managed care efficiencies.

Waiver and Expenditure Authorities

As specified in the MRT Waiver extension application, the State requests a continuation of the following waiver and expenditure authorities to operate the demonstration:

Waiver Authority	Reason and Use for Authority
1. Extension of Existing Demonstration Section 1115(a)	a. To the extent necessary to enable the State to extend the existing waiver for an additional three years.
2. Statewide Section 1902(a)(1)	a. To permit New York to geographically phase in the Managed Long-Term Care (MLTC) program and the Health and Recovery Plans (HARP) and to phase in Behavioral Health (BH) Home and Community Based Services (HCBS) into HIV Special Needs Plans (HIV SNP).
3. Comparability Section 1902(a)(10), section 1902(a)(17)	<p>a. To enable New York to apply a more liberal income standard for individuals who are deinstitutionalized and receive HCBS through the managed long-term care program than for other individuals receiving community-based long-term care.</p> <p>b. To the extent necessary to permit New York to waive cost sharing for non-drug benefit cost sharing imposed under the Medicaid State Plan for members enrolled in the Mainstream Medicaid Managed Care Plan (MMMC) – including Health and Recovery Plans (HARP) and HIV SNPs – and who are not otherwise exempt from cost sharing in §447.56(a)(1).</p> <p>c. Family of One Non-1915 Children, or "Fo1 Children" – To allow the State to target eligibility to, and impose a participation capacity limit on, medically needy children under age 21 who are otherwise described in 42 CFR §435.308 of the regulations who: 1) receive Health Home Comprehensive Care Management under the State Plan in replacement of the case management services such individuals formerly received through participation in New York's NY #.4125 1915(c) waiver and who no longer participate in such waiver due to the elimination of the case management services, but who continue to meet the targeting criteria, risk factors, and clinical eligibility standard for such waiver; and 2) receive HCBS 1915(c) services who meet the risk factors, targeting criteria, and clinical eligibility</p>

Waiver Authority	Reason and Use for Authority
	standard for the above-identified 1915(c) waiver. Individuals who meet either targeting classification will have excluded from their financial eligibility determination the income and resources of third parties whose income and resources could otherwise be deemed available under 42 CFR § 435.602(a)(2)(i). Such individuals will also have their income and resources compared to the medically needy income level (MNIL) and resource standard for a single individual, as described in New York's State Medicaid Plan.
4. Amount, Duration & Scope Section 1902(a)(10)(B)	a. To enable New York to provide behavioral health (BH) HCBS services, whether furnished as a State Plan benefit or as a demonstration benefit to targeted populations that may not be consistent with the targeting authorized under the approved State Plan, in amount, duration and scope that exceeds those available to eligible individuals not in those targeted populations.
5. Freedom of Choice Section 1902(a)(23)(A)	a. To the extent necessary to enable New York to require members to enroll in Managed Care Organizations, including the Mainstream Medicaid Managed Care (MMMC), and MLTC (excluding individuals designated as "Long-Term Nursing Home Stays") and HARP programs in order to obtain benefits offered by those plans. Members shall retain freedom of choice of family planning providers.
6. Reasonable Promptness Section 1902(a)(8)	a. To enable the State to limit the number of medically needy Fo1 Children not otherwise enrolled in the Children's 1915(c) waiver.
<i>Title XIX Requirements Not Applicable to Self-Direction Pilot Program (see Expenditure Authority 6, "Self-Direction Pilot")</i>	
7. Direct Payment to Providers Section 1902(a)(32)	a. To the extent necessary to permit the State to make payments to members enrolled in the Self Direction Pilot Program to the extent that such funds are used to obtain self-directed HCBS LTC services and supports.

The State is requesting the use of the same expenditure authorities as approved in the existing 1115 demonstration, except for expenditure authority to provide incentive payments and planning grants for the previously numbered Expenditure Authority 7, Delivery System Incentive Reform Payment (DSRIP) program, which are expiring in March of 2020, or previously numbered Expenditure Authority 6, Designated State Health Program Funding, which expired in 2020. While the State is not requesting the use of the DSRIP Expenditure Authority, CMS provided additional authority to provide DSRIP administration and a schedule of PPS payments until 2021, this additional authority is not part of this extension request. The State requests the continuation of the remaining expenditure authorities and are as follows:

Expenditure Authority	Reason and Use of Expenditure Authority
1. Demonstration-Eligible Populations.	Expenditures for healthcare related costs for the following populations that are not otherwise eligible under the Medicaid State Plan: a. Demonstration Population 2 (TANF Adult). Temporary Assistance for Needy Families (TANF) Recipients. Expenditures for health care related costs for low-income adults enrolled in TANF. These individuals are exempt from receiving a MAGI determination in accordance with §1902(e)(14)(D)(i)(I) of the Act.

Expenditure Authority	Reason and Use of Expenditure Authority
	<p>b. Demonstration Population 9 (HCBS Expansion). Individuals who are not otherwise eligible, are receiving HCBS, and who are determined to be medically needy based on New York's medically needy income level, after application of community spouse and spousal impoverishment eligibility and post-eligibility rules consistent with section 1924 of the Act.</p> <p>c. Demonstration Population 10 (Institution to Community). Expenditures for health care related costs for individuals moved from institutional nursing facility settings to community settings for long term services and supports who would not otherwise be eligible based on income, but whose income does not exceed the income standard described in STC 4(c) of section IV, and who receive services through the managed long term care program under the demonstration.</p> <p>d. Included in Demonstration Population 12 (Fo1 Children)- Medically needy children Fo1 Demonstration children under age 21 with a waiver of 1902(a)(10)(C)(i)(III) who meet the targeting criteria, risk factors, and clinical eligibility standard for #NY.4125 waiver including ICF, NF, or Hospital Level of Care (LOC) who are not otherwise enrolled in the Children's 1915(c).</p>
<p>2. Twelve-Month Continuous Eligibility Period.</p>	<p>a. Expenditures for health care related costs for individuals who have been determined eligible under groups specified in Table 1 of STC 3 in Section IV for continued benefits during any periods within a twelve-month eligibility period when these individuals would be found ineligible if subject to redetermination. This authority includes providing continuous coverage for the Adult Group determined financially eligible using Modified Adjusted Gross Income (MAGI) based eligibility methods. For expenditures related to the Adult Group, specifically, the State shall make a downward adjustment of 2.6 percent in claimed expenditures for federal matching at the enhanced federal matching rate and will instead claim those expenditures at the regular matching rate.</p>
<p>3. Facilitated Enrollment Services.</p>	<p>a. Expenditures for enrollment assistance services provided by managed care organizations (MCO), the costs for which are included in the claimed MCO capitation rates.</p>
<p>4. Demonstration Services for Behavioral Health Provided under Mainstream Medicaid Managed Care (MMMC).</p>	<p>a. Expenditures for provision of residential addiction services, crisis intervention and licensed behavioral health practitioner services to MMMC members only and are not provided under the State Plan [Demonstration Services 9].</p>
<p>5. Targeted Behavioral Health (BH) HCBS Services.</p>	<p>a. Expenditures for the provision of BH HCBS services under Health and Recovery Plans (HARP) and HIV Special Needs Plans (SNP) that are not otherwise available under the approved State Plan [Demonstration Services 8].</p>
<p>6. Self-Direction Pilot.</p>	<p>a. Expenditures to allow the State to make self-direction services available to HARP and HIV/SNP members receiving BH HCBS or children meeting targeting criteria for the Children's 1915(c) Waiver and in MMMC receiving HCBS under the Children's</p>

Expenditure Authority	Reason and Use of Expenditure Authority
	Waiver. The program will be in effect from January 1, 2017 through March 31, 2021 [Demonstration Services 8].

Submission and Review of Public Comments

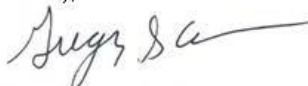
A draft of the proposed MRT Waiver extension request available for review at: https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/ext_request/index.htm. Due to COVID-19 pandemic, the Department of Health offices are operating at a reduced in-person capacity. For individuals with limited online access and require special accommodation to access paper copies, please call (518) 473-0919. While the State will be accepting physical written comments due to COVID-19, comments submitted electronically by email is preferred.

Written comments will be accepted by email at 1115waivers@health.ny.gov or by mail at:

Department of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Ave.
Suite 720, 7th floor
Albany, NY 12210

All comments must be postmarked or emailed by January 22, 2021. We look forward to our continued collaboration.

Sincerely,



Gregory S. Allen, Director
Division of Program Development & Management
Office of Health Insurance Programs

cc: Brett Friedman, NYSDOH
Phil Alotta, NYSDOH
Michele Hamel, NYSDOH
Sean Hightower, HHS
Nancy Grano, CMS

Attachments

Attachment A–Children’s Design Preliminary Interim Evaluation

Attachment B–HARP Preliminary Interim Evaluation

Attachment C–SDC Preliminary Interim Evaluation

Attachment D–1115 Demonstration Preliminary Interim Evaluation

Attachment E– Budget Neutrality Workbooks

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)			TOTAL
	DY 23 (4/1/21 - 3/31/22)	DY 24 (4/1/22 - 3/31/23)	DY 25 (4/1/23 - 3/31/24)	
Medicaid Populations				
MEG 1: TANF Children 1-20	\$ 6,633,801,558	\$ 6,953,057,793	\$ 7,287,705,169	\$ 20,874,564,520
MEG 2: TANF Adults 21-64	\$ 4,687,445,732	\$ 4,940,320,542	\$ 5,206,788,032	\$ 14,834,554,306
MEG 3: SSI 0-64	\$ 10,465,003,080	\$ 10,950,664,380	\$ 11,458,891,579	\$ 32,874,559,039
MEG 4: SSI 65+	\$ 915,549,462	\$ 958,915,012	\$ 1,004,336,323	\$ 2,878,800,797
MEG 5: Non-duals 18-64	\$ 1,420,804,138	\$ 1,500,258,894	\$ 1,584,156,760	\$ 4,505,219,792
MEG 6: Non-duals 65+	\$ 483,242,808	\$ 521,949,364	\$ 563,756,038	\$ 1,568,948,210
MEG 7: MLTC Adult 18-64 Duals	\$ 2,255,150,822	\$ 2,381,261,702	\$ 2,514,428,895	\$ 7,150,841,419
MEG 8: MLTC Adult 65+ Duals	\$ 14,909,033,788	\$ 16,103,201,605	\$ 17,393,029,021	\$ 48,405,264,414
MEG 9: HCBS Expansion	\$ 896,889	\$ 946,506	\$ 998,868	\$ 2,842,263
MEG 10: Institution to Community	\$ 18,571,304	\$ 18,998,274	\$ 19,435,089	\$ 57,004,667
MEG 11: New Adult Group	\$ 13,743,739,486	\$ 14,393,952,017	\$ 15,075,060,176	\$ 43,212,751,679
MEG 12: Family of One Non-1915 Children	\$ 32,787,500	\$ 32,787,500	\$ 32,787,500	\$ 98,362,499
MLTC NEMT Carve-out	\$ 291,604,197	\$ 285,749,008	\$ 293,236,885	\$ 870,590,090
Pharmacy Carve-out	\$ 6,282,375,003	\$ 6,003,296,390	\$ 6,007,036,918	\$ 18,292,708,311
TOTAL	\$ 55,566,026,567	\$ 58,756,313,589	\$ 62,141,373,450	\$ 176,463,713,605
TOTAL less Carve-outs	\$ 48,992,047,366	\$ 52,467,268,190	\$ 55,841,099,647	\$ 157,300,415,204

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)			TOTAL
	DY 23 (4/1/21 - 3/31/22)	DY 24 (4/1/22 - 3/31/23)	DY 25 (4/1/23 - 3/31/24)	
Medicaid Populations				
MEG 1: TANF Children 1-20	\$ 6,389,302,293	\$ 6,572,456,868	\$ 6,760,888,407	\$ 19,722,647,568
MEG 2: TANF Adults 21-64	\$ 4,529,739,704	\$ 4,693,117,420	\$ 4,862,386,427	\$ 14,085,243,551
MEG 3: SSI 0-64	\$ 10,616,086,718	\$ 11,188,685,167	\$ 11,792,165,633	\$ 33,596,937,518
MEG 4: SSI 65+	\$ 927,067,643	\$ 977,070,000	\$ 1,029,771,072	\$ 2,933,908,716
MEG 5: Non-duals 18-64	\$ 1,319,127,374	\$ 1,342,131,084	\$ 1,365,535,841	\$ 4,026,794,299
MEG 6: Non-duals 65+	\$ 447,840,632	\$ 465,656,541	\$ 484,180,664	\$ 1,397,677,838
MEG 7: MLTC Adult 18-64 Duals	\$ 2,093,766,222	\$ 2,130,282,268	\$ 2,167,433,092	\$ 6,391,481,582
MEG 8: MLTC Adult 65+ Duals	\$ 13,816,808,361	\$ 14,366,465,630	\$ 14,937,980,643	\$ 43,121,254,635
MEG 9: HCBS Expansion	\$ 896,889	\$ 946,506	\$ 998,868	\$ 2,842,263
MEG 10: Institution to Community	\$ 18,572,334	\$ 18,999,830	\$ 19,437,180	\$ 57,009,344
MEG 11: New Adult Group	\$ 13,743,739,486	\$ 14,393,952,017	\$ 15,075,060,176	\$ 43,212,751,679
MEG 12: Family of One Non-1915 Children	\$ 32,787,500	\$ 32,787,500	\$ 32,787,500	\$ 98,362,499
MLTC NEMT Carve-out	\$ 291,604,197	\$ 285,749,008	\$ 293,236,885	\$ 870,590,090
Pharmacy Carve-out	\$ 6,282,375,003	\$ 6,003,296,390	\$ 6,007,036,918	\$ 18,292,708,311
TOTAL	\$ 53,935,735,158	\$ 56,182,550,832	\$ 58,528,625,501	\$ 168,646,911,492
TOTAL less Carve-outs	\$ 47,361,755,957	\$ 49,893,505,434	\$ 52,228,351,699	\$ 149,483,613,090
VARIANCE	\$ 1,630,291,409	\$ 2,573,762,756	\$ 3,612,747,948	\$ 7,816,802,114



WP No. WR-A782-1

Independent Interim Evaluation of the New York State 1115 Waiver Amendment: The Children's Design Preliminary Report

Submitted to:

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November 13, 2020

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1. EXECUTIVE SUMMARY

As part of ongoing redesign efforts with input from the Medicaid Redesign Team (MRT), New York State (NYS) developed a set of coordinated amendments to its 1115 Medicaid Redesign Team Waiver and its 1915(c) Children's Waivers. Together, these changes are called the Children's Design. The Children's Design aims to consolidate and streamline care for children and youth under age 21 who have needs for Behavioral Health (BH) and Home and Community-Based Services (HCBS). The main research goals relevant to this interim evaluation are to assess:¹

- Goal 1. Effect of Managed Care on HCBS Population Outcomes;
- Goal 2. Effect of Timely Access to Early and Periodic Screening, Diagnostic, and Treatment Benefits on health outcomes and long-term financial savings;
- Goal 3. Effect of Access to HCBS on health; and
- Goal 5. Effect of Health Home Model on care coordination and access to services.

Two additional goals, Goals 4 and 6, are not included in the interim evaluation but will be included in the final summative evaluation. To address these research goals, the evaluation team at RAND will conduct approximately 10-15 interviews with key stakeholders of the Children's Design to understand implementation barriers and successes. The team will supplement these interviews with a review of State policy documents and existing meeting minutes from the Department of Health (DOH) with stakeholders.

In addition, the evaluation team will assess access to and quality of care primarily using baseline data. Post-implementation data are not readily available but will be included to the extent possible. A fee-for-service (FFS) group may be used as the comparison group to those enrolled in mainstream Medicaid managed care (MMMC).

The evaluation design received approval from CMS in April of 2020 when the coronavirus-19 (COVID-19) pandemic started. The significant impact of the pandemic on the NYS health care system required DOH personnel to shift attention, resources, and priorities. This shift created contract execution and data access delays. The independent contractor selection was completed and the evaluation contract was signed in October 2020. As a result, the independent evaluation timeline has changed, and no findings are available at the time of this writing.

Despite COVID-19-related administrative delays, a number of meetings have been held to plan the evaluation and to answer operative questions about the program. After significant

¹ Note that Goals 4 and 6 will be addressed in the Final Summative Evaluation.

scoping efforts, DOH has shared all required data except those on program enrollment and a quality of care measure, which are delayed due to the coronavirus-19 (COVID-19) pandemic. NYS has also shared a list of candidates for interviews, notes for meetings with various stakeholders, and State policy documents. The findings of this interim evaluation are expected to be available in Spring 2021.

2. DEMONSTRATION DESCRIPTION

Since 1997, the NYS MRT has worked to create an efficient managed care delivery system that will extend high-quality health care coverage to individuals needing long-term services and supports. The redesign has been updated multiple times, including coordination with the Affordable Care Act Medicaid Expansion and the addition of the Delivery System Reform Incentive Payment (DSRIP) program in 2014. As part of ongoing redesign efforts, NYS proposed, and the Centers for Medicare & Medicaid Services (CMS) approved, concurrent amendments to the 1115 MRT Waiver and the 1915(c) Children's Waiver that aim to consolidate and streamline care for children and youth under age 21 who have needs for BH services and HCBS. Together, these waiver amendments are called the Children's Design. Implementation of the Children's Design started in August 2019 for the following four groups of children who were already covered by the State's 1915(c) Children's Waiver:

1. Medically fragile children
2. Children with a behavioral health diagnosis
3. Children with medical fragility and developmental disabilities
4. Children with developmental disabilities who are in foster care

The Children's Design streamlines the care for these groups of children by authorizing NYS to require enrollment in MMMC for children receiving HCBS under the 1915(c) Children's Waiver and include children's HCBS, previously reimbursed through FFS, in managed care organization benefit packages. The Children's Design also allows NYS to target eligibility to medically needy Family of One (Fo1) children who meet clinical criteria but are not enrolled in the 1915(c) Children's Waiver.

The streamlined model of care aims to achieve broad improvements in the care that children with behavioral health and HCBS needs receive through the NYS Medicaid system. Specific goals include improved clinical and recovery health outcomes; timely access to health care services during childhood that can improve functioning and reduce health care needs in adulthood; improved integration of care that is commonly fragmented across behavioral health, general

medical, and community support systems; and increased capacity of provider networks to deliver community-based recovery-oriented services and supports.

Evaluation Objective

The objective of this evaluation is to examine the early implementation period of the approved Children's Design. The goals of the interim evaluation are to:

1. Identify the facilitators of and barriers to program implementation
2. Describe and delineate the baseline (i.e., pre-implementation) trends in the outcomes of interest
3. Assess the feasibility of identifying comparison groups and conducting difference-in-differences (DD) analyses or comparative interrupted time series analyses for the final summative evaluation.

Timeline and Progress to Date

The information provided in this report includes information pertaining to the design and implementation of the Children's Design interim evaluation. Due to contractual delays, all findings and conclusions will be discussed in a subsequent interim report, expected in early 2021. A final summative evaluation will be conducted at a later date.

Revised Timeline and Next Steps

Due to delays, the evaluation timeline was reevaluated to allow for additional time for data collection, analysis, and report writing. The COVID-19 response within the NYS DOH and other state partners, along with other related factors, delayed the execution of the contract, hampering the ability of the evaluation team to begin conducting interviews and to access the data necessary to conduct analyses. As discussed in the methodology below in Section 3, the ability to gather qualitative data and assess the client data is integral to responding to the evaluation questions. Figure 1 in Section 4 below provides the planned timeline for the completion of the interim evaluation. Appendix A outlines next steps, including the client interviews and data analysis.

3. EVALUATION DESIGN AND METHODS

To conduct the interim evaluation of the Children’s Design, the evaluation team will use a mixed-methods approach to answer the research questions outlined by NYS. Specifically, the team will conduct semi-structured interviews with various stakeholders to examine implementation barriers and successes. Quantitative assessments of access to and quality of care will use only baseline data, given that the post-implementation data are not readily available. In addition, due to the timing of the interim evaluation, the observation window may not be long enough for the evaluation team to observe outcome changes resulting from the Children’s Design. But, to the extent possible, post-implementation data points, such as the number of individuals enrolled in the Children’s Design or outcome measures that can be derived from the Medicaid Data Warehouse, will be included. The resulting interim report will lay a foundation for the final summative evaluation.

The qualitative interviews will be conducted with a mix of key informants representing diverse stakeholders in the Children’s Design implementation. Informants, who will include representatives of advocacy organizations, plan administrators, and care providers. Drawing on suggestions from DOH, the sampling goal will be to ensure that a broad range of perspectives is represented in the study sample, including diverse advocacy groups and providers from New York City (NYC), as well as both urban and rural regions upstate. The evaluation team anticipates conducting approximately 10-15 key informant interviews. In addition to key informant interviews, the analysis will be informed by review of documents that have been provided to the research team by DOH. The documents include policy documents, which describe how the program was administered, and meeting minutes, which describe public stakeholder meetings at which views of the Children's Design were discussed.

The interviews and documents will be analyzed by the RAND team to identify issues that have arisen in the course of the implementation of the Children’s Design. For instance, we will ask advocacy organizations whether the implementation has gone according to expectations, whether they have concerns about barriers to successful implementation, and whether there are aspects of the implementation that have been particularly promising. Issues raised by key informants will be summarized and compared across the categories of informants. While the key informant interviews cannot provide definitive information on the impact of the Children’s Design, they can be extremely helpful in identifying common areas of concern. The results will inform the interpretation of the quantitative results and the analytic plan for the summative evaluation report.

To the extent possible, a comparison group will be included in the quantitative assessments of the baseline data for the interim report, which will allow us to compare the demographics, medical acuity, the level of HCBS needs, and outcomes between the program target population and comparison populations. The evaluation team is working with DOH to find the best way to address this challenge.

- Option A is to use children or youth under 21 who are on FFS Medicaid as the comparison. The downside of this comparison is that most individuals are on FFS Medicaid on a temporary basis before they are enrolled in a MMMC plan. In other words, we would be comparing a relatively stable program target population to a comparison population that changes over time.
- Option B is to find a population that has always been in an MMMC plan as the comparison. The concern is that this comparison population is likely to be healthier and have no or a lower level of need for HCBS.
- Option C would consider using data from other states for a population that is similar to that of the Children’s Design, e.g., for outcomes that are part of the Core Set of Children’s Health Care Quality Measures for Medicaid. However, there might be significant variation in how states address such a population’s needs, and the barriers to accessing data would be difficult to overcome within the evaluation timeline.

In part due to a tight timeline for this interim evaluation, aggregate data points for both the target population and the comparison population will be used in the analysis. Depending on specific outcome measures, we will stratify our analyses based on the three subpopulations: HCBS, Health Home Serving Children, and FFS. Given the constraints in the timeline and data, the interim evaluation will be largely descriptive in nature. Although some questions will not be fully addressed in the interim evaluation, this work will provide a foundation for the summative evaluation.

Research Goals and Questions

The research goals for the interim evaluation are illustrated in Table 3.1 below. Note that as outlined in the approved Evaluation Design, Goals 4 and 6 are relevant only to the final summative evaluation, as are some research questions and hypotheses under Goals 1, 2, 3, and 5. These will not be addressed in the interim report and are thus excluded from the table and the summaries that follow.

Table 3.1. Evaluation Goals, Hypotheses, Measures, Data Sources, and Analytic Approaches

Goal	Research Question	Hypothesis	Measure	Data Source	Status
Goal 1. Improve the health outcomes for individuals under 21 receiving HCBS (HCBS Child/Youth) with access to the Medicaid managed care delivery system	1.1 What are the consequences of targeting availability of HCBS to a more narrowly-defined population than the criteria in the State Plan?	1.1.1 Targeting HCBS availability to a more narrowly-defined population will improve the health outcomes of the population most needing supports to remain in the community, as measured by Potentially Preventable Emergency Room Visits (PPVs) and stakeholder observations about the consequences of targeting HCBS availability to a more narrowly-defined population	Implementation barriers and successes; stakeholders' views of the consequences of targeting availability of HCBS to a narrowly-defined population	Semi-structured key Informant Interviews with advocates, plan administrators, and providers	Protocol in development; state has shared a list of potential candidates for interviews and relevant notes for the meetings with stakeholders
	1.3 To what extent are children with special needs accessing primary care providers who understand the child's needs?	1.3.1 Parents of children with special needs will report being satisfied with primary care providers' understanding of their children's special conditions (CPC-CH questions 44 and 45)	1. Does your child's personal doctor understand how your child's medical, behavioral, or other health conditions affect your child's day-to-day life? 2. Does your child's personal doctor understand how your child's medical, behavioral, or other health conditions affect your family's day-to-day life?	2018 CAHPS CCC survey data	Aggregate data received (10/15)
		1.3.2 Number of children in MMMC/HH/HCBS receiving child/adolescent well-care visits will increase (W15-CH, W34-CH and AWC-CH).	1. W15-CH: Well-child visits in the first 15 months of life 2. W34-CH: Well-child visits in the third, fourth, fifth, and sixth years of life 3. AWC-CH: Adolescent well-care visits	2017-2019 Medicaid Data Warehouse	Aggregate data received (10/15)

Goal	Research Question	Hypothesis	Measure	Data Source	Status
Goal 2. Improved timely access to the additional EPSDT benefits that address early behavioral health needs and health needs of children will improve health outcomes and long-term financial savings	2.1 To what extent are MMMC enrollees accessing community-based specialty services in a timely manner?	2.1.1 MMMC child enrollees will report being satisfied with their access to community-based specialty services for children with chronic conditions (CPC-CH)	<p>1. In the last 6 months, how often was it easy to get special medical equipment or devices for your child?</p> <p>2. In the last 6 months, how often was it easy to get this therapy for your child?</p> <p>3. In the last 6 months, how often was it easy to get this treatment or counseling for your child?</p>	2018 CAHPS CCC survey data	Aggregate data received (10/15)
	2.2 To what extent are MMMC enrollees accessing community-based health care or integrated health/behavioral health care in a manner that results in improved health care outcomes?	2.2.1 MMMC child enrollees will have improved follow up after hospitalizations (FUH-CH) compared to non-enrollees	Follow-up after hospitalization for mental illness among children or adolescents ages 6 to 17	2017-2019 Medicaid Data Warehouse	Aggregate data received (10/15)
		2.2.2 MMMC child enrollees will have enhanced integrated health/behavioral health care, as demonstrated through increased follow-up for children prescribed ADHD medication (ADD-CH)	Follow-up care for children prescribed ADHD medication	2017-2019 Medicaid Data Warehouse	Aggregate data received (10/15)
		2.2.3 MMMC child enrollees will have enhanced integrated health/behavioral health care, as demonstrated through increased metabolic monitoring for children and adolescents on antipsychotics (APM-CH)	Metabolic monitoring for children and adolescents on antipsychotics	2017-2019 Medicaid Data Warehouse	Aggregate data received (10/15)

Goal	Research Question	Hypothesis	Measure	Data Source	Status
Goal 3. Increase appropriate access to the uniform HCBS benefit package for children who meet level of care criteria to achieve improved health outcomes while recognizing that children’s needs, including the duration, scope, and frequency of services, change over time	3.1 How has enrollment in HCBS increased over the length of the Demonstration?	3.1.1 Enrollment in HCBS will increase over the length of the Demonstration	The number of children enrolled in HCBS	2017-2019 Medicaid Data Warehouse	Aggregate data received (10/15)
Goal 5. Improve access to the integrated Health Home model for all children to improve the coordination of care for children and increase access to services	5.1 To what extent are Health Home/HCBS enrollees accessing primary care?	5.1.1 Stakeholders will report improved care coordination	Stakeholders’ views of care coordination	Semi-structured key Informant interviews with advocates, plan administrators, and providers	Protocol in development; state has shared a list of potential candidates for interviews and relevant notes for the meetings with stakeholders
		5.1.2 The number of child/adolescent immunizations will increase (CIS-CH and IMA-CH)	1. Childhood immunization status 2. Immunizations for adolescents	2017-2019 Medicaid Data Warehouse	Aggregate data received (10/15)

Goal	Research Question	Hypothesis	Measure	Data Source	Status
	5.3. Are Health Home/HCBS enrollees accessing necessary services such as health monitoring and prevention services? Are chronic health and behavioral health conditions being managed appropriately?	5.3.2 The receipt of services in an integrated managed care setting will result in increased weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC-CH)	Weight assessment and counseling for nutrition and physical activity for children/adolescents – body mass index assessment for children/adolescents	2017-2019 NYS Quality Assurance Reporting Requirements (QARR) data	Aggregate data expected by 12/15/2020
		5.3.3 MMMC enrollees with chronic conditions will report that someone helped them coordinate care (CPC-CH questions 21, 24, 27, and 30)	1. Did anyone from your child's health plan, doctor's office or clinic help you get special medical equipment or devices for your child? 2. Did anyone from your child's health plan, doctor's office or clinic help you get this therapy for your child? 3. Did anyone from your child's health plan, doctor's office or clinic help you get this treatment or counseling for your child? 4. In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?	2018 CAHPS CCC survey data	Aggregate data received (10/15)

Goal 1. Effect of Managed Care on HCBS Population Outcomes: Improve the health outcomes for individuals under 21 receiving HCBS (HCBS Child/Youth) with access to the Medicaid managed care delivery system.

Research Question 1.1: Targeting HCBS Availability to a Narrowly-defined Population

What are the consequences of targeting availability of HCBS to a more narrowly-defined population than the criteria in the State Plan?

Hypothesis 1.1.1: Potentially Preventable Emergency Room Visits

Targeting HCBS availability to a more narrowly-defined population will improve the health outcomes of the population most needing supports to remain in the community, as measured by stakeholder observations about Potentially Preventable Emergency Room Visits (PPVs) and the consequences of targeting HCBS availability to a more narrowly-defined population.

Key Stakeholder Observations

Semi-structured interviews will be conducted with between 10 and 15 key informants representing three types of stakeholders: advocates, plan administrators, and providers. The interviews will address Hypothesis 1.1.1, concerning the consequences of targeting HCBS availability to a more narrowly defined population. As we describe below, the same interviews will also be used to address Hypothesis 5.1.1, concerning care coordination. It is important to note that qualitative methods cannot formally test these hypotheses. Rather, they will reveal stakeholders' views of implementation and explanations for challenges and successes.

Protocol Development

The RAND evaluation team will develop semi-structured interview protocols for each category of stakeholder. Each of the protocols will be designed to elicit key stakeholders' views regarding the success or lack of success of the Children's Design in achieving the goal of improving health outcomes and reducing PPVs. Stakeholders will be asked to describe barriers to implementation of the Children's Design as well as unanticipated challenges to successfully achieving the implementation goals. The protocols will be informed by review of documents provided by DOH that include minutes from stakeholder meetings and presentations related to implementation of the Children's Design.

Key Informant Selection

Between 10 and 15 key informant interviews will be conducted with individuals selected from a list of stakeholders provided by DOH, additional recommendations from DOH, suggestions by informants recommended by DOH, or identified through review of documents including minutes of stakeholder meetings. Informants will be selected from different regions of the state, ensuring representation of NYC, urban areas outside of NYC, and rural areas.

Key Informant Recruitment

The evaluation team will schedule all interviews. The team may obtain contact information for some informants from DOH. In addition, DOH may facilitate introductions to potential informants to facilitate timely recruitment.

Interviewer Training

In anticipation of conducting interviews, the qualitative team has received training on the Children's Design and the context of the NYS Medicaid policy for children. The training included a review of documents provided by DOH, participation in discussions with DOH subject matter expert staff, and internal discussions with the project leads and technical advisors who have experience with NYS Medicaid. The training ensured that the interviewers are aware of issues relevant to implementation when conducting interviews.

Conducting Interviews

Interviews will be conducted by phone, with audio recording if informants consent. At least two evaluation team staff will participate in each interview. One staff person will be the designated interviewer, and another will be the designated note taker. Interviews are expected to take 60 minutes on average.

Qualitative Data Analysis

Immediately after each interview, the note taker will summarize the interview using a structured template. The summary will describe the key points that were raised by the interviewee, highlighting implementation barriers and successes. The summaries, along with the interview notes and audio recordings, will then be uploaded to a qualitative data analysis platform called Dedoose that will enable the entire team to jointly read and analyze their contents. Analyses will focus on the summaries, drawing on the more detailed notes and audio recordings as needed for clarification. The research team will identify themes in each interview and compare and contrast themes that arise across interviews. To take one example, we expect that administrative procedures involved in the transition to the Children's Design will be a theme that emerges from key informants' comments during the interviews. The team will identify all the ways in which this theme arose, including positive and negative experiences with the transition. The informants'

perspectives on these procedures and their impact on PPVs will then be summarized in the report.

Reporting of Results

The results of the qualitative analysis will be reported in the interim report. The report will include a section on the qualitative analysis addressing Research Question 1.1 that describes the themes that arose in the qualitative interviews and compares the views of different stakeholders and stakeholder groups. The discussion will also aim to identify implementation issues that should be taken into account in the analysis plan for the summative evaluation. No names or identifiable information will be included in the report.

Research Question 1.3: Access to Primary Care in Children with Special Needs

To what extent are children with special needs accessing primary care providers who understand the child's needs?

Hypothesis 1.3.1: Satisfaction with Primary Care

Parents of children with special needs will report being satisfied with primary care providers' understanding of their children's special conditions.

Study Population and Data Sources

The evaluation team is testing this hypothesis for children with special needs using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0 data for children with chronic conditions (CCC) for 2018. The CAHPS CCC questionnaire asks parents or caretakers of children in health plans about their experiences with access to care, health care providers, and health plans. The survey is conducted every two years. For the interim evaluation, the 2018 CAHPS survey data is the baseline to reflect the implementation of the Children's Design in 2019.

Outcome Measures

Primary outcomes include parent reports of satisfaction with primary care providers' understanding of children's special conditions:

1. Does your child's personal doctor understand how your child's medical, behavioral, or other health conditions affect your child's day-to-day life?
2. Does your child's personal doctor understand how your child's medical, behavioral, or other health conditions affect your family's day-to-day life?

Analytic Approach

The evaluation team will describe the differences in the measure between Medicaid FFS and MMMC populations. A chi-square test may be used to test the difference. The limitation of this analysis is that we will not be able to identify the target populations of the Children’s Design— HCBS and Health Home— and the population surveyed at baseline (2018) may be different from those surveyed in later years when the target populations will be included.

Hypothesis 1.3.2: Well-care Visits

The number of children enrolled in MMMC/Health Home/HCBS who are receiving child/adolescent well-care visits will increase.

Study Population and Data Sources

The evaluation team will use aggregate measures (W15-CH, W34-CH, and AWC-CH, discussed below) generated by DOH using the July 2017 to July 2019 Medicaid Data Warehouse for the target populations of the Children’s Design, as well as the comparison population, comparable Medicaid FFS children or MMMC children.

Outcome Measures

Depending on a child’s age, one of the following measures will be used:

1. W15-CH: Well-child visits in the first 15 months of life
2. W34-CH: Well-child visits in the third, fourth, fifth, and sixth years of life
3. AWC-CH: Adolescent well-care visits

Analytic Approach

For the Interim Report, the evaluation team will use a FFS population as the comparison group. For the Final Summative Evaluation Report, we will determine the feasibility of using a comparison group who have been in FFS or in MMMC both prior to and after the Children’s Design implementation, potentially using a propensity score matching approach based on demographics, medical conditions, the level of HCBS needs, past medical utilizations, and other individual-level characteristics.

The trends in the outcome measure and the differences at baseline between the target population (e.g., HCBS or HHSC) and the comparison group (e.g., FFS) will be described. A χ^2 test or a logistic regression may be used to test the difference. If the number of well-child visits is available, a Poisson or negative binomial regression will be conducted. In addition, the analysis will be stratified for each of the target populations.

Goal 2. Effect of Timely Access to Early and Periodic Screening, Diagnostic, and Treatment Benefits: Improved timely access to the additional Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits that address early behavioral health needs and health needs of children will improve health outcomes and long-term financial savings

Research Question 2.1: Access to Community-based Specialty Services

To what extent are MMMC enrollees accessing community-based specialty services in a timely manner?

Hypothesis: 2.1.1: Satisfaction with Access to Community-based Specialty Services

MMMC child enrollees will report being satisfied with their access to community-based specialty services for children with chronic conditions.

Study Population and Data Sources

This hypothesis will be tested for children with special needs in the 2018 CAHPS CCC data.

Outcome Measures

Questions related to access to community-based specialty services for children with chronic conditions will be used, including:

1. In the last 6 months, how often was it easy to get special medical equipment or devices for your child?
2. In the last 6 months, how often was it easy to get this therapy for your child?
3. In the last 6 months, how often was it easy to get this treatment or counseling for your child?

Analytic Approach

The evaluation team will describe the differences in the measure between Medicaid FFS and MMMC populations. A χ^2 test may be used to test the difference.

Research Question 2.2: Effect of Access to Community-based Integrated Health/Behavioral Health Care

To what extent are MMMC enrollees accessing community-based health care or integrated health/behavioral health care in a manner that results in improved health care outcomes?

The data source and analytic approach are similar across the four hypotheses under this research question; they are described together below.

Hypothesis 2.2.1: Follow-Up after Hospitalization for Mental Illness

MMMC child enrollees will have better follow up after hospitalizations compared to non-enrollees.

Hypothesis 2.2.2: Follow Up for Children Prescribed ADHD Medication

MMMC child enrollees will have enhanced integrated health/behavioral health care, as demonstrated through increased follow up for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication.

Hypothesis 2.2.3: Metabolic Monitoring for Children on Antipsychotics

MMMC child enrollees will have enhanced integrated health/behavioral health care, as demonstrated through increased metabolic monitoring for children and adolescents on antipsychotics.

Study Population and Data Sources

The evaluation will use aggregate measures produced by DOH using the July 2017 to July 2019 Medicaid Data Warehouse for the target populations of the Children's Design, as well as for the comparison population, which may be comparable Medicaid FFS children or MMMC children.

Outcome Measures

1. Hypothesis 2.2.1: Follow-up after hospitalization for mental illness among children or adolescents ages 6 to 17
2. Hypothesis 2.2.2: Follow-up care for children prescribed ADHD medication
3. Hypothesis 2.2.3: Metabolic monitoring for children and adolescents on antipsychotics

Analytic Approach

The trends in these outcome measures and the differences at baseline between the target population and the comparison population will be discussed. Because these outcome measures come from the Medicaid Data Warehouse, a comparison population is likely feasible. Care will be taken in identifying such a comparison population, as the general MMMC population or FFS population may have fewer or less severe conditions and a lower level of HCBS needs. The propensity score matching approach may be used to find similar comparison individuals.

A χ^2 or t-test or a logistic, Poisson, negative binomial regression may be used to test the difference, as appropriate. For multiple data points for both groups, logistic regression may be used for dichotomous outcomes using the number of individuals in each group for each time period as the frequency weight. The analysis will be stratified for each of the target populations.

Goal 3. Effect of Access to HCBS: Increase appropriate access to the uniform HCBS benefit package for children who meet level of care criteria to achieve improved health outcomes while recognizing that children's needs, including the duration, scope, and frequency of services, change over time

Research Question 3.1: HCBS Enrollment

How has enrollment in HCBS increased over the length of the Demonstration?

Hypothesis 3.1.1: Increase in HCBS Enrollment

Enrollment in HCBS will increase over the length of the Demonstration.

Study Population and Data Sources

Medicaid Data Warehouse data will be used to identify children enrolled in HCBS, as well as the timing of enrollment and disenrollment. The same group of children may be used for a pre- and post-implementation comparison.

Outcome Measures

The number of children enrolled in HCBS.

Analytic Approach

Enrollment changes over time and the patterns of enrollment of the target populations will be delineated. If the enrollment timings are available at the aggregate level, enrollment patterns will be examined using survival analysis techniques as appropriate to describe the enrollment duration and compare the pre- and post-implementation patterns.

Goal 5. Effect of Access to Health Home Model: Improve access to the integrated Health Home model for all children to improve the coordination of care for children and increase access to services

Research Question 5.1: Access to Primary Care

To what extent are Health Home/HCBS enrollees accessing primary care?

Hypothesis 5.1.1: Improved care coordination

As noted above, Hypothesis 5.1.1 will be addressed in the interim report using qualitative methods. Data will be collected following the methods described under Hypothesis 1.1.1. It is important to reiterate that these methods cannot provide a formal test of the hypothesis and are not intended to do so. Rather, through key informant interviews, the evaluation team will collect and analyze stakeholder perspectives on whether the Children’s Design has met this important goal. In the interviews, stakeholders will be asked about their impressions of whether the Children’s Design implementation has improved care coordination or not and the evidence that has led them to these opinions. As evaluators, the aim is not to assess the validity of the stakeholders’ beliefs about the effects of the Children’s Design. However, it may be possible to ascertain whether stakeholders base their claims on their own clinical experience or on a more systematic assessment of evidence. As described above, the qualitative analysis of key informant interviews will summarize the themes that arise during the interviews and will compare and contrast these views across informant types (advocate, plan administrator, or provider).

Hypothesis 5.1.2: Increase in Immunization

The number of child/adolescent immunizations will increase.

Study Population and Data Sources

The immunization measures for children and adolescents will come from the Medicaid Data Warehouse.

Outcome Measures

1. Childhood immunization status
2. Immunizations for adolescents

Analytic Approach

Immunization status of children and adolescents will be analyzed over time. A comparison population may be constructed to compare the measures between the two groups. A χ^2 test or a logistic regression may be used to test the difference. If the sample size allows, the analysis can be conducted for each of the subpopulations.

Research Question 5.3: Effect of Health Home Model on Quality of Care

Are Health Homes Serving Children/HCBS enrollees accessing necessary services such as health monitoring and prevention services? Are chronic health and behavioral health conditions being managed appropriately?

Hypothesis 5.3.2: Improved Weight Management and Nutrition Counseling

The receipt of services in an integrated managed care setting will result in increased weight assessment and counseling for nutrition and physical activity for children/adolescents.

Study Population and Data Sources

The measure will be derived using NYS Quality Assurance Reporting Requirements (QARR) data for the population eligible for the Children's Design and the comparison population.

Outcome Measures

Weight assessment and counseling for nutrition and physical activity for children/adolescents – body mass index assessment for children/adolescents will be included.

Analytic Approach

A FFS population will be used as a comparison. The differences in the receipt of weight management and counseling for nutrition and physical activity will be described. A χ^2 test or a logistic regression may be used to test the difference. The analysis will be conducted for each of the three subpopulations.

Hypothesis 5.3.3: Care Coordination

MMMC enrollees with chronic conditions will report that someone helped them coordinate care.

Study Population and Data Sources

The 2018 CAHPS CCC survey data will be used to test this hypothesis among children and adolescents with chronic conditions.

Outcome Measures

Questions that elicit parents' reports of care coordination provided by a health plan or doctor's office or clinic will be used, including:

1. Did anyone from your child's health plan, doctor's office, or clinic help you get special medical equipment or devices for your child?
2. Did anyone from your child's health plan, doctor's office, or clinic help you get this therapy for your child?
3. Did anyone from your child's health plan, doctor's office, or clinic help you get this treatment or counseling for your child?
4. In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?

Analytic Approach

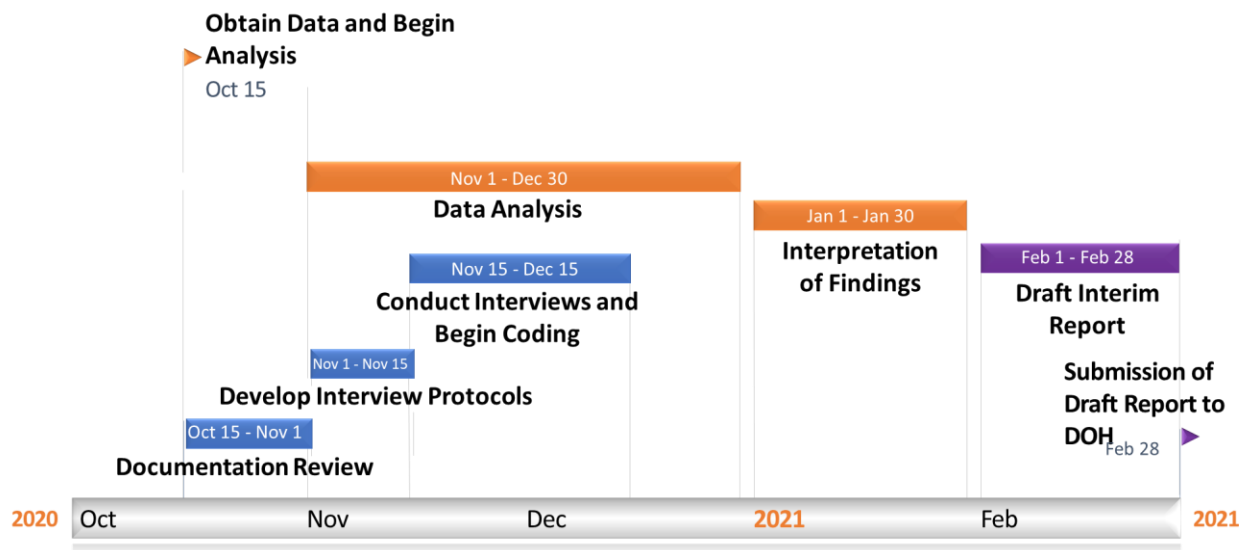
Differences in the measure between Medicaid FFS and MMMC children with chronic conditions will be described. A χ^2 test may be used to test the difference between the two groups.

4. FINDINGS

Beginning in March 2020, the significant impact of the COVID-19 pandemic on the NYS health care system required DOH personnel to shift attention, resources, and priorities. This understandable shift created contract execution and data access delays. As a result, the evaluation timeline has changed; no findings are available at the time of this writing given the recent receipt of the data, which did not allow for adequate analyses to develop findings.

Despite contractual delays, a number of meetings have been held between DOH and RAND to discuss and plan the evaluation and to answer RAND's questions related to program implementation. DOH has made significant progress on data curation and has shared all data except those on program enrollment and a quality of care measure (please see the "Status" column in Table 3.1). NYS has also shared a list of candidates for interviews, notes for meetings with various stakeholders, and State policy documents. The findings of this interim evaluation are expected to be available in Spring 2021. The timeline for the interim evaluation is presented in Figure 1.

Figure 1. Children's Design Evaluation Timeline



5. POLICY IMPLICATIONS

No policy implications are available to report at this time. A more thorough discussion will be included in the interim report, once the results and conclusions are available.

6. INTERACTIONS WITH OTHER STATE INITIATIVES

Interactions of Children’s Design implementation with other state initiatives will be described in the interim report.

APPENDIX A. TENTATIVE EVALUATION TIMELINE AND MILESTONES

Milestones	2020 - 2021						
	Prelim	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
Institutional Review Board approval							
Request submission	X						
Approval	X						
Data Access							
Request submission	X						
Access to aggregate data	X						
Obtain a list of key informants	X						
Goal 1: HCBS Population Outcomes							
Hypothesis 1.1.1: Potentially Preventable Emergency Room Visits and Stakeholder Observations							
Preliminary analyses		X	X				
Final analyses				X			
Interpretation of findings				X			
Hypothesis 1.3.1: Satisfaction with Primary Care							
Preliminary analyses		X	X				
Final analyses				X			
Interpretation of findings				X			
Hypothesis 1.3.2: Well-care Visits							
Preliminary analyses		X	X				
Final analyses				X			
Interpretation of findings				X			
Goal 2: EPSDT Benefits							
Hypothesis: 2.1.1: Satisfaction with Access to Community-based Specialty Services							
Preliminary analyses		X	X				
Final analyses				X			
Interpretation of findings				X			
Hypothesis 2.2.1: Follow-Up after Hospitalization for Mental Illness							
Preliminary analyses		X	X				
Final analyses				X			
Interpretation of findings				X			

Milestones	2020 - 2021						
	Prelim	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
Hypothesis 2.2.2: Follow Up for Children Prescribed ADHD Medication							
Preliminary analyses		X	X				
Final analyses				X			
Interpretation of findings				X			
Hypothesis 2.2.3: Metabolic Monitoring for Children on Antipsychotics							
Preliminary analyses		X	X				
Final analyses				X			
Interpretation of findings				X			
Hypothesis 2.2.4: Emergency Department Visits and Hospitalizations							
Preliminary analyses		X	X				
Final analyses				X			
Interpretation of findings				X			
Goal 3: Access to HCBS							
Hypothesis 3.1.1: HCBS Enrollment							
Preliminary analyses		X	X				
Final analyses				X			
Interpretation of findings				X			
Goal 5: Access to Health Home							
Hypothesis 5.1.1: Stakeholder Observations on Care Coordination							
Preliminary analyses		X	X				
Final analyses				X			
Interpretation of findings				X			
Hypothesis 5.1.2: Immunization							
Preliminary analyses		X	X				
Final analyses				X			
Interpretation of findings				X			
Hypothesis 5.3.2: Weight Management and Nutrition Counseling							
Preliminary analyses		X	X				
Final analyses				X			
Interpretation of findings				X			

Milestones	2020 - 2021						
	Prelim	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
Hypothesis 5.3.3: Care Coordination							
Preliminary analyses		X	X				
Final analyses				X			
Interpretation of findings				X			
Reports							
Monthly progress report		X	X	X	X	X	X
Draft interim report				X			
RAND Quality Assurance					X	X	
DOH-approved interim report					X		
CMS-approved interim report							X



WP No. WR-A783-1

Independent Evaluation of the New York State Health and Recovery Plans (HARP) Program

Interim Report

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ACRONYMS

ACT	Assertive Community Treatment
ANOVA	Analysis of variance
BH	Behavioral health
CAHPS	Consumer Assessment of Health Providers and Systems
CMH	Community Mental Health
CMS	Centers for Medicare and Medicaid Services
COVID-19	SARS-CoV-19
DOH	Department of Health
DSRIP	Delivery System Reform Incentive Payment
ECHO	Experience of Care and Health Outcomes
FEP	First Episode Psychosis
FFS	Fee-for-Service
F-SHRP	Federal-State Health Reform Partnership
GLMM	Generalized Linear Mixed Model
HARP	Health and Recovery Plans
HH	Health Home
HHS	Health and Human Services
HCBS	Home and Community-Based Services
MCO	Managed Care Organization
MHARS	Mental Health Automated Record System
MMC	Medicaid Managed Care
NYC	New York City
NYS	New York State
OASAS	New York State Office of Addiction Services and Supports
OMH	New York State Office of Mental Health
OTNY	OnTrackNY
PMPM/Y	Per Member per Month/Year
PPS	Performing Provider System

PROS	Personalized Recovery Oriented Services
ROS	Rest of the State
SMI	Serious Mental Illness
SNP	Special Needs Plans
SSI	Supplemental Security Income
SUD	Substance Use Disorder

1. EXECUTIVE SUMMARY

Through the New York Medicaid Redesign Team Section 1115 Demonstration, New York has pursued the goal of improving access to and quality of health care for the Medicaid population through a managed care delivery system. The Section 1115 Demonstration included reforms specifically targeted to beneficiaries with behavioral health (BH) needs (hereafter, BH Demonstration); one of them is the Health and Recovery Plans (HARP) program.

New York State contracted with the RAND Corporation to conduct an independent evaluation of the BH Demonstration programs, including a HARP program evaluation (New York State Department of Health, 2019).

The HARP program evaluation uses a mixed methods approach to determine the extent to which three goals of the Behavioral Health Demonstration have been achieved since implementation (October 2015 in New York City [NYC]; and July 2016 in Rest of State [ROS]). The three goals are as follows:

1. Improve health and BH outcomes for adults enrolled in Mainstream Medicaid Managed Care (MMC) plans whose BH care was previously covered under a fee-for-service (FFS) payment arrangement.
2. Improve health, BH, and social functioning outcomes for adults enrolled in the HARP program.
3. Develop BH home and community-based services (HCBS) focused on recovery, social functioning, and community integration for HARP enrollees meeting eligibility criteria for such services.

Beginning in March 2020, the significant impact of SARS-CoV-19 (COVID-19) pandemic on the NYS health care system resulted in the shift of NYS Department of Health (DOH) personnel, attention, resources, and priorities. This shift in focus resulted in understandable and unavoidable delays in providing the evaluation team with access to data and necessitated elongated timelines compared to those proposed prior to the COVID-19 epidemic. RAND, as the Independent Evaluator, and the NYS DOH are continuing to make progress in the sharing of data to allow RAND to complete the analysis of the HARP program evaluation research questions. At this time, there are no preliminary analyses available, and the proposed timeline to continue evaluative tasks is presented in Table 1.1 below:

TABLE 1.1. PROPOSED TIMELINE FOR REMAINING EVALUATION TASKS

Proposed Timeline	Remaining Tasks
November & December 2020	Complete Data Access for HARP Research Questions
January 2021	Data Analysis
February 2021	Data Interpretation
March 2021	Report Findings to DOH
April 2021	Summative Evaluation Report to CMS

This interim report describes RAND’s understanding of the Behavioral Health Demonstration as it pertains to the MMC and HARP programs, the questions the HARP program evaluation aims to answer, and the proposed methodology RAND will use to conduct the evaluation. The final summative report, available in 2021, will provide a full discussion of the HARP program evaluation findings and their implications for policy.

2. DEMONSTRATION DESCRIPTION

2.1 INTRODUCTION

Through the New York Medicaid Redesign Team Section 1115 Demonstration, New York pursued the goal of improving access to and quality of health care for the Medicaid population through a managed care delivery system. The Section 1115 Demonstration included reforms specifically targeted to Medicaid beneficiaries with BH needs (hereafter, Behavioral Health Demonstration). These included the MMC carve-in of BH specialty services for Supplemental Security Income (SSI) beneficiaries and the creation of the HARP program.

The RAND team is conducting a comprehensive, statewide independent evaluation of the Behavioral Health Demonstration. This interim report describes RAND’s understanding of these reforms, the questions the evaluation is aimed to answer, and the proposed methodology to conduct the HARP program evaluation. The final report will provide a full discussion of the HARP program evaluation findings.

The HARP program evaluation was designed to determine the extent to which the following three goals of the Behavioral Health Demonstration have been achieved since the program was implemented (October 2015, NYC; July 2016, ROS):

1. Improve health and BH outcomes for adults enrolled in Mainstream Medicaid Managed Care plans whose BH care was previously covered under an FFS payment arrangement.

2. Improve health, BH, and social functioning outcomes for adults enrolled in the HARP program.
3. Develop BH home and community-based services (HCBS) focused on recovery, social functioning, and community integration for HARP enrollees meeting eligibility criteria for such services.

The evaluation uses both primary (qualitative) and secondary (quantitative) data in a mixed methods empirical investigation of the beneficiary- and system-level impacts of the programs. The evaluation seeks to examine research questions related to a variety of intermediate and long-term outcomes of the Behavioral Health Demonstration.

Intermediate outcomes include access to outpatient services (primary and preventive services, BH specialty services including services for individuals experiencing first episode psychosis, BH HCBS, crisis services); quality of BH and physical health care; social outcomes, including functioning and recovery; satisfaction with care; and utilization of acute care, namely inpatient and emergency department (ED) services.

Long-term outcomes include BH and chronic physical health status; quality of life; social circumstances; Medicaid spending; and cost shift from spending on acute care to community-based services.

2.2 BACKGROUND

The New York Medicaid Redesign Team Section 1115 Demonstration (hereafter, Section 1115 Demonstration) was originally approved in 1997 with the goal of improving access to and quality of health care for the Medicaid population through a managed care delivery system (New York State, 2020).

The Demonstration has been amended numerous times since the initial design. As part of the renewal in 2006, authority to require some disabled and aged populations to enroll in mandatory managed care was transferred to the Federal-State Health Reform Partnership (F-SHRP). In April 2014, as F-SHRP was phased out, this authority was transferred to the Section 1115 demonstration. An amendment to the Demonstration approved on April 14, 2014, allowed NYS to take its first steps toward a major reform in the financing and delivery of health care to Medicaid beneficiaries through a Delivery System Reform Incentive Payment (DSRIP) program. The amendment provided funds to incentivize provider participation in DSRIP transformation activities beginning in 2015. Under the DSRIP program, all providers are required to form provider partnerships, known as Performing Provider Systems (PPSs), and collaborate to achieve

system transformation goals. The DSRIP program also includes a value-based payment reform targeting both PPSs and MMC plans.

2.3 BEHAVIORAL HEALTH DEMONSTRATION

In August 2015, NYS amended its Section 1115 Demonstration to enable qualified managed care organizations (MCOs) to comprehensively manage BH care for SSI beneficiaries whose BH benefit was previously covered under an FFS payment arrangement. Additionally, the amendment provided for BH HCBS to be made available to eligible individuals meeting defined functional needs criteria. The goals of the BH Demonstration were to improve health care quality, costs, and outcomes for the State's Medicaid BH population and to transform the BH system from an inpatient-focused system to a recovery-focused outpatient system.

The BH benefits were made available through all mainstream MMC plans and a separate coverage product, the HARPs, which are specialty lines of business operated by qualified mainstream MMC plans and available statewide. Mainstream MMC plans began to cover expanded BH benefits statewide on October 1, 2015; while HARPs also launched on October 1, 2015 in NYC, they launched in July 2016 for ROS. The BH HCBS were offered beginning in January 2016 in NYC and in October 2016 for ROS.

COMPONENTS OF THE BEHAVIORAL HEALTH DEMONSTRATION

The **mainstream MMC carve-in of BH specialty services (MMC BH carve-in program)** covers Medicaid state plan and Demonstration benefits (i.e., the full medical and BH benefit) through a managed care delivery system comprised of MCOs and primary care case management arrangements for adult MMC-eligible beneficiaries, except those with dual Medicare-Medicaid eligibility and certain other populations. The expanded BH benefit, under the MMC BH carve-in, includes psychiatric services (inpatient and outpatient) previously carved out in the Medicaid FFS program for the SSI population, SUD inpatient rehabilitation (previously carved out for the SSI population), SUD outpatient (previously carved out in the Medicaid FFS for both SSI and Non SSI), along with community-based BH specialty services such as Assertive Community Treatment (ACT), Personalized Recovery Oriented Services (PROS), and First Episode Psychosis (FEP) programs, some of which were previously covered only by the FFS program.

The **HARP program** covers a benefit package of BH HCBS in addition to the existing mainstream MMC benefit package for non-dual Medicaid beneficiaries meeting eligibility criteria. HARP benefit eligibility includes being age 21 or over; meeting eligibility for mainstream MMC; having serious mental illness (SMI) and/or substance use disorder (SUD) diagnoses (HARP Target

Criteria); and meeting HARP Risk Factor criteria, most of which are based on BH utilization patterns (Figure 2.1).

FIGURE 2.1. HARP ELIGIBILITY, TARGET CRITERIA, AND RISK FACTORS

Health and Recovery Plans: Adult Medicaid beneficiaries 21 and over who are eligible for mainstream MCOs are eligible for enrollment in the HARP program if they meet target criteria and risk factors as defined below.

HARP Target Criteria: NYS has chosen to define HARP Target Criteria as:

- i. Medicaid enrolled individuals age 21 and over
- ii. SMI/SUD diagnoses
- iii. Eligible to be enrolled in Mainstream MCOs
- iv. Not Medicaid/Medicare enrolled ("duals")
- v. Not participating or enrolled in a program with the NYS Office for People with Developmental Disabilities (OPWDD)
- vi. Not participating in the Traumatic Brain Injury Waiver or Nursing Home Transition and Diversion Waiver

HARP Risk Factors: Risk Factor criteria may include any of the following:

- i. SSI individuals who received an "organized" mental health service in the year prior to enrollment
- ii. Non-SSI individuals with three or more months of ACT or Targeted Case Management (TCM),* PROS, or prepaid mental health plan (PMHP)* services in the year prior to enrollment
- iii. SSI and non-SSI individuals with more than 30 days of psychiatric inpatient services in the three years prior to enrollment
- iv. SSI and non-SSI individuals with three or more psychiatric inpatient admissions in the three years prior to enrollment
- v. SSI and non-SSI individuals discharged from a NYS Office of Mental Health (OMH) Psychiatric Center after an inpatient stay greater than 60 days in the year prior to enrollment
- vi. SSI and non-SSI individuals with a current or expired Assisted Outpatient Treatment (AOT) order in the five years prior to enrollment
- vii. SSI and non-SSI individuals discharged from correctional facilities with a history of inpatient or outpatient BH treatment in the four years prior to enrollment.
- viii. Residents in OMH-funded housing for persons with SMI in any of the three years prior to enrollment
- ix. Enrollees with two or more services in an inpatient/outpatient chemical dependence detoxification program within the year prior to enrollment
- x. Enrollees with one inpatient stay with a SUD primary diagnosis within the year prior to enrollment
- xi. Enrollees with two or more inpatient hospital admissions with SUD primary diagnosis or members with an inpatient hospital admission for an SUD-related medical diagnosis-related group and a secondary diagnosis of SUD within the year prior to enrollment
- xii. Enrollees with two or more ED visits with primary substance use diagnosis or primary medical non-substance use that is related to a secondary substance use diagnosis within the year prior to enrollment
- xiii. Individuals transitioning with a history of involvement in children's services

**Adult TCM Transition to Health Home ended on 12/1/2015 and PMHP ended on 12/31/2015; both are no longer funded programs.*

Being an SSI beneficiary is not, in itself, an eligibility criterion. The HARP criteria have not changed since the launch of the program. HARP-eligible individuals are identified through

Medicaid data reviews of BH service utilization conducted every two months by Plans and/or NYS indicating that specific pre-determined criteria have been met (HARP algorithm).

The HARP benefit package may be accessed through HARPs or HIV SNPs. HARP-eligible individuals who are already enrolled in an HIV SNP receive the enhanced HARP benefits while enrolled in their current plan. Though these individuals may disenroll from an HIV SNP into a HARP, this is not encouraged as this would entail loss of the HIV SNP benefits.

Eligible beneficiaries are passively enrolled into HARPs; however, they are able to opt out within the first 90 days following passive enrollment and return to their original Mainstream MMC plan. Following the 90 day opt out-period, HARP beneficiaries may not change plans again until the remainder of the 12-month lock-in period has lapsed. HARP eligible individuals enrolled in a Mainstream MMC plan whose MCO does not operate a HARP line of business can voluntarily enroll in a HARP, with the MCO assisting with the transfer to the HARP.

Upon enrollment, the HARPs and HIV SNPs work with Health Homes or other state-designated entities to develop a person-centered care plan that includes assessment for BH HCBS eligibility and to provide care management for all services, including BH HCBS. The plan of care, including eligibility for BH HCBS, is reassessed at least annually; reassessment will also occur when the individual's circumstances or needs change significantly or at the request of the individual.

BH HCBS are delivered to HARP and HARP-eligible HIV SNP enrollees in residential and non-residential settings located in the community under a two-level tier structure determined by the person-centered plan of care. Tier 1 services include Individual Employment Support, Education Support, and Peer Services. Tier 2 services include all Tier 1 services plus additional services for beneficiaries with a higher level of need.

Eligibility for BH HCBS is assessed through the BH HCBS Eligibility Assessment, a standardized clinical and functional assessment tool derived from the interRAI™ Community Mental Health (CMH) Assessment (Hirdes et al., 2000), also referred to as *CMH Screen*. The eligibility threshold for Tier 2 services, higher relative to Tier 1 services, requires evidence of at least "moderate" level of need as indicated by a state-designated score on the CMH Screen (see Figure 2.2). While these are the current criteria, the original criteria were more stringent (Table 3.1 provides a timeline of key events). Until June 2018, eligibility for Tier 2 services required moderate need on at least four domains (or extensive need on at least one domain). A third criterion was added in June 2019 that permitted previously eligible BH HCBS users to continue receiving services.

FIGURE 2.2. DETERMINATION OF BH HCBS SERVICE ELIGIBILITY

- A. Criterion 1: Tier 1 Services
 - i. For Individual Employment Support, person must express desire to receive employment support services.
 - ii. For Education Support, person must express desire to receive education support services to assist with vocational goals.
 - iii. For Peer Support, person must express desire to receive peer support services.
 - B. Criterion 2: Tier 2 Services
 - i. Meets threshold score for MODERATE need on at least one domain of Functional and Safety Needs* OR
 - ii. Meets threshold score for EXTENSIVE need on at least one domain of Functional and Safety Needs.*
 - C. Criterion 3
 - i. Individuals who receive or have previously received BH HCBS in the past six months will maintain their eligibility level for the current assessment (i.e., algorithm will return the higher of the two scores to prevent loss of potentially beneficial services).
- * Domains of Functional and Safety needs include employment/education, instrumental activities of daily living (IADLs), cognitive skills, social relations, stress and trauma, co-occurring conditions, engagement, substance use, and risk of harm.

NYS DOH had expected that, by the end of the evaluation period, 75 percent of HARP enrollees would be eligible for Tier 1 BH HCBS, with fewer, 70 percent, eligible for Tier 2 services, and that among those deemed eligible, 75 percent would be utilizing BH HCBS. However, the new expectation based on recent fiscal discussions is that 30 percent of HARP enrollees would utilize BH HCBS (Marleen Radigan/OMH, 2/27/2020).

In addition to BH HCBS, all HARP enrollees, regardless of BH HCBS eligibility or tier, are eligible to receive crisis respite services, including intensive crisis respite and short-term crisis respite in a dedicated facility.

2.4 EVALUATION TIMELINE AND PROGRESS TO DATE

Due to significant impacts of COVID-19 on NYS DOH staff, this interim report only includes information pertaining to the design and implementation of the HARP program evaluation to date. All findings and conclusions will be discussed in a final summative report available in Spring 2021.

REVISED TIMELINE AND BARRIERS TO DATA ACCESS

The original evaluation timeline was revised to allow for additional time for analysis. The progress to date is presented in Figure 2.3. The COVID-19 response within the NYS DOH, along with other related factors, delayed the execution of data use agreements, hampering the ability

of the evaluation team to access the data necessary to conduct analysis. As discussed in Section 3, the ability to access and analyze the person-level data is integral to responding to the evaluation questions.

FIGURE 2.3. HARP EVALUATION PROGRESS TIMELINE TO DATE



NEXT STEPS

All evaluation components will be completed and will be published in a final summative report in 2021, as noted in Table 1.1.

3. EVALUATION DESIGN AND METHODS

RAND is conducting a comprehensive, statewide independent evaluation of the BH Demonstration implemented in 2015 as part of the latest amendment to the New York Medicaid Redesign Team Section 1115 Demonstration, with a focus on the MMC BH carve-in and the HARP programs (HARP program evaluation). The independent evaluation adheres to the evaluation standards set forth in the Special Terms and Conditions for the Demonstration (New York State, 2020, Section XI, Evaluation Requirements).

The evaluation design is a mixed-method investigation driven by research questions and testable hypotheses that address the goals of the BH Demonstration, including the beneficiary- and system-level impacts of the MMC BH carve-in and HARP programs. Quantitative methods will be used for descriptive purposes and for the outcome evaluations, and qualitative methods will be used to provide context for the quantitative findings and to inform the process evaluation with administrative, provider, and beneficiaries’ perspectives on HARP program functioning and effectiveness. Each type of method will be used as feasible and necessary to address the research questions.

The data sources for the HARP program evaluation include qualitative data collected during the course of the evaluation, and a variety of administrative and survey data previously collected by the NYS DOH, the NYS OMH, and NYS New York State Office of Addiction Services and Supports (OASAS) during the course of health care administrative or clinical operations and quality improvement initiatives. The evaluation team has also planned to integrate data describing county-level characteristics that have the potential to affect program outcomes.

The length of time to be covered by this evaluation—about three years or more (depending on region) after the launch of the BH Demonstration—ensures sufficient program maturity and adequate availability of post-policy patient populations (e.g., comparisons of eligible HARP enrollees receiving BH HCBS with those who have opted out or those deemed ineligible). Hence, RAND expects that the findings of this evaluation will be a valuable resource for NYS DOH and CMS in determining whether and what kinds of changes or corrections to the implementation of the BH Demonstration are needed.

Table 3.1 presents an overview of the goals of the evaluation, the original research questions related to each goal, and the methods proposed to answer each research question. Each will be discussed in Section 3.2; the data sources will be discussed more thoroughly in Sections 3.3 and 3.4.

TABLE 3.1 HARP GOALS AND EVALUATION METHODS AND RESEARCH QUESTIONS

Goals	Methods	Research Questions
<p>1. Improve health and BH outcomes for adults in Mainstream MMC whose BH care was previously carved out in a FFS payment arrangement.</p>	<p>Analyses of Medicaid claims and encounter data and data from the OTNY system; key informant interviews with BH providers.</p>	<p>1. <i>To what extent are MMC enrollees accessing community-based BH specialty services (e.g., ACT, PROS, and FEP programs)?</i> 2. <i>To what extent are MMC enrollees accessing community-based health care or integrated BH/physical health care?</i></p>
<p>2. Improve health, BH, and social functioning outcomes for adults in the HARP program (HARP eligible, HARP enrolled).</p>	<p>Analyses of Medicaid claims, encounter, and enrollment data; data from CMH screens; plan-reported HEDIS/QARR quality measures; Consumer Assessment of Health Providers and Systems (CAHPS) and HARP PCS patient experience data; interviews with HARP enrollees.</p>	<p>1. <i>How has enrollment in HARP plans increased over the length of the demonstration?</i> 2. <i>What factors are associated with individuals choosing to opt out of HARP plans?</i> 3. <i>What are the demographic, social, functional, and clinical characteristics of the HARP population? Are they changing over time?</i> 4. <i>What are the educational and employment characteristics of the HARP population? Are they changing over time?</i> 5. <i>To what extent are HARP enrollees accessing primary care?</i> 6. <i>To what extent are HARP enrollees accessing community-based BH specialty services? (ACT, PROS, OMH Outpatient Clinic, Continuing Day Treatment, Partial Hospitalization, OASAS Opioid Treatment Program, OASAS Outpatient Clinic, and FEP programs)</i> 7. <i>To what extent are HARP enrollees accessing Health Homes for care coordination?</i> 8. <i>To what extent is HARP quality of care improving, especially related to the HEDIS measures of health monitoring, prevention, and management of BH conditions, cardiovascular disease, asthma, diabetes, and other selected chronic health conditions?</i> 9. <i>To what extent are HARP enrollee experiences with care and access to health and BH services positive?</i> 10. <i>To what extent are HARP enrollees satisfied with the cultural sensitivity of BH providers and their wellness, recovery, and degree of social connectedness?</i> 11. <i>To what extent are HARPs cost effective? What are the PMPM cost of inpatient psychiatric services, SUD ancillary withdrawal, hospital-based detox, and ER services for the HARP population? Are these costs decreasing over time?</i></p>

3. Develop HCBS focused on recovery, social functioning, and community integration for individuals in HARPs meeting eligibility criteria.	Analyses of Medicaid claims and encounter data; data from CMH screens; data from the MMC HCBS Provider Network Data System; Complaints and Appeals data; interviews with HARP enrollees; key informant interviews with BH HCBS providers, Home Health and HARP administrators, and state officials.	<p><i>1 To what extent are HARP enrollees deemed eligible to receive HCBS?</i></p> <p><i>2. To what extent are HARP enrollees who are deemed HCBS-eligible receiving HCBS?</i></p> <p><i>3. To what extent has the demonstration developed provider network capacity to provide BH HCBS for HARPs?</i></p> <p><i>4. Does targeting of BH HCBS more narrowly lead to increased numbers of members without access to appropriate BH care? (What are the consequences of targeting availability of BH HCBS to a more narrowly defined population than the criteria in the State Plan?)</i></p>
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The evaluation approach described below is the approach as planned; additional modifications may be made if necessary, during analysis.

3.1 DISCUSSIONS WITH EXPERTS TO REFINE APPROACH

To better understand the policy context, objectives, and challenges to the implementation of the BH Demonstration, the RAND team held calls with subject matter experts within NYS DOH, NYS OMH, NYS OASAS, and OnTrackNY (OTNY) to discuss the background and implementation of the MMC BH carve-in and HARP programs. In addition, the evaluation team held discussions with data experts within these agencies to review the feasibility of fully addressing the research questions given constraints of the available data.

The evaluation team has been using the information thus gathered to inform the qualitative component of the evaluation and revise and enhance the planned quantitative analyses. Some research questions and outcome measures have already been refined to reflect the information available in the data. Moreover, at the time of this writing, it is not yet clear whether the evaluation team will have access to data as far back as 2011, which would be required to address some of the research questions. Additional modifications to the evaluation plan may be necessary.

Using the information gathered in these calls along with publicly available NYS DOH documents, a timeline was developed to indicate key events of the BH demonstration with the potential to impact the implementation and outcomes of the MMC BH carve-in and HARP programs. Table 3.2 presents these key events and associated dates.

TABLE 3.2. BH DEMONSTRATION TIMELINE

Year	Month	Event
2015	April	DSRIP (Performing Provider Systems)
	August	Amended 1115 Waiver includes BH reform initiatives: (a) qualified MCOs may manage BH benefits for SSI beneficiaries through MMC plans and HARPs (BH carve-in) (b) eligible individuals meeting defined functional needs criteria may access BH-HCBS
	October	MMC BH Carve-in launches in NYC
	October	HARP program launches in NYC (also for eligible HIV SNP enrollees)
2016	January	BH-HCBS become available in NYC (for eligible HARP & HIV SNP enrollees)
	July	MMC BH Carve-in launches in ROS
	July	HARP program launches in ROS (also for eligible HIV SNP enrollees)
	October	BH-HCBS become available in ROS (for eligible HARP & HIV SNP enrollees)
	December	DOH pauses Health Homes (HH) billing to Plans for payment for BH-HCBS assessment and authorizes direct FFS billing to DOH
2017	March	BH-HCBS assessment process was streamlined
	October	Quality Funds become available to MCOs to promote access to BH-HCBS for their HARP enrollees (awards retained based on number of new BH HCBS recipients)
	October – March 2019	BH-HCBS Infrastructure Funds added to the HARP premium for MCOs and providers to develop capacity, connectivity, and innovative service delivery
	October	Revision of BH-HCBS Workflow Guidance for HH-enrolled HARP enrollees
2018	January	Funds for BH-HCBS (including assessments and plans of care) are included in the HARPs' premium rates (NYC)
	February	Beneficiary-targeted BH-HCBS educational initiatives implemented (e.g., peer focused outreach & training about BH-HCBS)
	April	HARPs may contract with State Designated Entities (RCAs) to conduct BH-HCBS assessments and care planning for enrollees not enrolled in HHs
	May	Expansion of 'Health Home Plus' to include high-need SMI individuals
	June	HARP becomes an option on the NYS of Health (Exchange)
	June	Changes to eligibility criteria for BH-HCBS Tier 2 services
	July	DOH resumes payments to HHs for BH-HCBS assessment via HARPs' capitated budgets
	July	All health plans contracted with HHs need to submit Engagement & Enrollment (outreach) Optimization Proposal to enroll high-risk enrollees
	August	Launch of HARP performance measures for HHs
	October	Funds for BH-HCBS (including assessments and plans of care) are included in the HARPs' premium rates (ROS)
2019	January	Updated HH re-designation policy and chart review and scoring tools (including HARP performance)
	June	Addition of new criterion to eligibility criteria for BH-HCBS
	September	Update of (a) staff qualifications to serve 'Health Home Plus' SMI enrollees and (b) assessor qualifications for administering the BH-HCBS assessments
	September	Care managers and/or supervisors may request a waiver of education/experience qualifications

3.2 HARP GOALS AND RESEARCH QUESTIONS

The HARP program evaluation was designed to determine the extent to which three goals of the BH Demonstration have been achieved since the program was implemented (October 2015, NYC; July 2016, ROS). These include improving health outcomes (1) in mainstream MMC, (2) among HARP-enrolled beneficiaries, and (3) among BH HCBS-using beneficiaries. These three goals are described below:

GOAL 1: IMPROVE HEALTH OUTCOMES IN MAINSTREAM MMC

The first goal of the BH Demonstration is to improve health and BH outcomes for adults enrolled in Mainstream MMC plans whose BH care was previously carved out in an FFS payment arrangement. As presented in Table 3.3, this goal is broken into two research questions focused on determining the extent to which health and behavioral health outcomes changed. The data sources for this question are Medicaid data and OTNY data, coupled with key informant interviews.

TABLE 3.3: GOAL 1 PROGRAM GOALS, DATA SOURCES, AND OUTCOME MEASURES

Program Goals	Data Sources	Outcome Measures
1. Improve access to BH specialty services, including OTNY (pre: 2011-9/2015; post: 10/2015-2019; OTNY-based outcomes are only possible 2015-2019)	Medicaid Data (Claims and Encounters)	Percentage of Mainstream MMC enrollees receiving non-FEP BH specialty services (any, specific, average units), by annual period, pre and post (statewide)
	OTNY Data System	Percentage of Mainstream MMC receiving OTNY services, by annual period from baseline (statewide)
	Key informant interviews with BH Providers	Barriers and facilitators to BH specialty care under mainstream MMC
2. Improve access to primary and/or preventive services (pre: 2011-9/2015; post: 10/2015-2019)	Medicaid Data (Claims and Encounters)	Percentage of MMC enrollees not receiving primary and/or preventive services, by annual period, pre and post (statewide)
	Key informant interviews with BH Providers	Barriers and facilitators to primary and preventive care under mainstream MMC

GOAL 2: IMPROVE HEALTH OUTCOMES AMONG HARP-ENROLLED BENEFICIARIES

The second goal of the BH Demonstration is to improve health, BH, and social functioning outcomes for adults enrolled in the HARP program. This goal has 11 research questions described in Table 3.4.

TABLE 3.4: GOAL 2 PROGRAM GOALS, DATA SOURCES, AND OUTCOME MEASURES

Program Goals	Data Sources	Outcome Measures
1. Increase HARP Enrollment (10/2015-2019)	Medicaid Data (Enrollment Data)	Percentage of HARP eligible beneficiaries enrolled in MMC, HARP, or HIV SNP, by annual period, NYC and ROS
2. Describe characteristics of HARP eligible beneficiaries electing to or declining enrollment in HARP and reasons for declining enrollment in HARP (10/2015-2019)	Medicaid Data (Claims and Encounters)	Population-level differences in person-level characteristics (demographics and health status/clinical characteristics including BH service utilization) for HARP eligible enrollees who opt-in versus opt-out of HARP, by annual period, NYC and ROS
	Medicaid Choice Enrollment Data	Reasons for opting out of HARP, by annual period, NYC and ROS
	Key informant interviews with BH providers, care coordinators, and state officials	Barriers and facilitators to HARP enrollment, access to specialty BH, primary, and preventive care and use of care coordination services
3. Describe demographic, social, functional, and clinical characteristics of the HARP population (10/2015-2019)	Medicaid Data (Claims and Encounters)	Percentage of HARP enrollees with specific socio-demographics, by annual period, NYC and ROS: population level and individual level
	CMH Screen	Percentage of HARP enrollees with Risk and Protective factors, by annual period, NYC and ROS: population level and individual level
	Interviews with HARP enrollees	Barriers and facilitators to HARP enrollment, access to care and care coordination
4. Improve educational and employment characteristics of the HARP population (10/2015-2019)	CMH Screen	Educational and employment attainment for HARP enrollees, by annual period, NYC and ROS: population level and (risk-adjusted) individual level
5. Improve access to primary and/or preventive services for the HARP population (NYC pre: 10/2013-9/2015; NYC post: 10/2015; ROS pre: 7/2014-6/2016; ROS post: 7/2016-6/2018)	Medicaid Data (Claims and Encounters)	Percentage of HARP eligible enrollees not receiving primary or preventive health services, by annual period, NYC and ROS

Program Goals	Data Sources	Outcome Measures
6. Improve access to BH specialty services for the HARP population (NYC pre: 10/2013-9/2015; NYC post: 10/2015; ROS pre: 7/2014-6/2016; ROS post: 7/2016-6/2018)	Medicaid Data (Claims and Encounters)	Percentage of HARP eligible enrollees receiving BH specialty services, by annual period, NYC and ROS
	OTNY Data System	Percentage of HARP enrollees receiving OTNY services, by annual period from baseline (statewide)
7. Increase access to care coordination (Health Homes) for the HARP population (NYC pre: 10/2013-9/2015; NYC post: 10/2015; ROS pre: 7/2014-6/2016; ROS post: 7/2016-6/2018)	Medicaid Data (Claims and Encounters)	Percentage of HARP eligible enrollees engaged in Health Home services, by annual period, NYC and ROS
8. Improve quality of care related to health monitoring, prevention, and management of chronic health conditions for the HARP population (NYC pre: 10/2013-9/2015; NYC post: 10/2015; ROS pre: 7/2014-6/2016; ROS post: 7/2016-6/2018)	Plan-reported HEDIS® / QARR quality measures	Quality of care among HARP eligible enrollees, by annual period, NYC and ROS
	Medicaid Data (Claims and Encounters)	
9, 10. Improve experiences with and satisfaction with care for the HARP population (10/2015-9/2019)	CAHPS	Percentage of HARP enrollees who: 1) report it was easy to get BH treatment; 2) report it was easy to get SUD treatment; 3) rated their BH treatment positively; 4) rated their SUD treatment positively; 5) rated items related to communication with health care providers positively. By annual period when data are available, NYS and ROS.
	HARP PCS	Percentage of HARP enrollees who: 1) report that BH care was responsive to their cultural background; 2) had a positive overall rating of quality of life; 3) had overall positive beliefs about health and wellness; 4) rated PCS questions in the social connectedness domain positively. By annual period when data are available, NYS and ROS.
11. Decrease utilization and PMPM cost of acute care BH services (inpatient psychiatric services, SUD ancillary withdrawal, hospital-based detox, and ER services) for the HARP population (NYC pre: 10/2013-9/2015; NYC post: 10/2015; ROS pre: 7/2014-6/2016; ROS post: 7/2016-6/2018)	Medicaid Data (Claims and Encounters)	Risk-adjusted utilization of acute care and non-acute care (outpatient) BH services among HARP eligible enrollees, by annual period (PMPM/Y), NYC and ROS
	MHARS	Risk-adjusted PMPM cost of acute care and non-acute care (outpatient) BH services among HARP eligible enrollees, by annual period (PMPM/Y), NYC and ROS

GOAL 3: IMPROVE HEALTH OUTCOMES AMONG BH HCBS-USING BENEFICIARIES

The third goal of the BH Demonstration is to develop BH HCBS focused on recovery, social functioning, and community integration for HARP enrollees meeting eligibility criteria for such services. This goal, presented in Table 3.5, has four research questions focused on assessing the level of enrollment in BH HCBS by HARP enrollees and cost reduction. The data sources for this question are Medicaid claims and encounters data, CMH Screen data, MMC data, complaints and appeals data, coupled with key informant interviews.

TABLE 3.5: GOAL 3 PROGRAM GOALS, DATA SOURCES, AND OUTCOME MEASURES

Program Goals	Data Sources	Outcome Measures
1. Increase the number of HARP enrollees assessed for eligibility to receive BH HCBS and describe those deemed BH HCBS- eligible (10/2015-2019)	Medicaid Data (Claims and Encounters) CMH Screen	Percentage of HARP enrollees who are assessed for BH HCBS eligibility, by annual period, NYC and ROS Percentage of HARP enrollees who are deemed BH HCBS eligible (any, by Tier), by annual period, NYC and ROS Population-level characteristics of HARP enrollees deemed eligible for BH HCBS – these include HARP Plan membership, socio-demographics (including geographical region), health status/clinical characteristics, and functional status). By annual period, NYC and ROS.
2. Increase the number of BH HCBS-eligible HARP enrollees who are receiving BH HCBS (2016-2019)	Medicaid Data (Claims and Encounters) CMH Screen Interviews with HARP Enrollees	Percentage of BH HCBS-eligible HARP enrollees receiving any BH HCBS, by month and annually, at the HARP plan level, regionally (NYC, ROS, by county) and statewide; and annual percent change <i>Eventually:</i> Risk-adjusted percentage of BH HCBS-eligible HARP enrollees receiving BH HCBS (any, at least 6 months) (compared to those receiving none, less than 6 months) Barriers and facilitators to accessing BH HCBS services
3. Develop provider network capacity to provide BH HCBS for HARPs (2016-2019)	Medicaid Data (Claims and Encounters)	Number of providers contracted for BH HCBS in HARP plans, by HARP plan, by annual period, regionally (NYC, ROS, by

Program Goals	Data Sources	Outcome Measures
	MMC HCBS Provider Network Data System	county) and statewide Rate of BH HCBS providers per 1000 BH HCBS eligible enrollees, by annual period, regionally (NYC, ROS, by county) and statewide
	Complaints and Appeals Data	Rate of complaints and appeals due to denial of BH HCBS services per 1000 BH HCBS eligible enrollees, by annual period, regionally (NYC, ROS, by county) and statewide
	Key informant interviews with BH HCBS providers, Health Home and HARP administrators, State officials	Barriers and facilitators to provision of BH HCBS services and the effectiveness of the services provided
4. Reduce total PMPM costs for BH HCBS recipients through reductions in higher cost (acute-care) services (NYC pre: 10/2013-9/2015; NYC post: 10/2015; ROS pre: 7/2014-6/2016; ROS post: 7/2016-6/2018)	Medicaid Data (Claims and Encounters)	Risk-adjusted total Medicaid PMPM costs, by annual period (PMPM/Y), NYC and ROS Risk-adjusted PMPM costs for acute care BH services, by annual period (PMPM/Y), NYC and ROS Percentage using acute care BH services, by annual period, NYC and ROS Percentage using non-acute (outpatient) BH services, by annual period, NYC and ROS

3.3 QUANTITATIVE METHODS

This evaluation will adopt a rigorous analytic approach that combines descriptive statistical analyses with state-of-the-art methods, allowing for unbiased inferences. These methods include quasi-experimental methods that can allow for causal inference of the impact of the BH Demonstration while also utilizing the temporal trends in the data. Where possible, RAND plans to strengthen the validity and robustness of the analyses by leveraging features of the BH Demonstration including the regional and temporal phasing-in of the HARP program and the BH HCBS benefit package, HARP enrollees' ability to opt out of the program, and the ability of those who are eligible to receive BH HCBS to opt in or out.

Our approach will permit minimizing threats to valid causal inferences posed by the effect of other ongoing health care policies (e.g., other Medicaid redesign initiatives, provisions of the Affordable Care Act). Concurrent policies and other unobserved factors could affect estimates of

program effects if they are correlated with the BH Demonstration and specifically HARP. This possibility will be investigated in three ways: (1) examining the relative timing of other key policies with HARP implementation, (2) including controls for other policies in the causal models, and (3) estimating models with time period indicators in difference-in-differences model settings to account for other time invariant unobserved policies or idiosyncratic effects.

A critically important task of the HARP program evaluation is to identify comparison beneficiaries for several of the analytic tasks. Because HARP-eligible beneficiaries can opt out, those who opt out provide a potential comparison group. The evaluation team will assess whether, at the time of the initiation of the HARP program, the identified comparison group is comparable to the specific population of HARP enrollees being considered (the “treatment” group). RAND will begin this task with the definition and identification of comparison group beneficiaries that will be matched to the treatment group with respect to person- and small area-level characteristics prior to the implementation of the program. To adjust for differences across measured variables in these treatment and control settings, RAND plans to apply propensity weights in order to achieve good balance across treatment and comparison groups. To further assure comparability between treatment and comparison groups, RAND will examine trends over time in both groups during the years prior to the program implementation to assess the model assumptions that trends in utilization and access, process (quality of care), and costs are parallel.

DATA SOURCES

A variety of secondary data sources will be used to construct study variables (outcome measures and covariates for risk adjustment) for the quantitative component of the HARP program evaluation. Data will be provided by the NYS DOH and OMH and will include:

1. **ONTrackNY (OTNY) Data System.** Patient and program-level information collected by the OTNY Coordinated Specialty Care program, a statewide program that began in earnest in 2015. The data system includes socio-demographics, clinical history and treatment, and program outcomes of enrolled patients with FEP, and OTNY program components. These data will be used primarily for the assessment of access to OTNY services for patients with FEP (outcome measure); they may also be used for risk adjustment in regression models.
2. **CMH Screen data.** A mix of lifetime and current patient self-reported information and assessor-gathered information collected as part of the assessment of BH HCBS eligibility with the BH HCBS Eligibility scale, brief and full,¹ a standardized clinical and functional assessment tool derived from the interRAI™ Community Mental Health Assessment

¹ The BH HCBS Full Assessment ceased to be required in March 2017.

(Hirdes et al., 2000). The CMH Screen is required annually for all HARP and HARP-eligible HIV SNP enrollees, but not for HARP eligible beneficiaries who opt out and return to Mainstream MMC plans. Domains include socio-demographic characteristics (e.g., marital status, homelessness); health status (BH and chronic health conditions); functional status (independent living skills, cognitive skills, social relations, employment, education and finances); BH service utilization; risky behaviors (substance use, harmful/self-injurious behaviors); traumatic events; and criminal justice system involvement. As such, the data may be used to describe program outcomes (e.g., health status, functional status), as well as *risk factors* (e.g., traumatic life events, homelessness, criminal justice involvement, substance use, chronic physical health conditions) and *protective factors* (e.g., social relations, education, employment, adequate finances). The CMH screen is required annually for all HARP and HARP-eligible HIV SNP enrollees; the number of individuals who have been assessed with the CMH screen has varied over the years but has not met expectations. These data, as available, will permit assessment of sociodemographics, health status/clinical, and recovery-related outcomes (outcome measures); they may also be used for risk adjustment in regression models.

3. **HEDIS®/QARR Plan-Reported Metrics.** Person-level quality of care information in the form of HEDIS®/QARR quality measures collected by Mainstream MMC plans, HARPs, and HIV SNPs and reported annually to NYS DOH. These data will permit assessment of quality of care (outcome measures).
4. **CAHPS® survey data.** De-identified patient self-reported information on experience with access to care and experiences with health care providers and health plan staff, assessed through the Health Plan version of the CAHPS® survey and *collected every other year* from a sample of adults enrolled in all MMC product lines; BH-specific questions include need for BH/SUD treatment, access to BH/SUD treatment, satisfaction with BH/SUD treatment, and self-rating of overall BH. These data will permit assessment of self-rated need for care, experiences/satisfaction with care, and self-rated BH (outcome measures).
5. **HARP Perception of Care (PCS) survey data.** Patient self-reported information on perception of outcomes, access and quality of care, appropriateness of services, social connectedness, wellness, and quality of life collected through a survey of randomly selected enrollees in HARPs or HIV SNPs; demographics are also collected. The survey was adapted from the Experience of Care and Health Outcomes (ECHO) Survey, the Mental Health Statistics Improvement Program (MHIP)/OMH Consumer Assessment of Care Survey, and others. It was piloted in early 2017 and implemented in the fourth quarter of 2017 and again in 2019. These data will permit assessment of experience and satisfaction with care, enrollees' satisfaction with their BH providers' cultural sensitivity, and enrollees' satisfaction with their wellness, recovery, and degree of social connectedness (outcome measures).
6. **Medicaid Data.** Information maintained by the Medicaid Data Warehouse containing billing records for health care services, including pharmacy, for individuals enrolled in

Medicaid in a given year, whether under FFS arrangements or MCOs (i.e., claims and encounters). Source of information on Medicaid enrollment status, plan membership, BH HCBS eligibility status, demographic, health status (diagnoses including BH and chronic physical health conditions; Clinical Risk Group categories), service utilization, provider associated with the billed services, and cost of health care for all Medicaid enrollees; available with a six-month lag. These data will permit assessment of HARP enrollment, BH HCBS eligibility, diagnostic characteristics, service utilization patterns, including BH HCBS and cost of health care (outcome measures), and may also be used for risk adjustment in regression models.

7. **Medicaid Choice Enrollment Data.** Information on the HARP enrollment process collected on an ongoing basis by New York Medicaid Choice, the enrollment broker, and available since program implementation. Data include passive enrollment, opt-out acknowledgement letters distributed and returned, number of beneficiaries who are enrolled, number of beneficiaries who opt out, and reasons for opting out. These data will permit assessment of reasons for opting out of HARPs (outcome measure).
8. **Complaints and Appeals Data.** Complaint and appeal information pertaining to denials of access to BH HCBS. Complaint information collected through a designated email address available to BH HCBS providers since October 2015 has been systematized to allow for tracking of a number of fields (e.g., type of inquiry, fields for MCOs to indicate if they are part of the inquiry, etc.). This information is monitored and acted upon by NYS DOH, OMH, and OASAS; OMH is able to generate complaint reports from a linked database. These data will permit assessment of the number of complaints and appeals related to access to BH HCBS (outcome measure).
9. **MMC HCBS Provider Network Data System.** Information on providers who have applied to provide BH HCBS, including contact information, location, services provided, staff qualifications, and funding information. These data will permit assessment of BH HCBS provider availability to meet the need, and HARP/HIV SNP contracts by geographic area (outcome measures).
10. **Mental Health Automated Record System (MHARS) data.** Information maintained by OMH on inpatient, residential, and outpatient utilization in NYS Psychiatric Centers, used to identify psychiatric inpatient utilization not captured in the Medicaid data. These data permit a complete assessment of the number of inpatient admissions and inpatient days (outcome measure).

In addition to these NYS DOH/OMH data, the evaluation will incorporate contemporaneous data from Area Health Resource Files (ARF), a collection of publicly available data assembled by the Health Resources & Services Administration (HRSA) or PolicyMap, a web-based data warehouse. Both datasets aggregate information from multiple sources including the Centers for Disease Control and Prevention, HRSA, the U.S. Census, and other neighborhood-level datasets. Small

area-level information being considered include sociodemographic characteristics (e.g., urbanicity, household income) and characteristics of the healthcare infrastructure (e.g., psychiatrists per 1,000 population, HRSA-designated health professional shortage area). This information is available at various geographic levels, including ZIP code and county.

ANALYTIC APPROACHES

Throughout the evaluation, different analytic approaches will be used depending on the research questions of interest. They include descriptive methods as well as quasi-experimental state-of-the-art methods to enable causal inferences.

1. **Descriptive Statistics.** This approach will be used for simple population-level, year-to-year comparisons in NYC and ROS during the evaluation period. With it, RAND will examine the characteristics of HARP enrollees in NYC and ROS in each annual period since program implementation. For categorical variables, this will consist of Chi-square test and McNemar's chi-square test (to compare binary outcomes between correlated groups for each region before and after implementation). For continuous variables on the other hand, we will use the Analysis of Variance (ANOVA) test; paired t-test (to compare pairs of years); and the Bonferroni adjustment for multiple pair comparisons. Whenever repeated measures are analyzed with ANOVA for yearly changes within each region, the RAND team will evaluate whether the sphericity assumption of this method is violated.
2. **Interrupted Times Series.** This pre-post approach will be used for the evaluation of trends/trajectory of outcomes over an extended period of time that covers the implementation of the HARP program. Depending on the research question, the period was two or four years before, and two or four years after program implementation. For the HARP evaluation, the outcome domains to use are health status, functional status, and service utilization. This quasi-experimental method will be utilized when non-BH/non-HARP control groups are not available as it minimizes the confounding effect of other potential drivers of observed effects, including ongoing health care reform initiatives. The RAND team will also utilize a segmented regression (Wagner et al., 2002) to analyze the interrupted time series data. Variables to include in the regression adjustment potentially include health status (diagnostic history), prior service utilization patterns (inpatient, ED, primary care), and other resource use. This analysis will enable the evaluation of changes in the level and trend in the outcome variable from pre- to post-intervention and use the estimates to test causal hypotheses about the HARP program. In the post-intervention period, actual rates for the various metrics for each month will be compared to expected rates, while controlling for patient-level confounders, secular trend, serial autocorrelation, and seasonal fluctuation in the outcome variable.
3. **Difference-in-Differences.** This pre-post approach will be employed when concurrent comparison groups are available, thus enabling a robust assessment of program

outcomes. For the HARP program evaluation, the outcome domains are quality, service utilization, and cost. The treatment and control groups will be:

- a. HARP-eligible individuals who opt into HARP (treatment), versus those who opt out of the HARP (HARP-Opt Out) and were enrolled in mainstream MMC (control)
- b. HARP enrollees who are BH HCBS eligible who opt for BH HCBS services (treatment) versus those who do not opt for BH HCBS and received only traditional (non-BH HCBS) services (control)

The outcomes of interest were measured over consecutive periods of two (2) years before/after program implementation:

Period 1: 10/2013-9/2015 (NYC), 7/2014-6/2016 (ROS)

Period 2: 10/2015-9/2017 (NYC), 7/2016-6/2018 (ROS)

This quasi-experimental approach accounts for any secular trend/changes in the outcome metrics as it eliminates fixed differences not related to program implementation; thus, remaining significant differences may be validly attributable to the impact of program implementation (Harman et al., 2011). The difference-in-differences approach requires that pairs of “treatment” and “control” individuals comparable on key observed confounders be identified through Propensity Score Matching – see below.

4. **Longitudinal Mixed Effect Regression.** This approach uses a Generalized Linear Mixed Model (GLMM) to estimate an average program effect while adjusting for key covariates when examining change trajectories (Diggle et al., 2002; Tooze, Grunwald and Jones, 2002). For the HARP evaluation, the outcome domains are health status, functional status, and service utilization. This quasi-experimental approach separates the effects of time from that of the HARP program implementation, accommodating the heterogeneity in the program implementation effect, and accounting for serial correlations within individuals and variation of risk/protective factors and outcomes over time due to strong temporal trends. The multivariable mixed effects regressions to be used will include *fixed effects*, namely demographics (age, gender, and race/ethnicity) and time, and *random effects* assessed at each annual time point, namely risk and protective factor levels as assessed with the CMH Screen. Random effects will be incorporated in the models on two (2) levels: for persons within areas/site and for change over time within persons. The HARP evaluation research questions to be addressed with GLMM are the one that were assessed following program implementation.
5. **Propensity Score Matching.** This approach controls for potential confounding by identifying individuals with similar characteristics belonging to the treatment and control groups, thus enabling the use of quasi-experimental causal models (Austin, Grootendorst and Anderson, 2007). In the HARP evaluation, propensity score matching will be used in combination with the difference-in-differences approach to examine the impact of the HARP benefit on health outcomes and to examine the impact of the BH HCBS on recovery outcomes. The method uses a logistic regression or a generalized boosting method (GBM) to estimate each individual’s conditional probability (or propensity score) of belonging to the treatment group. *Predictors* include variables included in the HARP

algorithm and others related to sociodemographics, health status/clinical characteristics, and functional status not included in the algorithm. A greedy matching algorithm with an appropriate matching ratio of treatment to control individuals will be used to create a matched analytic cohort based on the estimated propensity score and other variables such as service utilization variables assessed prior to program implementation. The RAND team will a priori select the confounding variables for inclusion in the models using the team's subject matter expertise and also consulting with other subject matter experts. Balance in covariate distribution between treatment and control individuals in the matched analytic cohort will be assessed with weighted standardized difference.

3.4 QUALITATIVE METHODS

The qualitative component of the HARP evaluation seeks to provide additional context and multiple perspectives on program implementation, including barriers and facilitators to implementation success and insight into potential mechanisms of impact on program outcomes. As described below, the qualitative data collection component of the HARP evaluation is near complete. Interviews with key informants other than the HARP enrollees have been completed. Due to the COVID-19 pandemic, procedures for interviews with HARP enrollees had to be revised. The interview protocol, recruitment methods, and institutional review board (IRB) approval for the interviews with HARP enrollees are being developed.

DATA SOURCES

For the completed interviews, the evaluation team has employed a combined purposive and snowballing sampling approach to recruit key informants. Through maximum variation sampling, the evaluation team sought to maximize the diversity of organizations represented by key informants and considered factors such as agency type, geographic region within NYS, degree to which areas served were urban or rural, and the program size and number of beneficiaries served (e.g., number of HARP enrollees within an MCO, number of BH HCBS enrollees served by a provider organization). Publicly available data and state agency reports were reviewed to identify and sample potential agencies and stakeholders in order to capture variation along key factors. This was complemented by snowball sampling, wherein several key informants identified other stakeholders who could provide additional perspectives and who were subsequently invited to participate (e.g., Health Home organizations identifying Care Management Agencies in different regions with varying numbers of HARP enrollees).

The key informants that have already been interviewed represent organizational leadership staff, from the program director to senior executive management levels, in organizations including MCOs, Health Homes, Care Management Agencies, providers of BH services (e.g., ACT, PROS, BH HCBS), statewide groups (e.g., patient, provider, and trade associations), and NYS agencies (e.g.,

OMH, OASAS). The evaluation team has already conducted 32 key informant interviews. The interview tool is described below and in Appendix A.

A similar approach will be taken for the interviews with HARP enrollees. To identify HARP enrollees for participation, evaluators will utilize purposive and convenience sampling strategies. To capture a range of perspectives, the evaluation will seek to maximize the diversity of HARP enrollees who participate, considering factors such as geographic region within NYS, location in urban or rural areas, status of enrollment in BH HCBS, and a range of demographic characteristics (e.g., gender, race, diagnosis). The evaluation team anticipates conducting approximately 10 interviews with HARP enrollees.

RESPONDENT RECRUITMENT

Potential key informants received an e-mail inviting them to participate in the evaluation interview and to contact the evaluators if they were interested in participating. An information sheet was e-mailed to key informants in advance of scheduled interviews and reviewed prior to commencing the interview.

For the HARP enrollee interviews, provider agencies will identify potential HARP enrollees and provide them with information about the evaluation. HARP enrollees interested in participating will contact the evaluators directly or inform the provider agency staff that they consent to have the evaluators contact them.

INTERVIEWER TRAINING

Prior to beginning the key informant interviews, the qualitative team received training on the MMC BH carve-in, the HARP Program, the BH HCBS program, and the roles of various stakeholder agencies involved in the implementation and operation of these initiatives and programs. The training included a review of documents, participation in discussions with DOH, OMH, and OASAS subject matter expert staff, and internal discussions with the project leads and technical advisors who have experience with NYS Medicaid and the development and implementation of these initiatives. The training ensured that the interviewers were aware of issues relevant to the program implementation for each type of key informant.

DATA COLLECTION/CONDUCTING INTERVIEWS

A semi-structured interview guide for key informants representing a diversity of (non-HARP enrollee) stakeholders was developed (Appendix A) and covered the MMC BH carve-in, the HARP program, and the BH HCBS program. The interview guide focuses on understanding the

implementation and operation of each initiative/program, including barriers and facilitators to implementation, as well as factors that may influence program access and outcomes.

Interviews with key informants other than the HARP enrollees were conducted virtually and lasted one hour, on average. The majority of data collection consisted of individual interviews with one identified key informant; in several cases the originally recruited key informant suggested additional informants to be included in the interview.

Interviews are conducted by one qualitative researcher, with an additional researcher taking notes concurrently that are used to produce a written interview summary. Interviewers cover core topic areas but flexibly maneuver through the interview guide and probe certain topics more in-depth as appropriate. Interviews are audio-recorded and transcribed verbatim. The IRB of the NYS Psychiatric Institute determined that data collection with key informants who were not HARP enrollees did not constitute human subjects research and was thus exempt from review. Review of data collection with HARP enrollees is pending.

Interviews with HARP enrollees will be conducted individually by phone or virtually. A semi-structured interview guide for HARP enrollees is being developed. Interview guides for HARP enrollees will focus on HARP and BH HCBS barriers and facilitators to program enrollment and access to care management and services, as well as satisfaction with providers/services, and perceived impact on individual outcomes (e.g., recovery, functioning, community integration).

ANALYSIS

Analytic methods, aligned with recommendations of Bradley, Curry, and Devers (2007), will follow a grounded theory approach to developing coding structures that emphasize inductive codes emerging directly from the data (Bradley, Curry and Devers, 2007). Consistent with grounded theory, qualitative analysis begins concurrently with data collection, allowing interviews to be shaped by preliminary concepts and themes emerging from the data. The analysis will proceed in a series of steps: developing initial codes (open-coding), validating & using the codes (i.e., coding all transcripts with a final code list), clustering and interpreting the codes, and developing broader findings and themes. Strategies to ensure rigor include weekly data collection and analysis debrief meetings, development of interview summaries and memos, and the use of multiple coders. As described below, analyses of the qualitative data will inform evaluation of each of the HARP program evaluation goals.

Goal 1 (Improve health and BH outcomes for adults in Mainstream MMC whose BH care was previously carved out in an FFS payment arrangement): This goal will be addressed using data from key informant interviews with MCOs, Health Homes, Care Management Agencies, providers

of BH services (e.g., ACT, PROS, substance use treatment), statewide groups (e.g., patient, provider, and trade associations), and NYS agencies (e.g., OMH, OASAS). Analyses will be informed by interview content that focuses on how the mainstream MMC BH carve-in has affected stakeholders' work, and barriers and facilitators that, according to these informants, may impact Medicaid beneficiaries' access to services.

Goal 2 (Improve health, BH, and social functioning outcomes for adults in the HARP): In addition to the key informants in Goal 1, this goal will also draw on interviews with HARP enrollees, who will provide additional perspectives on barriers and facilitators to enrollment, accessing primary/preventive services, specialty behavioral health care services, and care coordination. In addition, the RAND team will explore HARP enrollees' perceptions of care quality, including experiences interacting with providers and receiving services, satisfaction with these services, and how these services are aligned with educational, employment, wellness, recovery, social functioning, and community integration outcomes. Analyses will focus on identifying factors that, in the view of key informants, affect the impact of the HARP program on enrollee health, BH, and social functioning.

Goal 3 (Develop BH HCBS focused on recovery, social functioning, and community integration for individuals in HARPs meeting eligibility criteria): Data from all key informant interviews will be used to address Goal 3. Analysis will examine informant perspectives on assessment of BH HCBS eligibility, linkages between MCOs, Health Homes and BH HCBS providers; BH HCBS providers' assessment processes for specific services; and ongoing approval processes from Health Homes providers and Managed Care Organizations.

Analysis of interviews with HARP enrollees and with HARP enrollees receiving BH HCBS will explore their experiences with qualifying and using BH HCBS. Finally, a systematic document review will be used to examine complaints and appeals related to BH HCBS services.

4. FINDINGS

Due to the delays in initiating the HARP program evaluation, findings for the three Goals and aligned Research Questions listed in Table 3.1 are not yet available for presentation. The proposed timeline for remaining evaluative tasks is presented above in Table 1.1. All findings will be presented in the final summative report, available Spring 2021.

5. POLICY IMPLICATIONS

Because there are no findings yet available, no policy implications can be provided at this time. A thorough discussion of the policy implications of the evaluation findings will be included in the final summative report.

6. INTERACTIONS WITH OTHER STATE INITIATIVES

An in-depth empirical investigation of the manner in which the implementation and effects of the BH demonstration, namely the MMC BH carve-in and the HARP programs, were affected by other state initiatives is out of scope for the HARP program evaluation as proposed and executed under the RFP and RAND contract. Information on other policy initiatives implemented by the state and potentially affecting the BH demonstration was alternatively collected to assist with the design of the analyses and to interpret and provide context to the pending findings. Potential statistical interactions will be explored and discussed in the final summative report, available Spring 2021.

The state initiatives that will be reviewed for potential interactions with the implementation of the HARP program in the final summative report include:

- Other provisions of the DSRIP Program, including payment reform in the form of a Value Based Payment (VBP) Roadmap
- Provisions of the Affordable Care Act (ACA), including the Medicaid Health Home program and Medicaid access expansion.

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APPENDIX A. KEY STAKEHOLDER INTERVIEW PROTOCOL

HARP & HCBS: Interview Guide: Non-Client Stakeholder

Participant ID: _____ Interview Date: _____

Region: Central ___ Hudson River ___ Long Island ___ NYC ___ Western ___

Providers Only Number of HCBS Clients Served: 1-10 11-20 21-40 41-60 61-80 81-100 100+

Stakeholder Type: _____

Agency Type: _____

Interviewer: _____

The purpose of this interview is to explore your perspective and experience regarding the shift of behavioral health services for adults with Medicaid into Managed Care in New York State. This included enrolling eligible adults with Medicaid and significant behavioral health (BH) needs into Health and Recovery Plans (HARPs). HARPs sought to offer an enhanced benefits package that would expand access to specialized services and care coordination of physical health, mental health, and substance use services. HARP members work with Health Home agencies, or other state-designated entities, to develop a person-centered plan and to meet wellness goals, including accessing an array of specialty services, such as BH Home and Community Based Services (HCBS). BH HCBS seek to help people move forward in their recovery and life goals, such as improving quality of life, finding employment, going to school, managing stress, and living independently.

The interview will take approximately 60 minutes to complete. Again, the goal is to learn about your views and experience of the shift in behavioral health services to Medicaid Managed care, and in particular the implementation of HARPs and HCBS in New York State. There are no right or wrong answers to these questions. We are only interested in your honest opinions. Any questions before we begin?

INTERVIEWER PROBES

- a. Enrollment issues
- b. Administrative issues/burden - billing? Paperwork/documentation?
- c. Developing plans of care?
- d. Care coordination/integration – coordinating care among mental illness, substance use, and physical healthcare providers
- e. Communication with other agencies (e.g., OMH, Health Homes, Managed Care)
- f. Clients' access to services?

- i. What services are most accessible? What services are now available to clients that didn't used to be?
- ii. What services are harder to access or are under-utilized? What services are no longer available to clients?
- g. Quality of services/care?
- h. Impact/Measuring impact; recipient/enrollees/client outcomes?
- i. Funding/Financing

<< BEGIN RECORDING >> << BEGIN RECORDING >> << BEGIN RECORDING >>

Role

What is your **role** in this organization/agency?

- a. How do your responsibilities relate to HARPs and HCBS?
- b. How familiar are you with HARPs and HCBS?

I. Behavioral Health Carve-in for Adults in Mainstream Managed Care *Goal One: Improve health and BH outcomes for adults in Mainstream MMC whose BH care was previously carved out in an FFS payment arrangement*

Now I'm going to ask you questions about your experience and thoughts on transitioning behavioral health services to mainstream managed care.

- 2. What has your **experience** been with the transition to mainstream managed care for individuals whose behavioral health benefits were previously carved out in a Fee for Service arrangement?
 - a. How has it been different from when behavioral health had been carved out through a fee-for-service arrangement?
- 3. How has the transition to Medicaid Managed Care for behavioral health **impacted your agency**?
 - a. SEE PROBES
- 4. How has the switch to mainstream Medicaid Managed Care **impacted Medicaid recipients** with behavioral health needs?
 - a. How has it impacted recipients' administrative burden (e.g., paperwork, applications)?
 - b. How has it impacted recipients' access to services?
 - c. How has it impacted recipient outcomes (e.g., health, recovery, wellness goals, quality of life, stress management, employment, school, community involvement/integration, functioning)?
- 5. What have been some of the **benefits** of having mainstream Medicaid Managed Care plans manage behavioral health for adults in New York State?
 - a. For recipients? Are there certain recipients who have benefited more/less?

- b. For your organization? Are there certain organizations who have benefited more/less?
 - c. For systems of care? Are there certain systems of care who have benefited more/less?
 - d. SEE PROBES
6. What have been some of the **challenges** of having behavioral health managed by mainstream Medicaid Managed Care?
- a. For recipients?
 - b. For your organization?
 - c. For the system of care?
 - d. SEE PROBES
 - e. What can be done to address those challenges?
 - f. *If not addressed:* What can be done to improve access to services? Quality of services? Coordination or integration of care? Client outcomes?

II. HARP *Goal 2: Improve health, BH, and social functioning outcomes for adults in the HARP*

Now I'm going to ask you some specific questions about Health and Recovery Plans.

7. What has been your **experience** with the HARP program?
- a. Experiences with HARPs in general and care management?
 - b. Experiences specifically with HCBS aspects of HARP?
8. How has the implementation of HARP **impacted your agency's** work?
- a. SEE PROBES
 - b. What has made your agency's work easier? More difficult?
9. How would you describe your **interactions with other agencies/organizations** involved in HARPs?
- a. Managed Care Companies
 - b. Health Homes
 - c. DOH, OMH, OASAS
 - d. Service Providers
 - i. Mental Health
 - ii. Substance use
 - iii. Primary care
 - iv. Other psychiatric services (ACT, PROS)
 - v. Other services/providers?
10. How has belonging to a HARP program **impacted enrollees**?
- a. Ability to access care?
 - b. Quality of care received?

- c. The degree to which their care is integrated?
 - d. Enrollee outcomes (e.g., health, recovery, wellness goals, quality of life, stress management, employment, school, community involvement/integration, functioning)?
 - e. In what areas have you seen the biggest improvement for enrollees?
 - f. In what areas have you seen less improvement for enrollees?
 - g. Are there any potential long-term benefits for enrollees?
11. What have been some of the **benefits** of having the HARP program? What has gone well?
- a. For HARP enrollees? Are there certain enrollees who have benefited more/less?
 - b. For your organization? Are there certain organizations who have benefited more/less?
 - c. For systems of care? Are there certain systems of care who have benefited more/less?
 - d. SEE PROBES
 - e. How would you define or measure HARP success?
12. What have been some of the **challenges** of the HARP program?
- a. For HARP enrollees?
 - b. For your organization?
 - c. For systems of care?
 - d. SEE PROBES
 - e. What could be improved? What would help address some of the challenges?
 - f. *If not addressed:* What can be done to improve access to services? Quality of services? Coordination or integration of care? Client outcomes?
13. What other **changes** would you suggest making to the HARP program?
- a. SEE PROBES

III. HCBS Goal 3: Develop HCBS focused on recovery, social functioning, and community integration for individuals in HARPs meeting eligibility criteria

Finally, I'm going to ask you some questions specifically about Home and Community Based Services:

14. What has been your **experience** with HCBS?
- a. With Tier 1 HCBS?
 - b. With Tier 2 HCBS?
15. How has the implementation of HCBS **affected your agency**?
- a. SEE PROBES
16. How would you describe **your interactions with other agencies/organizations** involved in HCBS?

- a. Managed Care Companies
 - b. Health Homes
 - c. DOH, OMH, OASAS
 - d. Service Providers
 - i. Mental Health
 - ii. Substance use
 - iii. Primary care
 - iv. Other psychiatric services (ACT, PROS)
 - v. Other services/providers?
17. How has HCBS **impacted individuals** with behavioral health needs?
- a. How well is HCBS meeting clients' needs?
 - b. Ability to access services?
 - c. Quality of services received?
 - d. The degree to which their care is integrated?
 - e. Enrollee outcomes (e.g., health, recovery, wellness goals, quality of life, stress management, employment, school, community involvement/integration, functioning)?
 - f. In what areas have you seen the biggest improvement for enrollees?
 - g. In what areas have you seen less improvement for enrollees?
 - h. Are there any potential long-term benefits for enrollees?
18. What have been some of the **benefits** of having HCBS? What has gone well?
- a. For people with behavioral health needs? Are there certain people who have benefited more/less?
 - b. For your organization? Are there certain organizations who have benefited more/less?
 - c. For systems of care? Are there certain systems of care who have benefited more/less?
 - d. SEE PROBES
 - e. How would you define or measure the success of HCBS?
 - f. To what degree are clients receiving the care they need through HCBS?
19. What have been some of the **challenges** of HCBS?
- a. For HARP enrollees?
 - b. For your organization?
 - c. For systems of care?
 - d. SEE PROBES
 - e. What could be improved? What would help address some of the challenges?
20. What do you see as the **future** for HCBS services?

21. We are also interested in speaking with HARP/HCBS enrollees to get their perspective on the program. Do you have any suggestions on how best to **recruit and/or contact HARP/HCBS enrollees** to get their perspectives?

22. Is there **anything else** that we did not ask that is important for us to know?



WP No. WR-A783-2

Independent Evaluation of the New York State Self-Directed Care (SDC) Program

Interim Report

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ACRONYMS

ACA	Affordable Care Act
BH	Behavioral Health
CMH	Community Mental Health
COVID-19	Severe Acute Respiratory Syndrome Coronavirus 19 (SARS-CoV-19)
DOH	Department of Health
DSRIP	Delivery System Reform Incentive Payment
ED	Emergency Department
FFS	Fee for Service
GLMM	Generalized Linear Mixed Models
HARP	Health and Recovery Plans
HCBS	Home and Community-Based Services
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
IRB	Institutional Review Board
MCO	Managed Care Organization
MHARS	Mental Health Automated Record System
MMC	Medicaid Managed Care
NYC	New York City
NYS	New York State
NYSHF	New York State Health Foundation
OASAS	Office of Addiction Services and Supports
OMH	Office of Mental Health

PCS	Perception of Care Survey
PSM	Propensity Score Matching
ROS	Rest of the State
SAMHSA	Substance Abuse and Mental Health Services Administration
SDC	Self-Directed Care
SMI	Serious Mental Illness
SNP	Special Needs Plans
VBP	Value Based Payment

1. EXECUTIVE SUMMARY

Through the New York Medicaid Redesign Team Section 1115 Demonstration, New York State (NYS) pursued the goal of improving access to and quality of health care for the Medicaid population through a managed care delivery system. The Self-Directed Care (SDC) pilot program was implemented as part of the behavioral health (BH) reforms included in the larger Section 1115 Demonstration. In 2019 NYS contracted with the RAND Corporation to conduct an independent evaluation of the SDC pilot program.

This SDC pilot program evaluation uses a mixed methods approach to determine the extent to which three goals of the program were achieved during the first two years of the pilot (January 1, 2018 to December 31, 2019):

1. Implementation of a viable and effective SDC program for Health and Recovery Plans (HARP) enrolled/ BH Home and Community-Based Services (HCBS) eligible individuals throughout NYS
2. Improvement in recovery, health, BH, social functioning, and satisfaction with care for SDC participants
3. Maintenance of Medicaid cost neutrality overall and reduction of BH inpatient and crisis service utilization and cost for SDC participants.

The impacts of the SARS-CoV-19 (COVID-19) pandemic have affected the implementation of the SDC evaluation. The significant strain on the health care system required NYS Department of Health (DOH) staff to shift their priorities. These shifts delayed the execution of the evaluation contract and data access activities. At the time of this writing, NYS is working to make data available to the evaluation team to address the evaluation research questions. The original timeline for the evaluation has also shifted, and a list of ongoing tasks and a new timeline are proposed below.

Table 1.1. Proposed Timeline for Evaluation Tasks

Proposed Timeline	Remaining Tasks
November & December 2020	Complete Data Access for SDC Research Questions
January 2021	Data Analysis
February 2021	Data Interpretation
March 2021	Report Findings to DOH
April 2021	Summative Evaluation Report to CMS

This interim report describes RAND’s current understanding of the SDC pilot program and the questions the SDC pilot program evaluation aims to answer, and it outlines the methodology RAND proposed to conduct the evaluation. The final summative report, expected to be completed in Spring 2021, will provide a full discussion of the SDC pilot program evaluation findings and its implications for policy.

2. SELF-DIRECTED CARE AND THE LARGER DEMONSTRATION

2.1 INTRODUCTION TO THE SDC PILOT PROGRAM EVALUATION

The New York Medicaid Redesign Team Section 1115 Demonstration (hereafter, Section 1115 Demonstration) was originally approved in 1997 with the goal of improving access to and quality of health care for the Medicaid population through a managed care delivery system (New York State, 2020). The Section 1115 Demonstration included reforms specifically targeted to Medicaid beneficiaries with BH needs (hereafter, BH Demonstration), including the HARP program, which was phased in between 2015 and 2016. The SDC pilot program was implemented starting in 2018 as part of the BH Demonstration.

The RAND Corporation, a private non-profit research organization with a mission to provide policymakers with objective, rigorous, and credible research evidence to inform decisionmaking, was selected to conduct an independent evaluation of the SDC pilot program (New York State Department of Health, 2019). The objective of this evaluation is to examine the implementation and impact of the SDC pilot program. This interim report describes the SDC pilot program and its policy background, the questions the independent evaluation aims to answer, and the proposed methodology to conduct the SDC evaluation. A Final Evaluation Report with a full discussion of the SDC pilot program evaluation findings will be submitted to CMS in 2021.

The SDC pilot program evaluation is designed to determine the extent to which three goals of the program were achieved during its first two years (January 1, 2018 to December 31, 2019). These goals are:

1. Implementation of a viable and effective SDC program for HARP enrolled/BH HCBS eligible individuals throughout NYS
2. Improvement in recovery, health, BH, social functioning, and satisfaction with care for SDC participants

3. Maintenance of Medicaid cost neutrality overall and reduction of BH inpatient and crisis service utilization and cost for SDC participants.

The SDC pilot program evaluation will use both primary (qualitative) and secondary (quantitative) data in a mixed methods empirical investigation of the program's beneficiary- and system-level impacts. The evaluation seeks to examine SDC pilot program research questions related to implementation, intermediate outcomes, and long-term outcomes. Implementation and intermediate outcomes pertain to enrollment of eligible participants; access to outpatient services (primary and preventive services, BH services); utilization of acute care, namely, inpatient and emergency department (ED) services; and satisfaction with care, as well as a variety of qualitatively assessed outcomes. Long-term outcomes pertain to health and wellness, social outcomes (education, employment, community tenure), quality of life, social connectedness, Medicaid spending, and cost shifts from spending on acute care to community-based services.

2.2 THE SELF-DIRECTED CARE PILOT PROGRAM

The SDC program, grounded in the belief that greater autonomy and choice will permit a better match between individuals' needs and health care and related services, aims to promote progress toward recovery goals, health, and stability in the community. An earlier version of the SDC program began to be offered in the 1990s by state Medicaid programs as part of the optional state plan personal care services benefit. With support from the Robert Wood Johnson Foundation, self-direction of Medicaid services has evolved over the years; currently, states have a number of mechanisms available to finance the self-direction option to Medicaid beneficiaries (Centers for Medicare & Medicaid Services).

In 2014, the NYS Office of Mental Health (OMH) was awarded a Substance Abuse and Mental Health Services Administration (SAMHSA) Transformation Transfer Initiative grant to fund the design of a self-directed care model to be pilot-tested and eventually scaled-up for delivery to eligible Medicaid beneficiaries with serious mental illnesses in a managed behavioral health delivery system (New York). At the time the BH benefit for most eligible beneficiaries was carved out of existing managed care arrangements, but that would soon change. In April 2015, NYS launched its Section 1115 Demonstration to improve access to and quality of health care delivered through managed care to Medicaid beneficiaries.

The Demonstration included several behavioral health components; this evaluation focuses on the BH Demonstration. In August 2015, NYS amended its Section 1115 Demonstration to enable qualified Managed Care Organizations (MCOs) to comprehensively manage BH care for SSI and non-SSI beneficiaries whose BH benefit was previously covered under a fee-for-service (FFS)

payment arrangement. Additionally, the amendment provided for BH HCBS to be made available to eligible individuals meeting defined functional needs criteria.

The BH Demonstration sought not only to improve health care quality, costs, and outcomes for the New York's Medicaid BH population but also to transform the BH system from an inpatient-focused system to a recovery-focused outpatient system. The BH benefits were made available through all mainstream Medicaid Managed Care (MMC) plans and through a separate coverage product, the HARPs, which are specialty lines of business operated by qualified mainstream MMC plans and available statewide. The HARP program was phased in, launched first in New York City (NYC) in October 2015 and the Rest of the State (ROS) in July 2016. BH HCBS were only available to qualified HARP and HIV SNP enrollees; the BH HCBS were offered beginning in January 2016 in NYC and in October 2016 for ROS.

Starting in September 2015, OMH began conducting preparatory activities to implement a BH SDC pilot program (e.g., selecting sites, creating a web-based portal) targeted to HARP enrollees. Under the demonstration extension approved December 7, 2016, a program making self-direction services available to eligible individuals was authorized as a pilot initiative with the goal of testing the viability and effectiveness of SDC prior to a statewide implementation. The effective dates of the pilot SDC program are January 1, 2017 through June 30, 2022.

The SDC pilot program allows individuals who are eligible for the HARP program benefit package and BH HCBS to use public dollars to purchase services and/or to employ service providers. SDC participants select a support broker with whom they work to identify recovery goals. The support broker then assists the participant with the creation and implementation of a budget to purchase the goods and services required to meet the recovery goals. SDC participation is voluntary, and participants may opt out at any time. Eligible enrollees wishing to participate after capacity has been exceeded are placed on a waiting list.

Two agencies, one in NYC and one in Newburgh (a small city close to Poughkeepsie), were chosen as SDC pilot sites. The agencies are responsible for recruiting and enrolling participants and for hiring, training, and supervising support brokers. (Support brokers work with a fiscal intermediary based at NYS OMH who provide training, support, and monitoring for the authorization and purchasing of goods and services.) Contracts between the agencies and NYS were finalized in July 2017, and the two-year SDC pilot program launched in January 2018 (Table 3.2 provides a timeline). NYS expected a total of 200 SDC participants at the two pilot sites.

2.3 SERVICES ELIGIBLE FOR SELF-DIRECTION

The services that the SDC pilot participants can purchase with their SDC funds include all BH HCBS services offered by the HARP program, as well as individual directed goods and services.

BH HCBS are delivered to HARP and HARP-eligible HIV SNP enrollees under a two-level tier structure determined by a person-centered plan of care developed by the Health Homes or other state-designated entities. Tier 1 services include Individual Employment Support, Education Support, and Peer Services. Tier 2 services include all Tier 1 services plus additional services for beneficiaries with a higher level of need. Eligibility for BH HCBS is assessed through the BH HCBS Eligibility Assessment, a standardized clinical and functional assessment tool also referred to as CMH Screen. Current eligibility threshold for Tier 2 services, higher relative to Tier 1 services, requires evidence of at least “moderate” level of need as indicated by a state-designated score on the CMH Screen (see Figure 2.1 for eligibility criteria). The original criteria were more stringent: until June 2018, eligibility for Tier 2 services required moderate need on at least four domains or extensive need on at least one domain. In addition, a third criterion permitting previously eligible BH HCBS users to continue receiving services was added in June 2019.

Figure 2.1. Determination of BH HCBS Service Eligibility

- A. Criterion 1: Tier 1 Services
 - i. For Individual Employment Support, person must express desire to receive employment support services.
 - ii. For Education Support, person must express desire to receive education support services to assist with vocational goals.
 - iii. For Peer Support, person must express desire to receive peer support services.
- B. Criterion 2: Tier 2 Services
 - i. Meets threshold score for MODERATE need on at least one domain of Functional and Safety Needs* OR
 - ii. Meets threshold score for EXTENSIVE need on at least one domain of Functional and Safety Needs.*
- C. Criterion 3
 - i. Individuals who receive or have previously received BH HCBS in the past six months will maintain their eligibility level for the current assessment (i.e., algorithm will return the higher of the two scores to prevent loss of potentially beneficial services).

* Domains of Functional and Safety needs include employment/education, instrumental activities of daily living (IADLs), cognitive skills, social relations, stress and trauma, co-occurring conditions, engagement, substance use, and risk of harm.

The goods and services eligible for self-direction can be other services, equipment, or supplies that address an identified need in the service plan and are not otherwise available to the beneficiary (see Appendix A for a non-exhaustive list of non-treatment goods and services). These items or services must decrease the need for other Medicaid services, promote inclusion

in the community, and increase the participant’s safety in the home environment. Not all goods and services are eligible for self-direction. Ineligible items include experimental treatments, room and board in an assisted living or other residential facility, and services or goods that are recreational.

2.4 EVALUATION TIMELINE AND PROGRESS TO DATE

In early 2020, NYS DOH required a shift in priorities and resources to address the COVID-19 pandemic. This resulted in a delay executing data use agreements, applying for institutional review board (IRB) approval, and accessing data for analysis. At this time, this interim report only includes information pertaining to the design and implementation of the SDC pilot program evaluation. All findings and conclusions will be discussed in a final summative report, available in Spring 2021.

Revised Timeline

The original evaluation timeline was revised to allow for additional time for analysis. The timeline of activities to date are presented in Figure 2.2. As discussed in the methodology in Section 3, the ability to complete the analysis of the person-level data is integral to responding to the evaluation questions.

Figure 2.2. SDC Independent Evaluation Timeline of Activities to Date



Next Steps

All evaluation components will be completed per Table 1.1 and are expected to be published in a final summative report in Spring 2021.

3. EVALUATION DESIGN AND METHODS

The following sections provide an overview of the evaluation design and a description of the data sources and methods. Most of the methodology presented below is the design as planned; modifications have been made and more may be made during the analysis.

3.1 OVERVIEW

RAND is conducting an independent evaluation of the SDC pilot program that adheres to the evaluation standards set forth in the Special Terms and Conditions for the Section 1115 Demonstration (New York State, 2020, Section XI, Evaluation Requirements). The SDC pilot program evaluation employs a mixed method design and includes a process evaluation component and an outcome evaluation component.

Process Evaluation

The process evaluation will seek to understand how the SDC pilot program has been implemented, focusing on the elements that are critical to achieving program outcomes according to the logic model, with an eye toward informing broader scale-up of SDC. The evaluation will explore issues associated with barriers and facilitators to SDC implementation; clarity of roles and adequacy of training for key personnel (e.g., financial intermediary, support brokers); adequacy of policies, procedures, oversight, and monitoring from agency leadership and NYS; integration of SDC within agency services; coordination between pilot sites and the financial intermediary; recruitment and enrollment of SDC participants; and provision and receipt of SDC services, including experiences developing recovery plans and budgets.

This part of the evaluation will use a combination of quantitative and qualitative methods to address the three process-related research questions stated in Goal 1. The first question concerns enrollment in the SDC program and will be addressed through descriptive analyses of data from several administrative and survey sources (see Section 3.3, Quantitative Data Sources). The second and third questions of the process evaluation will be addressed using qualitative methods, i.e., a combination of focus groups, key informant interviews, site visits, and document reviews. Participants in the qualitative components of the process evaluation will include SDC participants, support brokers, pilot site agency leadership, Advisory Council members, fiscal intermediary staff, and OMH program staff, as well as any additional stakeholders identified as having relevant expertise and exposure to the SDC pilot program (e.g., policymakers, members of provider network).

Outcome Evaluation

The outcome evaluation will be used to address research questions related to recovery, health, functioning, and satisfaction outcomes (Goal 2) and to Medicaid service utilization and cost (Goal 3). The design of the outcome evaluation will be quasi-experimental. The outcome measures will be risk-adjusted to control for individuals' characteristics such as sociodemographics, health status, clinical characteristics, and functional status. Risk adjustment will require multivariable analyses based on individual-level data. Causal models will permit appropriate adjustment for confounding factors, including the effects of other ongoing health care initiatives, time-varying covariates, and potential heterogeneity in program implementation effects. The evaluation team will use a difference-in-differences design (pre-post approach) and generalized linear mixed models (GLMM) with appropriate individual-level fixed and random effects to estimate post-policy individual level change in outcomes over time. The concurrent comparison groups for both approaches, when appropriate, will be constructed with a propensity score matching approach (see section 3.4, Analytic Approaches).

Concurrent policies as well as other unobserved factors could affect estimates of program effects if they are correlated with the BH Demonstration and specifically, the SDC pilot program. This possibility will be investigated by examining the relative timing of other key policies with the implementation of the SDC Pilot program, including controls for other policies in the causal models, and estimating models with time period indicators in difference-in-differences model settings to account for other time invariant unobserved policies or idiosyncratic effects.

The mixed methods approach planned for the SDC pilot program evaluation will provide a deeper and more nuanced understanding of client outcomes and implementation barriers and facilitators than would be possible using only one method. The mixed methods approach will primarily focus on seeking complementarity, wherein qualitative data will help inform interpretation of the quantitative results. In addition, qualitative data, in turn, will provide in-depth information on individual experiences of the pilot, the broader context, and other domains not covered by quantitative data, such as development of adequate policies (Tariq and Woodman, 2013).

The program goals, along with the associated research questions, data sources, and planned outcome measures, are illustrated in Table 3.1. Methods to address each of the research questions are discussed in further detail in section 3.6, Integration of Quantitative and Qualitative Methods.

Table 3.1. Outcome Measures by Goal and Research Question

Goals	Research Questions	Data Sources	Outcome Measures
1. Implementation of a viable and effective SDC program for HARP enrolled/BH HCBS eligible individuals throughout NYS	1. What are the characteristics of SDC participants and how do they compare to the HARP and BH HCBS eligible population?	Pilot Site Enrollment Data Medicaid Data (Claims and Encounters) CMH Screen HARP PCS	Count of SDC participants stratified by sociodemographics, health status/clinical characteristics, and functional status
	2. What was the experience of HARP enrolled/BH HCBS eligible individuals participating in the SDC Pilot program in relation to satisfaction with the SDC program and its impact on their recovery, quality of life, and benefit from health and BH services?	Transcripts of SDC participant focus groups	Description of participant perspectives on SDC program, staff, and process; impacts on their recovery, quality of life, health, and BH; satisfaction with services
	3. What was the experience of non-participant stakeholders in the SDC Pilot program (e.g., support brokers, pilot site agency staff, State program development/oversight staff, fiscal intermediary) in relation to SDC implementation including State oversight and contracting, fiscal policies and procedures, hiring of SDC staff, recruitment and work with participants, and coordination with the fiscal intermediary?	OMH administrative documentation OMH administrative staff interviews Pilot site staff interviews Pilot site documentation on hiring, training, and supervising of support brokers Transcripts from interviews with support brokers, pilot site agency leadership/supervisory, fiscal intermediary, and State oversight staff Pilot site administrative documents	Description of program policies regarding selection, agreements, ongoing monitoring of SDC sites and fiscal intermediary, participant eligibility criteria, budgeting/use of funds, conflict of interest, and complaint/incident handling Description of support broker and supervisory staff demographics, credentials, training, supervision, and their perspectives on the pilot program and their relationship with participants and fiscal and State oversight Description of pilot site agencies' process for recruiting participants, educating participants about

Goals	Research Questions	Data Sources	Outcome Measures
		Pilot site staff interviews SDC participant focus groups	what SDC is and how they can participate, enrolling participants, and facilitating ongoing participation
		Fiscal intermediary administrative and technical documents Interviews with fiscal intermediary staff, pilot site staff, State oversight staff	Description of fiscal intermediary's policy and infrastructure for providing payments, monitoring payments, and supporting customers
	4. What were the facilitators and challenges to SDC Pilot implementation and how would they impact statewide roll-out?	Interviews with State oversight, fiscal intermediary, pilot site agency staff Focus groups with participants	Description of facilitators and challenges to the implementation of the SDC Pilot program
2. Improvement in recovery, health, BH, social functioning, and satisfaction with care for SDC participants between baseline and three (3) year and subsequent follow-up	1. Do HARP enrollees have improved quality of life after participating in SDC?	HARP PCS	Risk adjusted percentage of SDC participants whose quality of life is improved as a result of the program, by annual period when data are available
	2. Do HARP enrollees show improved indicators of health, BH, and wellness after participating in SDC?	HARP PCS CMH Screen	Risk adjusted percentage of SDC participants whose BH, overall health, and wellness is improved as a result of the program, by annual period when data are available (i.e., experience reduction in substance abuse/other harmful behaviors, misuse of prescription medications)
	3. Do HARP enrollees show improvement in education and employment after participating in SDC?	HARP PCS CMH Screen	Risk adjusted percentage of SDC participants whose employment status/hours worked in competitive employment and educational status/enrollment in educational programs is improved as a result of the program, by annual period when data are available
	4. Do HARP enrollees show improvement in community tenure (i.e., maintaining stable long-term independence in the community) after participating in SDC?	HARP PCS CMH Screen	Risk adjusted percentage of SDC participants whose community tenure is improved as a result of the program, by annual period when data are available (i.e., experience improved residential status/housing stability, reduced criminal justice system involvement, are under Assisted Outpatient Treatment order, achieve functional independence)

Goals	Research Questions	Data Sources	Outcome Measures
	5. Do HARP enrollees show improvement in social connectedness after participating in SDC?	CMH Screen	Risk adjusted percentage of SDC participants whose social connectedness is improved as a result of the program, as manifested by social relationship strengths and level of social activity, by annual period
	6. Do HARP enrollees report increased satisfaction with health and BH services after participating in SDC?	HARP PCS	Risk adjusted percentage of SDC participants who report that quality of care and helpfulness of services are improved as a result of the program, by annual period when data are available
3. Maintenance of Medicaid cost neutrality overall and reduction of BH inpatient and crisis service utilization and cost for SDC participants, between baseline and three (3) year and subsequent follow-up.	1. Does participation in SDC result in increased use (and cost) of outpatient BH services and primary care?	Medicaid Data (Claims and Encounters)	Risk adjusted percentage of SDC participants receiving BH services and primary care/preventive services, by annual period
	2. Does participation in SDC result in decreased use and cost of acute care services (BH inpatient, ED, and crisis services)?	Medicaid Data (Claims and Encounters) MHARS	Risk adjusted SDC participant rates of inpatient admissions and days for BH inpatient stays; rates of BH ED use; rates of non-BH ED use; and rates of BH crisis service use. By annual period.
	3. How does participation in SDC impact overall Medicaid spending?	Medicaid Data (Claims and Encounters)	Risk adjusted Medicaid PMPM costs, by annual period (PMPM/Y), for: BH outpatient services; primary care/preventive services; acute care services (ED use, BH inpatient use, and BH crisis services); overall.

3.2 DISCUSSIONS WITH EXPERTS TO REFINE APPROACH TO THE EVALUATION

To better understand the policy context, objectives, and challenges to the implementation of the SDC pilot program, the evaluation team held calls with SDC subject matter experts to discuss the background and implementation of the program. The evaluation team has been using the information gathered in these calls and the internal report on OMH’s preliminary evaluation of the SDC pilot program to inform the qualitative component of the evaluation and to revise and enhance the planned quantitative analyses (Chung, Elwyn and Radigan, 2019). In addition, the evaluation team held discussions with data experts within DOH, OMH, and the New York State Office of Addiction Services and Supports (OASAS) to review the feasibility of fully addressing the research questions, given the constraints on data availability. As a result, some of the planned analyses have been refined to better reflect the information available; subsequent changes may need to be made depending on data availability at the time analyses are conducted.

Using the information gathered in these calls along with publicly available NYS DOH documents, a timeline was developed to indicate key program-related events with the potential to impact the implementation and outcomes of the SDC pilot program. Table 3.2 presents these key events and associated dates.

Table 3.2. Timeline of SDC Implementation

Year	Date	Event
2014	February	SAMHSA awarded OMH a Transformation Transfer Initiative to fund the design of the SDC program for individuals with serious mental illness (SMI)
2015	March	New York State Health Foundation (NYSHF) provided start-up funding to OMH to conduct a preliminary evaluation of the SDC pilot program
	August	Amended Section 1115 Demonstration behavioral health reform initiatives include SDC
	September	OMH conducted preliminary activities for SDC (e.g., site selection, hiring an OMH fiscal intermediary, creating a web-based SDC portal)
2017	July	Contracts finalized with two SDC pilot site agencies
	October	Both sites began advertisement and outreach activities to recruit participants
2018	January	Start of 2-year SDC pilot
	March	Substantive pilot program enrollment begins
2019	May	219 participants enrolled (166 active)
	August	SDC Pilot Program Implementation Evaluation Report Released by OMH
2020	June	Contracts with site agencies are extended through June 30, 2022

3.3 QUANTITATIVE DATA SOURCES

The secondary data available for the evaluation of the SDC pilot program include data available within the NYSDOH and OMH from five main sources: pilot site enrollment data, Mental Health Automated Record System (MHARS) data, Community Mental Health (CMH) Screen data, HARP Perception of Care Survey (PCS) data, and Medicaid data.

Pilot Site Enrollment Data: Information on SDC enrollment information by site and recovery goal-related expenditures contained in a secure web application designed by OMH for use by SDC participants and support brokers. These data permit assessment of SDC pilot enrollment (outcome measure).

MHARS data: Information maintained by OMH on inpatient, residential, and outpatient utilization in NYS Psychiatric Centers, used to identify psychiatric inpatient utilization not captured in the Medicaid data. These data permit a complete assessment of number of inpatient admissions and inpatient days.

CMH Screen data: A mix of lifetime and current patient self-reported information and assessor-gathered information collected as part of the assessment of BH HCBS eligibility with the BH HCBS Eligibility Assessment, brief and full scales,¹ a standardized clinical and functional assessment tool derived from the interRAI™ CMH Assessment (Hirdes et al., 2000). The CMH Screen is required annually for all HARP and HARP-eligible HIV SNP enrollees, including SDC pilot participants. Domains include sociodemographic characteristics (e.g., marital status, homelessness), health status (BH and chronic health conditions), functional status (independent living skills, cognitive skills, social relations, employment, education, and finances), BH service utilization, risky behaviors (substance use, harmful/self-injurious behaviors), traumatic events, and criminal justice system involvement. As such, the data may be used to describe program outcomes (e.g., health status, functional status), as well as risk factors (e.g., traumatic life events, homelessness, criminal justice involvement, substance use, chronic physical health conditions) and protective factors (e.g., social relations, education, employment, adequate finances). These data permit assessment of sociodemographic, clinical, and recovery-related outcomes for SDC participants (outcome measures), and they may also be used for risk adjustment in regression models.

HARP PCS data: Patient self-reported information on the HARP program, including perception of outcomes, access, and quality of care, appropriateness of services, social connectedness, wellness, and quality of life, that is collected through a survey of randomly selected HARP

¹ The BH HCBS Full Assessment ceased to be required in March 2017.

enrollees enrolled in HARPs or HIV SNPs. The survey was adapted from the Experience of Care and Health Outcomes (ECHO) Survey, the Mental Health Statistics Improvement Program (MHIP)/OMH Consumer Assessment of Care Survey, and others. All SDC participants are administered the HARP PCS survey. These data permit assessment of SDC participant experience and satisfaction with care; satisfaction with BH providers' cultural sensitivity; and satisfaction with wellness, recovery, and degree of social connectedness.

Medicaid Data. Information maintained by the Medicaid Data Warehouse containing billing records for health care services, including pharmacy, for individuals enrolled in Medicaid in a given year, whether under FFS arrangements or MCOs (i.e., claims and encounters). Source of information on Medicaid enrollment status, plan membership, BH HCBS eligibility status, demographic, health status (diagnoses including BH and chronic physical health conditions; Clinical Risk Group categories), service utilization, provider associated with the billed services, and cost of health care for all Medicaid enrollees; available with a six-month lag. These data will permit assessment of SDC participants' diagnostic characteristics, service utilization patterns, including BH HCBS, and cost of health care (outcome measures). May also be used for risk adjustment in regression models.

In addition to these NYS DOH/OMH data, the evaluation will incorporate contemporaneous data from Area Health Resource Files (ARF), a collection of publicly available data assembled by the Health Resources & Services Administration (HRSA) or PolicyMap, a web-based data warehouse. Both datasets aggregate information from multiple sources including the Centers for Disease Control and Prevention, HRSA, the U.S. Census, and other neighborhood-level datasets. Small area-level information being considered include sociodemographic characteristics (e.g., urbanicity, household income) and characteristics of the health care infrastructure (e.g., psychiatrists per 1,000 population, HRSA-designated health professional shortage area). This information is available at various geographic levels, including ZIP code and county.

3.4 ANALYTIC APPROACHES

The quantitative methods that will be employed in the evaluation of the SDC pilot program include descriptive statistics, difference-in-differences design, longitudinal mixed effect regression, and propensity score matching.

Descriptive Statistics (with corresponding graphical illustrations): This approach permits population-level, year-to-year comparisons during the evaluation period. For the SDC pilot program evaluation, this approach will be used to examine characteristics of SDC participants in each annual period since program implementation; that is, the outcome domain for Goal 1 of

the evaluation. For categorical variables, this will consist of chi-square test and McNemar's chi-square test (to compare binary outcomes between correlated groups for each region before and after implementation). For continuous variables, on the other hand, we will use the Analysis of Variance (ANOVA) test; paired t-test (to compare pairs of years); and across analyses, the Bonferroni adjustment for multiple pair comparisons. Whenever repeated ANOVA tests for yearly changes within each region may be desirable, the RAND team will evaluate whether the sphericity assumption is violated.

Difference-in-Differences: This design is a pre-post approach that may be employed when concurrent comparison groups are available, thus enabling a robust assessment of program outcomes. For the SDC pilot program evaluation, the outcome domains are those related to service utilization and cost (Goal 3). The treatment versus control groups are: HARP-enrolled and BH HCBS-eligible enrollees who participate in the SDC program versus HARP-enrolled and BH HCBS-eligible enrollees who do not participate in the SDC program and who reside in the same geographic areas as the pilot sites. An alternative control group will be HARP-enrolled and BH HCBS-eligible enrollees meeting SDC participation criteria residing in areas similar to the pilot locations.

Outcomes will be measured over two consecutive 18-month periods, prior to and following enrollment in the SDC pilot program. The measurement periods are approximate as the actual trends will be based on SDC participant enrollment:

Pre-Period: July 2016 to December 2017

Post-Period: January 2018 to June 2019

This quasi-experimental approach accounts for any secular trend/changes in the outcome metrics as it eliminates fixed differences not related to program implementation; thus, remaining significant differences may be validly attributable to the impact of program implementation. The difference-in-differences approach requires that pairs of treatment and control individuals comparable on key observed confounders be identified through Propensity Score Matching (discussed below).

Longitudinal Mixed Effect Regression: This approach employs a GLMM to estimate an average program effect while adjusting for key covariates when examining change trajectories. For the SDC pilot program evaluation, the outcome domains are quality of life; health status including physical health, BH, and wellness; functional status including education and employment, community tenure and social connectedness; and satisfaction with health and BH services (Goal 2). This quasi-experimental approach separates the effects of time from that of the SDC pilot implementation, accommodating the heterogeneity in the program implementation effect and accounting for serial correlations within individuals and variation of risk/protective factors and

outcomes over time due to strong temporal trends. The multivariable mixed effects regressions will include fixed effects, namely demographics (age, gender, and race/ethnicity) and time, and random effects assessed at each annual time point, namely risk and protective factor levels as assessed with the CMH Screen. Random effects will be incorporated in the models on two levels: for changes over time nested within persons and persons nested within areas/site.

Propensity Score Matching: This approach controls for potential confounding by identifying individuals with similar characteristics belonging to the treatment and control groups, thus enabling the use of quasi-experimental causal models (such as the difference-in-differences design discussed above). In the SDC pilot program evaluation, propensity score matching (PSM) will be used in combination with difference-in-differences (for double robustness) to examine the impact of the program on the outcomes of interest. The comparison group will strengthen the planned analyses, as it will control for the effects of other policies and initiatives implemented concurrently with SDC. The method uses a logistic regression to estimate each individual's conditional probability (or propensity score) of belonging to the treatment group (i.e., having the outcome of opting to enroll into SDC). Predictors will include variables related to sociodemographic, health status/clinical characteristics, functional status, and other variables such as service utilization variables assessed prior to program implementation. A greedy matching algorithm with an appropriate matching ratio of treatment to control individuals will be used to create a matched analytic cohort based on the estimated propensity score. RAND will *a priori* select the confounding variables for inclusion in the models using the team's expertise but may also consult with additional subject matter experts. Balance in covariate distribution between treatment and control individuals in the matched analytic cohort will be assessed with standardized difference.

3.5 QUALITATIVE METHODS

The qualitative component of the SDC pilot program evaluation will consist of interviews with key informants and participants in the pilot program, and a review of program-related policy documents. The key informant interviews will be conducted with informants who represent diverse stakeholders in the SDC pilot program, including support brokers, agency leadership, clinical supervisors, fiscal intermediary, and NYS oversight staff. Informants will include representatives of advocacy organizations, plan administrators, and care providers, and they will be selected using a snowballing approach. An initial group of informants will be selected from a list provided by the DOH, and additional informants will be selected based on recommendations of individuals on the list. An effort will be made to ensure that a broad range of perspectives is represented in the study sample, including diverse advocacy groups and providers from New York City as well as both urban and rural regions upstate. The evaluation team anticipates

conducting approximately 15 key informant interviews. In addition, SDC participant interviews will be conducted to understand perspectives on the pilot and to gauge satisfaction. The qualitative analysis will also be informed by review of documents that have been provided to the research team by DOH. The documents include policy documents, which describe how the program was designed.

The interviews and documents will be analyzed by the evaluation team to identify issues that have arisen in the course of the implementation of the SDC pilot. The interviews will also be used to understand staff perspectives on their relationships with participants, fiscal and state oversight, and the SDC program as a whole. For instance, the evaluation team will ask advocacy organizations whether the implementation has gone according to expectations, whether they have concerns about barriers to successful implementation, and whether there are aspects of the implementation that have been particularly promising. Issues raised by key informants will be summarized and compared across the categories of informants. While the key informant interviews cannot provide definitive information on the impact of the SDC pilot, they can be extremely helpful in identifying common areas of concern.

Protocol Development

A semi-structured interview guide for key informants representing a diversity of SDC pilot stakeholders was developed (Appendix B). It covers topics including barriers and facilitators to SDC pilot implementation; clarity of roles and adequacy of training for key personnel (e.g., financial intermediary, support brokers); adequacy of policies, procedures, oversight, and monitoring from agency leadership and NYS; integration of SDC within agency services; coordination between NYS, pilot sites, and the financial intermediary; recruitment and enrollment of SDC participants; provision and receipt of SDC services including experiences developing recovery plans and budgets; and participant outcomes.

A semi-structured interview guide for SDC participants is being developed. It will focus on topics including participant perceptions regarding enrollment, the process of developing recovery plans and budgets, relationships between participants and support brokers, satisfaction with health and BH services, and the impact of SDC on participant recovery and quality of life.

Respondent Selection

The evaluation team is using a purposive sampling approach to recruit key informants. To capture a range of perspectives, key informants representing various stakeholder organizations will be recruited, including the two pilot sites, the NYS Office of Mental Health, and provider/trade associations. Potential key informants will be identified through state and site-provided lists, as well as suggestions for additional informants from those who completed interviews. Key informants from the two pilot sites will include SDC direct provider staff (i.e.,

support brokers), other pilot site staff serving participants who are enrolled in SDC, and SDC program and agency leadership. Key informants from OMH will be recruited from several divisions/departments and generally represent leadership at the program or senior executive management level as well as staff directly involved in administering the program (e.g., fiscal intermediary functions). Key informants from the provider/trade associations will represent staff from the senior executive leadership level. The evaluation team anticipates conducting approximately 15 key informant interviews.

To identify SDC participants for interviews, evaluators will utilize purposive and convenience sampling strategies. To capture a range of perspectives, the evaluation will seek to maximize the diversity of SDC participants who participate, considering factors such as referring pilot site, length of time in SDC, SDC utilization patterns, and a range of demographic characteristics (e.g., gender, race, diagnosis). The evaluation team anticipates approximately ten interviews with SDC participants, with approximately five participants from each pilot site.

Respondent Recruitment

Potential key informants will receive an e-mail inviting them to participate in the evaluation interview and to contact the evaluators if they are interested in participating. An information sheet will be e-mailed to key informants in advance of scheduled interviews and reviewed prior to commencing the interview. SDC pilot site staff will identify potential SDC participants and provide them with information about the evaluation. SDC participants interested in participating can contact the evaluators directly or inform SDC staff that they consent to having the evaluators contact them.

Interviewer Training

Prior to conducting interviews, the qualitative team received training on the SDC pilot and the context of the state pilot implementation, including relevant Medicaid policies. The training included a review of documents provided by DOH, participation in discussions with DOH subject matter expert staff, and internal discussions with the project leads and technical advisors, who have experience with NYS Medicaid and the SDC program development. The training ensured that the interviewers were aware of issues relevant to the implementation when conducting interviews.

Conducting Interviews

Interviews with key informants representing SDC stakeholders will be conducted virtually and last one hour, on average. The majority of data collection will consist of individual interviews with one identified key informant; however, informants will be able to invite additional

individuals to the interviews as needed to cover the relevant expertise and experience. Interviews with SDC pilot client participants will be conducted by phone or online.

Interviews will be conducted by one qualitative researcher, with an additional researcher taking notes concurrently that will inform a written interview summary. Interviewers will cover core topic areas but will flexibly maneuver through the interview guide and probe certain topics more in-depth as appropriate. Interviews will be audio-recorded and transcribed verbatim. The institutional review board of the NYS Psychiatric Institute determined that data collection with stakeholders who were not SDC pilot participants does not constitute human subjects research and was thus exempt from review. Review of data collection with SDC participants is pending.

Qualitative Data Analysis

Analytic methods, aligned with recommendations of Bradley, Curry, and Devers (2007), will follow a grounded theory approach to developing coding structures that emphasize inductive codes emerging directly from the data (Bradley, Curry and Devers, 2007). Consistent with grounded theory, qualitative analysis occurs concurrently with data collection, allowing interviews to be shaped by preliminary concepts and themes emerging from the data. The analysis will proceed in a series of steps: developing initial codes (open-coding), validating and using the codes (i.e., coding transcripts with a final code list), clustering and interpreting the codes, and developing broader findings and themes. Strategies for rigor include weekly data collection and analysis debrief meetings, development of interview summaries and memos, and the use of multiple coders.

3.6 INTEGRATION OF QUANTITATIVE AND QUALITATIVE METHODS

Findings from the quantitative and qualitative analyses will be integrated to refine and deepen the results from the different methods. Qualitative information from participant interviews will be combined with quantitative findings on change indicators (Goal 2) to gain a more nuanced understanding of participant outcomes. In addition, barriers and facilitators of SDC implementation identified through the qualitative data and methods of the process evaluation will be combined with quantitative findings derived from the two pilot sites to gain an understanding of whether there are elements critical to effective implementation.

3.7 DISCUSSION OF EVALUATION GOALS AND RESEARCH QUESTIONS

Goal 1. Implementation of a viable and effective SDC program for HARP enrolled/BH HCBS eligible individuals throughout NYS (Process Evaluation)

The evaluation team will develop a detailed design for the process evaluation through review of the SDC logic model; the literature on SDC programs; initial discussions with NYS DOH personnel;

and review of documents describing the program developed by OMH, OASAS, the SDC Advisory Council, fiscal and administrative entities, and the pilot site agencies. The review will inform selection of respondents for the qualitative components of the process evaluation and the questions that will be included in the interview protocols. Descriptive analyses of the administrative and survey data on enrollment in the SDC programs, which will be conducted concurrently, will also inform the study design, guiding decisions regarding the diversity of participants.

Research Question 1.1: What are the characteristics of SDC participants and how do they compare to the larger HARP and BH HCBS eligible population?

Data from pilot site enrollment records and data from CMH Screens, HARP PCS, and Medicaid will be used to characterize the participants in the SDC programs. The enrolled population will be described with respect to basic sociodemographic characteristics (e.g., age, sex, race/ethnicity), prior behavioral and general medical health care utilization, behavioral and general medical diagnoses, and other characteristics of interest. In addition, the evaluation team will conduct comparisons of the SDC population with other HARP- and BH HCBS-eligible Medicaid beneficiaries from the same regions in which the SDC programs are located and statewide. The analyses will use basic descriptive statistics, with the possible addition of regression modeling to compare the SDC participants with other HARP- and BH HCBS-eligible Medicaid beneficiaries on multiple characteristics simultaneously. The comparative analyses will allow the evaluation team to observe whether the SDC participants are comparable to HARP and BH HCBS populations statewide. In addition, these analyses can help policymakers understand the potential scope of the SDC programs, were they to be expanded statewide using similar eligibility criteria and recruitment processes.

Research Question 1.2: What was the experience of HARP enrolled/BH HCBS eligible individuals participating in the SDC Pilot program in relation to satisfaction with the SDC program and its impact on their recovery, quality of life, and benefit from health and BH services?

Methods to address this question are designed to highlight the perspectives of SDC participants themselves. Interviews with SDC participants at both of the two SDC sites will be conducted with up to ten participants, recruited with the assistance of the site agencies. The evaluation team will work with each pilot site to identify and recruit individuals representing a diversity of SDC participants by individual characteristics such as race, gender, and diagnoses, as well as extent of SDC service use. The semi-structured discussion guide will focus on key aspects of the logic model as viewed by the participants. Topics will include participant perceptions about the process of developing recovery plans and budgets; relationships between participants and

support brokers; satisfaction with health and BH services; and SDC impact on participant recovery and quality of life.

Research Question 1.3: *What was the experience of non-participant stakeholders in the SDC Pilot program (e.g., Support Brokers, pilot site agency staff, State program development/ oversight staff, fiscal intermediary) in relation to SDC implementation including State oversight and contracting, fiscal policies and procedures, hiring of SDC staff, recruitment and work with participants, and coordination with the fiscal intermediary?*

This question will be addressed through qualitative analysis of documents and interviews, focusing on identification of implementation barriers and facilitators, staff roles, SDC processes, and coordination among stakeholder organizations. Documents from NYS and the pilot sites will be analyzed, as will the interviews that are conducted with NYS agency officials/staff (e.g., OMH administrators, fiscal intermediary staff) and pilot site staff.

Research Question 1.4: *What were the facilitators and challenges to SDC Pilot implementation and how would they impact statewide roll-out?*

The final question of the process evaluation will draw on all the qualitative data described above, including interviews with pilot site agency staff (e.g., support brokers, leadership), state agency staff (leadership, financial/fiscal intermediary staff), and SDC participants to address the broad issues of facilitators and challenges that were faced during the pilot program and how these might impact a statewide roll-out of the program. Transcripts from qualitative data collection efforts will be analyzed with specific attention to codes related to barriers and facilitators and linkage of themes across the respondent types. This will allow the evaluation team to address issues from multiple perspectives. For instance, state officials may have concerns about enrollment based on the counts and characteristics of HARP-enrolled/ BH HCBS-eligible individuals who are successfully enrolled, whereas staff of the pilot sites have insights into the reasons that some HARP-enrolled/ BH HCBS-eligible individuals may or may not prefer to enroll in the program. Bringing these multiple perspectives together can provide useful lessons for the statewide rollout.

Goal 2. Improvement in Recovery, Health, BH, Social Functioning, and Satisfaction with Care for SDC Participants (Outcome Evaluation)

Research Question 2.1: *Do HARP enrollees have improved quality of life after participating in SDC?*

Research Question 2.2: *Do HARP enrollees show improved indicators of health, BH, and wellness after participating in SDC?*

Research Question 2.3: *Do HARP enrollees show improvement in education and employment after participating in SDC?*

Research Question 2.4: *Do HARP enrollees show improvement in community tenure (i.e., maintaining stable long-term independence in the community) after participating in SDC?*

Research Question 2.5: *Do HARP enrollees show improvement in social connectedness after participating in SDC?*

Research Question 2.6: *Do HARP enrollees report increased satisfaction with health and BH services after participating in SDC?*

To address the Goal 2 research questions, the evaluation team will use GLMM to assess changes in outcomes for SDC participants between baseline and multiple follow-up points over the first two years of the pilot program (January 1, 2018 to December 31, 2019), while controlling for variation in outcomes and risk factors over time and potential heterogeneity in program implementation. For the SDC pilot program evaluation, random effects will be incorporated in the models on two levels: for persons within areas/site and for change over time within persons. This approach will assess average trends on outcome measures derived from the CMH Screen and HARP PCS while controlling for possible confounding factors. Using data from the CMH screen, Research Questions 2.2 through 2.5 will be addressed with the additional benefit of an appropriate comparison group identified through PSM. It is not possible to rely solely on HARP PCS data for Research Questions 2.1 and 2.6, as the HARP PCS for non-SDC participants is based on annual random sampling. However, those data will be used to descriptively compare the larger HARP-enrolled population with SDC participants.

Goal 3. Maintenance of Medicaid Cost Neutrality Overall and Reduction of BH Inpatient and Crisis Service Utilization and Cost for SDC Participants

Research Question 3.1: *Does participation in SDC result in increased use and cost of outpatient BH services and primary care?*

Research Question 3.2: *Does participation in SDC result in decreased use and cost of BH inpatient, ED, and crisis services?*

For the Goal 3 Research Questions, the evaluation team will use difference-in-differences to assess the effect of the SDC pilot on rates of service utilization (BH outpatient, primary care, BH inpatient, and ED and crisis services) and Medicaid spending over a 36-month period. Outcomes over two consecutive 18-month periods will be measured, prior to and following enrollment in the SDC pilot program, and changes from the prior measurement period to the post measurement period will be compared between the SDC pilot participants and a comparison group identified through PSM. As mentioned above, the approximate measurement periods are July 1, 2016 to December 31, 2017 (pre-period) and January 1, 2018 to June 30, 2019 (post-period).

4. FINDINGS

Due to the Spring 2020 delays in initiating the SDC pilot program evaluation, no findings are yet available for discussion at this time. All findings will be reported in the final summative report in 2021. Proposed Timeline capturing the ongoing data access and analysis is presented above in Table 1.1.

5. POLICY IMPLICATIONS

Because there are no findings yet available, no policy implications can be provided at this time. A thorough discussion of the policy implications of the evaluation findings will be included in the 2021 final summative report.

6. INTERACTIONS WITH OTHER STATE INITIATIVES

An in-depth empirical investigation of the manner in which the implementation and effects of the SDC pilot were affected by other state initiatives is out of scope for the SDC pilot evaluation as proposed and executed in the RFP and RAND contract. As an alternative, information on other policy initiatives implemented by the state and potentially affecting the SDC pilot is being collected to assist with the design of the analyses and to interpret and provide context to the findings. Potential interactions with the SDC pilot will be discussed in the 2021 final summative report.

The state initiatives that will be reviewed for potential interactions with the implementation of the SDC pilot in the final summative report include:

- Other provisions of the Delivery System Reform Incentive Payment (DSRIP) Program, including payment reform in the form of a Value Based Payment (VBP) Roadmap
- Provisions of the Affordable Care Act (ACA), including the Medicaid Health Home program and Medicaid access expansion.

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APPENDIX A. LIST OF SDC GOODS AND SERVICES

Non-treatment goods and services that support treatment goals in a Participant's Action Plan may include, but are not limited to (Chung, Elwyn and Radigan, 2019):

- Wellness activities
 - o Gym/ health club membership
 - o Wellness coaching
 - o Smoking cessation tools/ education
 - o Dental care
 - o Eyeglasses/care
 - o Out of network health/BH/specialty services
 - o Family planning and sexual health education/ services
 - o Acupuncture/pressure
 - o Yoga classes/meditation guidance
 - o Massage/reiki/ shiatsu/tai chi instruction
 - o Pet adoption funds, including appointments/resources related to pet health and maintenance
 - o Workout equipment and clothing
 - o Nutritional supplements and vitamins

- Occupational/skills development
 - o Computer literacy
 - o Resume development
 - o Interview preparation
 - o PC/communication technology
 - o Personal preparation/resources to prepare for interviews or to enhance confidence during employment, including purchase of a wardrobe or maintenance of personal hygiene (including but not limited to skin and hair care)
 - o Resources for entrepreneurial development, including business cards, website development
 - o Educational course fees and materials

- Transportation
 - o Public transportation costs
 - o Car repair/maintenance
 - o Bicycle and related costs

- In-home/social/community supports
 - o Training and supports for daily living including cooking and nutrition classes, sequencing, time management, etc.
 - o Housing start-up (down payments), non-recurring housing bills or costs related to home maintenance, including furniture or air conditioner

- o Groceries
- o Travel to and from family or social functions, including special trips to visit family members or friends
- o Meetings in the community with friends or family members at restaurants, coffee houses, or other social venues, that promote the social inclusion of the participant
- o Financial contributions at social activities including church services
- o Registration fees for conferences, trainings, community activities
- o Membership dues in groups, societies, guilds, leagues

APPENDIX B. KEY STAKEHOLDER INTERVIEW PROTOCOL

Interview Guide: Non-Client Agency Leadership Stakeholder

Participant ID: _____ Interview Date: _____

Region: NYC ___ Beacon ___

Stakeholder Type: _____

Agency Type: _____

Interviewer: _____

The purpose of this interview is to explore your perspective and experience with the Self-Directed Care pilot program. The Self-Directed Care program allows individuals with behavioral health needs who are participating in the pilot program to use State funds to purchase goods and services and/or to hire service providers that can facilitate the person's recovery. The SDC pilot seeks to increase autonomy and choice over benefits in order to enhance participants' progress toward recovery goals and improve health for individuals with behavioral health needs. The SDC pilot is being implemented at two behavioral health agencies in New York State.

Before we begin, I want to discuss the process of this interview. The interview will take approximately 60 minutes to complete. Again, the goal of this interview is to learn about your views and experiences regarding the implementation of the SDC Pilot Program. There are no right or wrong answers to these questions. We are only interested in your honest opinion. Any questions before we begin?

<< *BEGIN RECORDING* >> << *BEGIN RECORDING* >> << *BEGIN RECORDING* >>

Role:

1. What is your current role at [organization]?
Probe: How do your responsibilities relate to the SDC pilot?

SDC Pilot

2. How would you describe the mission and goals of the SDC pilot?
3. What has been your experience with the SDC program?
4. How were participants enrolled in the program?
 - a. How was eligibility assessed? Were there any challenges?
 - b. To what degree is it reaching the target population?
 - c. What were the most common reasons that participants were not eligible? Would this need to be changed if the program were to scale-up?
 - d. What motivated participants to join the SDC program?

- e. How many participants were eligible but did not enroll? Why?
5. What have been some of the benefits of implementing SDC?
 - a. What has gone well with SDC? For participants? For the organizations? For the overall system of care?
 - b. How would you define success for SDC?
 6. How has the SDC program impacted SDC participants?
 - a. How has it impacted the paperwork they have to do (e.g., purchase requests) regarding managing their benefits?
 - b. How has it impacted their access to services?
 - c. How has it impacted their access to goods?
 - d. How has it impacted participants' sense of autonomy and choice?
 - e. How has it impacted participant outcomes (e.g., recovery, quality of life, health/wellness, community integration, functioning)?
 - f. For whom does the program work well?
 - g. For whom does it not work as well? Can you give an example?
 7. What services or goods has SDC increased access to the most?
 - a. How do these services or goods meet participants' needs?
 8. What services or goods have been more challenging for SDC participants to utilize?
 - a. What has been challenging about accessing these services or goods?
 9. How does access to goods and use of services differ between SDC participants and other people with behavioral health needs served by [organization(s)]?
 - a. What goods/services are SDC participants more likely to use/access?
 - b. What goods/services are SDC participants less likely to use/access?
 10. How well has the process of SDC participants identifying goals and needs, requesting funds, and having them reviewed been going?
 - a. Developing participant goals? Developing budgets?
 - b. Participants identifying goods/services needed?
 - c. Participants requesting funds?
 - d. Review/approval of funding requests?
 - e. Placing funds on participants' cards?
 - f. Which parts of the process do participants need the most support with?
 11. What are some of the most common reasons that participants' purchase requests are denied?
 - a. How is it determined whether requests are an appropriate use of SDC funds?
 - b. How is it determined whether requests are related to goals?
 - c. Can participants appeal request denials?
 12. What is the process for identifying misuse of funds?
 - a. What are the most common ways in which funds have been misused?

- b. Do any changes need to be made to the types of oversight that are now in place?
13. What have been some of the challenges of providing SDC services?
- a. Engaging participants?
 - b. Staff delivering the services? Staff retention?
 - c. Communicating/coordinating across staff/agencies?
 - d. Reviewing/approving purchases?
 - e. Timeliness with which requests/purchases are completed?
 - f. Funding for SDC?
 - g. Administrative burden for organizations/agencies?
 - h. Any dilemmas or ethical issues that arise?
 - i. What could be improved? What would help address some of these challenges?
14. What changes would you suggest to the program?
- a. What changes would be needed to help scale-up the program to other organizations and participants throughout the state?

Support Brokers

15. What is the role of the support broker within the organization?
- a. To what degree does the work of the support broker match how the role was planned?
 - b. What aspects of the role have had to be clarified or negotiated over time?
 - c. What changes might need to be made to the role of the support broker?
16. How did the organization select a support broker to work with participants?
- a. Were there any challenges to hiring the support broker?
 - b. Any challenges to integrating this role into the agency?
 - c. To what extent do support brokers work with other staff at the organization?
17. How were support brokers oriented and trained in the SDC program?
- a. How are they introduced to participants?
 - b. What additional training might be needed for support brokers?
18. How are support brokers supervised?
- a. Who provides supervision?
 - b. Do supervisors receive any specialized SDC training?
 - c. What type of issues are discussed in supervision/with supervisors?
19. What are the benefits of having the support broker role compared to folding this into other staff roles?
20. What are the challenges of having the support broker role?
21. How does the SDC pilot fit in with other types of behavioral health services that are delivered by the [organization(s)]?

Fiscal Intermediary Role:

22. What is the role of the fiscal intermediary?
 - a. To what degree does the work of the fiscal intermediary match how the role was planned?
 - b. What aspects of the role have had to be clarified or negotiated over time?
 - c. What changes might need to be made to the role of the fiscal intermediary?
23. What is communication/coordination like between the fiscal intermediary as part of SDC?
24. What are the benefits specifically of having the fiscal intermediary role?
25. What are the challenges of having the fiscal intermediary role?

Overall Program Evaluation

26. How would you evaluate the overall success of the program?
27. Do you believe the program should be expanded?
 - a. Probe: Why or why not?
28. Any thoughts on how to improve the program?
29. What are the next steps for SDC?
 - a. Probe: Do you believe that SDC is an effective and viable program for HARP enrollees across NYS?
 - b. Long-term sustainability?
30. Is there something we didn't ask that you would like to add?



PR-A951-1

Independent Evaluation of the New York State Medicaid Redesign Team, Section 1115 Demonstration

Preliminary Interim Report

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Executive Summary

Evaluation Objective

To meet the special terms and conditions specified by the Centers for Medicare and Medicaid Services under New York State’s 1115 Medicaid Redesign Team (MRT) Waiver, the RAND Corporation was competitively selected as the independent evaluator to assess two components under this 1115 Demonstration Waiver: the Managed Long-Term Care (MLTC) program and the 12-month continuous eligibility policy. Starting in September 2012, the state required individuals who are over 21, eligible for both Medicare and Medicaid, and in need of 120 days or more of long-term care to enroll in MLTC plans, which are reimbursed on a capitated basis. The 12-month continuous eligibility policy was implemented in January 2014 for individuals eligible for Medicaid, based on the Modified Adjusted Gross Income guideline, including pregnant women; childless adults who are not pregnant, are younger than 65, and are not on Medicare; parents or caretaker relatives; and individuals eligible for the Family Planning Benefit Program. Individuals who qualified for 12-month continuous eligibility were guaranteed Medicaid coverage regardless of changes in income in the 12 months after enrollment. This interim evaluation aims to examine whether these two programs have achieved the following goals:

- expanding access to long-term services and supports and improving patient safety, quality of care, and consumer satisfaction (in the case of MLTC)
- reducing enrollment gaps and increasing Medicaid enrollment duration (in the case of 12-month continuous eligibility).

Because of a delay in access to data, at the time of this writing (December 2020), the analysis of the 12-month continuous eligibility policy has not been completed; the results of this analysis will be presented in the final interim report.

Analytical Approach

To achieve the goals of this interim evaluation, RAND researchers have conducted a number of analyses using various data sources provided by the New York State Department of Health (NYS DOH), including the 2010–2018 MLTC monthly enrollment by county; 2007–2019 MLTC plan-level aggregate data¹ on patient safety, quality of care, and consumer satisfaction; and 2010–2018 American Community Survey data. The evaluation team described the trends in various outcomes over time and conducted statistical modeling and testing to answer the evaluation questions. As described in the request for proposal, only aggregate data at the state-







¹ The data years vary across different outcome measures. Please see the study design section for more details.












and plan-level were available for the analysis; the absence of individual-level data did not allow us to control for individual-level characteristics or identify individuals under the mandate and thus has reduced the statistical power to detect MLTC’s effects on outcomes.

Findings and Conclusions

The results of our analyses showed that the MLTC mandate was associated with a large increase in MLTC enrollment during 2012–2018, with its effect stabilizing after 19 months; there is no evidence of a decline in patient safety, quality of care, or consumer satisfaction, except for a decrease in satisfaction with care managers (Table ES1). Among those who transitioned from institutional settings to community settings, enrollment in MLTC increased during 2015–2018, but no statistically significant changes in patient safety and quality of care were observed except for an increase in receipt of dental exams.

Table ES1. Summary of Evaluation Results

Domain	Goal	Outcome	Result
Domain 1, Component 1: Managed Long- Term Care (MLTC)	Goal 1: Expand access to MLTC for Medicaid enrollees in need of long-term services and supports (LTSS)	Time for the MLTC mandate’s effect on enrollment to stabilize	 19 months, stabilizing at +2.4 percentage points per year; a 37-percentage point increase in enrollment rates during the first 79 months post-mandate (p<0.05)
		Percentage without emergency room visits	 +0.8 percentage points (p>0.05)
	Percentage without falls requiring medical intervention or resulting major or minor injuries	 -1.8 percentage points (p>0.05)	
	Goal 3: Demonstrate stability or improvement in quality of care	Receipt of timely care	 -0.8 percentage points (p>0.05)
		Influenza vaccination	 +0.2 percentage points (p>0.05)
		Dental exam	 -5.6 percentage points (p>0.05)

Domain	Goal	Outcome	Result
	Goal 4: Stabilize or reduce preventable acute hospital admissions	Potentially avoidable hospitalization	 -1.3 hospitalizations per 10,000 enrollee days (p>0.05)
	Goal 5: Demonstrate stability or improvement in consumer satisfaction	Satisfaction with MLTC plans	 -1.8 percentage points (p>0.05)
		Satisfaction with care managers	 -3.1 percentage points (p<0.05)
		Satisfaction with provider timeliness	 -2.2 percentage points (p>0.05)
		Satisfaction with service quality	 -1.2 percentage points (p>0.05)
Domain 1, Component 2: Individuals Moved from Institutional Settings to Community Settings for LTSS	Goal 1: Improve access to MLTC for those who transitioned from an institutional setting to the community	Enrollment in MLTC within one year post discharge from an institution	 7% in 2015; 60% in 2018 (p<0.05)
	Goal 2: Stability or improvement in patient safety	Percentage without emergency room visits	 50% in 2015; 85% in 2018 (p>0.05)
		Percentage without falls requiring medical intervention or resulting major or minor injuries	 50% in 2015; 93% in 2018 (p>0.05)
	Goal 3: Stability or improvement in quality of care	Percentage in community within one year post discharge from an institution	 85% in 2015; 81% in 2018 (p>0.05)
		Influenza vaccination	 50% in 2015; 73% in 2018 (p>0.05)
		Dental exam	 50% in 2015; 64% in 2018 (p<0.05)
	Domain 2: Mainstream Medicaid Managed Care and Temporary Assistance to Needy Families (TANF)	Goal 1: Increase access to health insurance through Medicaid enrollment—Express Lane Eligibility	Medicaid enrollment, demographic characteristics, and percentage of ineligible enrollees

Domain	Goal	Outcome	Result
	Goal 2: Limit gaps in Medicaid eligibility due to fluctuations in recipient income—12-month continuous eligibility	Medicaid enrollment, demographic characteristics, enrollment duration, health care utilization and cost, and percentage of ineligible enrollees	Results are not available yet due to the delay in data access

NOTE: For Domain 1, Component 2, since no pre-MLTC mandate data were available, only the post-period trends are presented.

Domain 1, Component 1, Goal 1: MLTC Enrollment

The MLTC mandate increased enrollment rapidly and dramatically. Within 20 months of the mandate’s implementation, its impact on statewide enrollment stabilized at a growth rate of about 0.2 percent per month, or 2.4 percent per year (Table ES1). Increases in enrollment and time for the MLTC mandate’s effect on enrollment to stabilize differed across regions, however, suggesting that idiosyncratic factors may have affected implementation across the state. New York City, for which the mandate was implemented first, drove the results.

Domain 1, Component 1, Goals 2–5: Patient Safety, Quality of Care, and Consumer Satisfaction Among the MLTC Population

In our examination of patient safety (without emergency room visits and without falls) and quality of care (influenza vaccinations, dental exams, and potentially avoidable hospitalizations), we found no evidence of changes in these key measures. Satisfaction measures remained high with MLTC, with no statistically significant evidence of decline occurring except for satisfaction with care managers. Thus, results indicate that MLTC plans were able to accommodate the large increases in enrollment without noticeably compromising patient safety, quality of care, or consumer satisfaction with care. These results are particularly important given the rapid and large increase in MLTC enrollment.

Domain 1, Component 2, Goals 1–3: Individuals Moved from Institutional Settings to Community Settings

Among those who transitioned from institutional to community settings, enrollment in MLTC increased, which is not surprising given that MLTC enrollment of new nursing home residents became mandatory starting in February 2015. We found no evidence of changes in patient safety measures (either without emergency room visits or without falls requiring medical intervention or resulting in major or minor injuries) among MLTC enrollees who transitioned from institutions to the community from 2015 through 2018. We also found that a significant majority or more (65–85 percent) of the home- and community-based services (HCBS)

expansion population remained in the community. Among the HCBS expansion population, the changes in influenza vaccination rates were not statistically significant. Receipt of dental exams increased, perhaps in response to a performance improvement project for MLTC enrollees during the period.

Domain 2, Goal 2: 12-Month Continuous Eligibility

We have been delayed in completing the tasks under Domain 2, Goal 2, regarding 12-month continuous eligibility. This is largely due to data acquisition delays resulting from the considerable time, attention, and resources NYS DOH has had to devote to addressing the coronavirus disease 2019 (COVID-19) pandemic. We have thus far obtained access to all the data needed to answer the research questions except for (1) health care utilization and cost data and (2) medical diagnoses required to answer Research Question 5.² We are currently in the process of cleaning the data and constructing an analytic file. Domain 2 results will be presented in the final interim evaluation report, a complete draft of which is expected to be delivered in spring 2021. A proposed timeline for the remaining tasks related to the evaluation of the 1115 Demonstration is presented below:

Proposed Timeline	Remaining Tasks
November 2020	Complete data access
December 2020	Data processing
January 2021	Data analysis
February 2021	Draft report to NYS DOH
March 2021	Quality assurance
April 2021	Final report to CMS

Conclusions

Based on the results of our analyses, the MLTC program under the 1115 Demonstration Waiver has achieved its goal of increasing access to LTSS via MLTC, as illustrated by the rapid expansion of MLTC across the state from 2012 through 2018. There is little evidence suggesting that the rapid access expansion has led to a significant change in patient safety (as measured by without emergency room visits and without falls requiring medical interventions or resulting in major or minor injuries) or quality of care (as measured by timeliness of care access, preventive screenings, potentially avoidable hospitalizations, and consumer satisfaction). Note that the evidence from the evaluation Domain 1 objectives is weakened by important data limitations, which reduced statistical power to detect MLTC's effects on outcomes.

² How do outpatient, inpatient, and emergency department visits compare pre- and post-implementation of this policy? How have costs been impacted because of the change in utilization?

In brief, the state has achieved the demonstration’s first goal of expanding access. We did not find evidence to support the second goal of improving quality of care, but increasing access without compromising quality of care is a success in its own right. Questions remain about whether the MLTC mandate has generated efficiencies in spending—the third goal of the demonstration—and the extent to which public reporting and quality assurance programs have affected quality of care. Future evaluations may be conducted to answer these questions to guide state policies.

Abbreviations

CHA	Community Health Assessment Data
CIN	client identification number
CMS	Centers for Medicare and Medicaid Services
COVID-19	SARS-CoV-19
FFS	fee-for-service
FIDA	Fully Integrated Duals Advantage
HCBS	home- and community-based services
IPRO	Island Peer Review Organization
LOC	level of care
LTSS	long-term services and supports
MAGI	modified adjusted gross income
MAP	Medicaid Advantage Plus
MDS	Minimum Data Set
MFP	Money Follows the Person Demonstration
MLTC	Managed Long-Term Care
MMC	Medicaid Managed Care
NYS DOH	New York State Department of Health
OASIS	Outcome and Assessment Information Set
PACE	Program for All-Inclusive Care for the Elderly
PIP	Performance Improvement Project
RFP	request for proposal
SAAM	Semi-Annual Assessment of Members
SD	standard deviation
SPARCS	Statewide Planning and Research Cooperative System
TANF	Temporary Assistance for Needy Families
UAS-NY	Uniform Assessment System for New York

1. Introduction

The 1115 Demonstration

New York State’s Medicaid Redesign Team Section 1115 Demonstration—originally approved in 1997 through a federal Medicaid Section 1115 Waiver and named the Partnership Plan Demonstration—was established to improve the health of low-income residents through the implementation of a mandatory Medicaid managed care program (New York State Department of Health [NYS DOH], 2019a). The goals of the demonstration were to enroll a majority of the state’s Medicaid population into a managed care plan, improve access to and quality of care, and capitalize on efficiencies gained by using managed care to expand insurance coverage to low-income individuals who would otherwise be uninsured.

The Medicaid Redesign Team Section 1115 Demonstration has evolved over time. It was originally authorized for a five-year period and has been extended multiple times through amendments that included different Medicaid populations, such as people living with HIV/AIDS or receiving supplemental security income, and certain populations in need of long-term services and supports (LTSS).

Demonstration Evaluation

According to the special terms and conditions specified by the Centers for Medicare and Medicaid Services (CMS) for the demonstration, New York State is required to submit an interim evaluation report to CMS “as part of the state’s request for any future renewal of the demonstration.”³ After a competitive bidding process, the RAND Corporation was selected by the state as the independent evaluator to conduct an interim evaluation to determine the effectiveness of the 1115 Demonstration in achieving its goals. The original evaluation plan covered three components: (1) Domain 1, Components 1 and 2—the Managed Long-Term Care (MLTC) program; (2) Domain 2, Goal 1—the Express-Lane Eligibility; and (3) Domain 2, Goal 2—the 12-month continuous eligibility. As communicated to CMS in early 2020, Domain 2, Goal 1, was removed, because the Express Lane Eligibility was not part of the 1115 Demonstration, and four additional questions were added to Domain 2, Goal 2 (Table 1).

³ Request for Proposal (RFP) #20020, “Independent Evaluation of the New York State (NYS) 1115 Program,” was released November 5, 2018. The RFP can be found at the following NYS DOH webpage: <https://www.health.ny.gov/funding/rfp/inactive/20020/20020.pdf>

Table 1. Key Domains, Goals, and Outcomes

Domain	Goal	Outcome	Note
Domain 1, Component 1: Managed Long- Term Care (MLTC)	Goal 1: Expand access to MLTC for Medicaid enrollees in need of LTSS.	Time for the MLTC mandate's effect on enrollment to stabilize	
	Goal 2: Demonstrate stability or improvement in patient safety	Without emergency room visits and without falls requiring medical intervention	
	Goal 3: Demonstrate stability or improvement in quality of care	Receipt of timely care, influenza vaccination, and dental exam	
	Goal 4: Stabilize or reduce preventable acute hospital admissions	Potentially avoidable hospitalizations	
	Goal 5: Demonstrate stability or improvement in consumer satisfaction	Satisfaction with MLTC plans, care managers, care providers, and services	
Domain 1, Component 2: Individuals Moved from Institutional Settings to Community Settings for LTSS	Goal 1: Improve access to MLTC for those who transitioned from an institutional setting to the community	Enrollment in MLTC within one year post-discharge from an institution	
	Goal 2: Stability or improvement in patient safety	Without emergency room visits and without falls requiring medical intervention	
	Goal 3: Stability or improvement in quality of care	Community residence and receipt of influenza vaccination and dental exam	
Domain 2: Mainstream Medicaid Managed Care and Temporary Assistance to Needy Families (TANF)	Goal 1: Increase access to health insurance through Medicaid enrollment—Express Lane Eligibility	Medicaid enrollment, demographic characteristics, and percentage of ineligible enrollees	Removed from the evaluation
	Goal 2: Limit gaps in Medicaid eligibility due to fluctuations in recipient income—12-month continuous eligibility	Medicaid enrollment, demographic characteristics, enrollment duration, health care utilization and cost, and percentage of ineligible enrollees	Four new questions added

The broad goals of the MLTC program evaluation are to assess (1) the number of individuals who are MLTC-eligible and able to access LTSS through the program and (2) whether MLTC affects patient safety, quality of care, or consumer satisfaction. This includes the general MLTC population, as well as those who transitioned from institutions to the community and enrolled in MLTC. Specifically, Domain 1 covers the following questions:

- At what point in the demonstration did the MLTC enrollee population stabilize in size?
- Is MLTC enrollment associated with improved or stabilized patient safety, quality of care, or satisfaction with care?
- Among individuals who were discharged from an institution to the community and enrolled in the Money Follows the Person Demonstration (MFP) and MLTC (the Home-

and Community-Based Services [HCBS] expansion population), is MLTC enrollment associated with improved or stabilized patient safety and quality of care?

The key difference between fee-for-service (FFS) LTSS and MLTC is that MLTC plans receive capitated payments. On the one hand, such plans are incentivized to deliver services more efficiently. For example, MLTC plans could direct care from institutions to communities because LTSS in institutions are more expensive than those in communities.⁴ For MLTC plans that integrate acute medical care with LTSS, unnecessary and expensive acute medical utilization, such as non-urgent emergency room visits and potentially avoidable hospitalizations, may be reduced to improve efficiency. On the other hand, the potential side effect of capitation is that service quality might be affected by financial incentives—though this might be mitigated by the fact that the New York State Department of Health (NYS DOH) publishes an annual MLTC report disclosing various service quality measures for each MLTC plan and implements quality assurance programs.

Presumably, mandatory MLTC enrollment could ensure budgetary certainty for the state Medicaid program, lead to efficiencies in spending, and expand access. Given this, mandatory MLTC enrollment would be a win for the state if patient safety, quality of care, and consumer satisfaction do not decline after the mandate. Although the evaluation goals of the MLTC mandate are to demonstrate stability or improvement in patient safety, quality of care, and consumer satisfaction, considering the various factors discussed above (financial incentives, quality assurance programs, and public reporting of quality of care), the direction of MLTC’s impact on these outcomes is largely unclear. We hypothesize that, overall, mandatory MLTC enrollment is not associated with

- costly medical events, such as falls requiring medical interventions and potentially avoidable hospitalizations
- preventive medical services, such as influenza vaccination
- access to services covered by MLTC
- consumer satisfaction with LTSS, providers, or the MLTC plan.

The purpose of the 12-month continuous eligibility initiative is to prevent lapses in Medicaid coverage because of family income fluctuations. The goal of Domain 2 of this independent evaluation is to assess whether 12-month continuous eligibility has reduced enrollment gaps or increased enrollment duration. Continuous enrollment ensures enrollees’ timely access to medical care and thus may increase outpatient utilization and cost—but timely access to care may lead to the avoidance of costly events and reduce cost in the future. We hypothesize that 12-month continuous eligibility is associated with increased Medicaid enrollment duration and increased outpatient visits, but decreased emergency room visits, inpatient admissions, and cost.

This preliminary interim report is organized as follows, as per guidance from NYS DOH: Chapter 2, “Demonstration Description,” presents the background of the programs involved in

⁴ MLTC’s effect on LTSS expenditures is outside the scope of this evaluation.

this evaluation. Chapter 3, “Study Design,” describes research questions, study populations, data sources, and outcome measures for each evaluation domain and component in the order they appear in the request for proposal (RFP). The results of our analyses are presented in a similar order in Chapter 4, “Discussion of Findings and Conclusions,” and discussed further in Chapter 5, “Policy Implications.” Finally, Chapter 6, “Interactions with Other State Initiatives,” examines the interactions between the programs in the 1115 Demonstration and other state initiatives. Because of the delay in access to data, at the time of this writing (December 2020), the analysis of the 12-month continuous eligibility initiative has not been completed—those results will be presented in the final interim report.

2. Demonstration Description

MLTC Mandatory Enrollment

MLTC plans benefit participants by delivering care plans to meet individual care needs, preferences, and goals and by providing coordination of care and related services for the participant to streamline the delivery of LTSS. Services can be provided at home, in an assisted living facility, in community residential settings, or in a nursing home. All MLTC plans provide home-and community-based services (HCBS) covered by Medicaid, such as care management, assistance with personal care (e.g., bathing and eating), adult day care, home-delivered meals, non-emergency transportation services, durable medical equipment, dental services, hearing aids, optometry and eyeglasses, podiatry, and nursing home care. Medicaid Advantage Plus (MAP), Program for All-Inclusive Care for the Elderly (PACE), and Fully Integrated Duals Advantage (FIDA) plans also cover medical services under Medicare. While MLTC programs help states provide services to their most vulnerable and medically complex populations, states can potentially reduce their costs by using managed care plans to effectively and efficiently manage resources to deliver LTSS (NYS DOH, 2003). In 2013, 42 percent of national Medicaid spending was attributed to 6 percent of Medicaid beneficiaries who used FFS to access LTSS (Medicaid and CHIP Payment and Access Commission [MACPAC], 2018).

Prior to 2012, New York State primarily operated three voluntary MLTC programs: (1) the MLTC Partial Capitation Program (“Partial Capitation”) for adults age 18 to 64 with physical disabilities and adults age 65 or older who required a nursing home level of care; (2) the MAP program, which offered both acute medical care and LTSS to dually eligible individuals needing a nursing home level of care; and (3) the PACE program for adults age 55 and older who are otherwise eligible for nursing home admission to receive care at home. Despite the availability of these programs, the majority of Medicaid beneficiaries received LTSS on a FFS basis before the demonstration.

MLTC plans are required to conduct an initial assessment of new enrollees; a routine assessment is conducted every six months thereafter. An assessment is required if an individual returns from a hospital or when there is a significant change in health status. The assessment collects information on enrollees’ physical function, cognitive function, behaviors such as wandering and resisting care, and clinical diagnoses.

Beginning in September 2012, under the demonstration, the state required individuals age 21 and over who are eligible for both Medicare and Medicaid and who are in need of 120 days or more of LTSS to enroll in an MLTC plan under one of these three programs (Partial Capitation, MAP, or PACE). Enrollment in an MLTC plan is optional for nursing home eligible individuals age 18 to 21 who are dual-eligible, or those who are over 18 and eligible for Medicaid only; it is

not allowed for individuals who need fewer than 120 days of LTSS, are younger than age 18, or are in other programs, including 1915(c) waivers (Traumatic Brain Injury, Nursing Home Transition and Diversion, or Office for People with Developmental Disabilities), a hospice program, or an assisted living program.

Mandatory enrollment in MLTC was rolled out region by region throughout the state over a three-year period, starting in New York City in September 2012 and ending in July 2015. During the implementation process, an announcement letter was sent to eligible individuals who were not yet in an MLTC plan. The following month, a 60-day notice letter advised individuals about the need to enroll in an MLTC plan. Enrollment applications were typically processed about two months later, and enrollment would then take effect sometime in the next two months, depending on the month in which the application was processed. For example, for an announcement letter sent out in January, the 60-day notice letter was sent out in February, the enrollment application was processed in April, and enrollment was effective in May or June, depending on when the application was processed. Individuals could enroll at any time in the program prior to the start date for a given region as long as at least one MLTC plan was offered in their community.

Two notable changes occurred during the rollout of the mandate. Starting in January 2015, the FIDA demonstration, an MLTC demonstration program for dually eligible individuals that includes both LTSS and medical care, was launched in New York City; FIDA was later expanded to a small number of counties around New York City. Enrollment in a FIDA plan also satisfied the MLTC mandate in counties where it was offered. The FIDA plans were phased out by the end of 2019. Also, prior to February 2015, eligible individuals who lived in a nursing home or who were newly admitted to a nursing home were not required to participate in an MLTC plan. Starting in February 2015, enrollment for these eligible individuals became mandatory.

At the start of 2018, managed care LTSS programs were available in 24 states (MACPAC, 2018). Some of these programs have been implemented in the past few years, but several were adopted earlier, including programs in Arizona (1989), Wisconsin (1996), and Texas (1998) (MACPAC, 2018). Prior MLTC studies are sparse and range from rollout evaluations to interim outcome evaluations. A 2018 interim evaluation sponsored by CMS examined the MLTC programs of New York and Tennessee. The study showed that MLTC led to higher use of HCBS and lower institutional and hospital services in New York, but MLTC was associated with more hospitalizations in Tennessee; these results are consistent with those of a 2004 study for New York City (Libersky et al., 2018; Nadash, 2004).

The Money Follows the Person Program

In 2007, the federal Money Follows the Person Rebalancing Demonstration Program, authorized first by the Deficit Reduction Act and then by the Affordable Care Act, was designed to shift LTSS delivery from institutions to the community. Specifically, the Money Follows the

Person (MFP) program in New York State helps elderly individuals and individuals with intellectual disabilities (added in 2013), physical disabilities, and/or traumatic brain injury return to a qualified community-based setting from long-term care institutions, including hospitals, nursing homes, or intermediate care facilities (NYS DOH, 2016b; 2019b). Transition specialists assist potentially MFP-eligible individuals in the transition process by providing information about LTSS available in the community, identifying additional services offered in the community to facilitate independent living, and, once transitioned, conducting periodic check-ins to assess ongoing service needs (NYS DOH, 2016b). MFP provides information and transition planning assistance—a “bridge” between institutional and HCBS—but does not provide or pay for LTSS, which are covered by MLTC. MFP contracts with the New York Association on Independent Living to coordinate the Open Doors Transition Center Program (Open Doors) to provide for transition specialists and peer support (New York Association on Independent Living, 2019).

Individuals are eligible to participate in MFP if they have at least 90 or more consecutive days in a qualified institution, are eligible for Medicaid at least one day prior to the transition from an institution to the community, have health needs that can be met through services available in the community, meet enrollment criteria for a constituent partner program,⁵ voluntarily consent to participate, and transition into a qualified residence, including a house, apartment, or a group home with a maximum of four residents (NYS DOH, 2017b).

MFP enrollment starts at the time of transition from an institution to the community, or within 90 days post-discharge, and continues for 365 days after enrollment (NYS DOH, 2017b). If a participant returns to an institution before the end of the 365-day period, their MFP time is put on hold until they return to the community. MFP enrollment ends when a participant completes 365 days in the community, requests an exit from the program, or is disenrolled from a constituent program. Individuals may re-enroll in the MFP program if they qualify again for MFP. Open Doors follows up with participants on a regular basis, and participants are asked to voluntarily complete a quality of life survey pre-transition as well as 11 months post-transition.

Transition specialists work with individuals who are potentially eligible for MFP to arrange for services and supports for when the individuals return to the community. This pre-transition assistance is provided by Open Doors. While there is no prescribed time limit, the typical range for transition is 2–18 months (New York Association on Independent Living, 2019). The pre-transition period is not counted toward the time an individual is enrolled in the MFP program. Medicare- and Medicaid-certified nursing facilities are required to conduct the Minimum Data Set (MDS) assessment for residents at regular intervals, or when there is a significant change in health status. The MDS assessment includes the following question (Section Q): “Do you want

⁵ Constituent partner programs include the New York State Nursing Home Transition and Diversion waiver, Traumatic Brain Injury waiver, New York State Office for People With Developmental Disabilities waivers, mainstream Medicaid managed care, and MLTC.

to talk to someone about the possibility of returning to live and receive services in the community?” If residents express interest, nursing facilities are required to refer residents to Open Doors (NYS DOH, 2016b).

Initially, MFP was available to those who were eligible for specific Medicaid FFS 1915(c) waiver programs. As of January 2016, and retroactive to transitions that occurred on or after July 1, 2015, MFP was made available to those eligible for MLTC, as well as mainstream Medicaid managed care plans (NYS DOH, 2017b). MLTC plans have been tasked with educating their members about the availability of Open Doors assistance, in addition to other required actions, although the absence of such plan actions does not preclude eligible individuals’ access to MFP.⁶ MLTC assessments can be completed prior to MFP enrollment, and while MFP does not administer such assessments, Open Doors transition specialists can help arrange for the assessment. For MLTC enrollment, initial assessments may be conducted up to 45 days in advance of MLTC enrollment (NYS DOH, 2019b).

As of October 2019, MFP operated in 44 states (Lipson et al., 2007; Musumeci, Chidambaram, and Watts, 2019; Mathematica Policy Research, 2017), providing assistance with the transition back to the community for enrollees. From 2007 through December 2017, more than 100,000 people across the United States benefited from the MFP program (Liao and Peebles, 2019). States set a target for the number of participants they would like to transition each year. In 2016, 21 states achieved at least 85 percent of their transition goals; states that did not meet at least 85 percent of their transition goal for two years (excluding the state’s first year) were required to draft an action plan for CMS describing how the goal would be achieved in the next year (Coughlin et al., 2017). In 2015, participants across the United States reported improvement in all seven categories of a quality of life survey at one year after their transition to the community, with the largest quality of life improvements associated with living arrangements (Irvin et al., 2017).

Twelve-Month Continuous Eligibility

In January 2014, under the Section 1115 Demonstration Waiver, New York State implemented the 12-month continuous eligibility policy for individuals eligible for Medicaid, based on the Modified Adjusted Gross Income (MAGI) guideline, including pregnant women; infants and children age 19 or younger; childless adults who are not pregnant, are younger than 65, and are not on Medicare; parents or caretaker relatives; and individuals eligible for the Family Planning Benefit Program. Eligible individuals were guaranteed Medicaid coverage regardless of changes in income in the 12 months after enrollment, even though they may have lost eligibility under a MAGI or MAGI-like rule. Individuals could lose coverage for other

⁶ MLTC plans must include an “MFP Attestation” in their existing Enrollment Agreement, include specific language describing MFP in their handbook, and review “NYS Money Follows the Person Guidance for Managed Care Organizations” and share it with all appropriate plan staff to encourage recommended practices (NYS DOH, 2019b).

reasons, however, such as moving out of the state or failure to provide documentation of citizenship.

The 12-month continuous eligibility policy is not new to New York State. In January 1999, the state provided 12 months of continuous coverage to children determined eligible for Medicaid under low-income family budgeting, regardless of income changes or circumstances during the subsequent 12 months. In 2007, the state revised laws to allow the provision of 12-month continuous coverage to certain adults eligible for Medicaid. Further, CMS authorized New York State, as of 2011, to provide a 12-month continuous eligibility period for select groups of adults under the Section 1115 Waiver, which, implemented in 2014, is evaluated under Domain 2, Component 2.

Prior studies have shown that continuous eligibility is effective in increasing Medicaid coverage. States adopting a 12-month continuous eligibility option increased the average length of enrollment by nearly two percent (Ku, Steinmetz, and Bruen, 2013). As of 2018, 25 states have adopted a 12-month continuous eligibility policy for children eligible for Medicaid. A simulation study by Swartz et al. (2015) showed that, compared with other policy options, extending eligibility to the end of a calendar year, or ensuring coverage for the following 12 months, could generate the greatest reduction in churning—that is, frequent or recurring Medicaid entries and exits due to monthly income fluctuation.

3. Study Design

Given the non-experimental nature of the demonstration, we developed descriptive statistics, estimated associations, and specified multivariable quasi-experimental models to evaluate the effects of the Medicaid Redesign Team Section 1115 Demonstration. Specifically, we described trends in various outcomes and used statistical models based on a difference-in-differences approach for MLTC-related research questions or survival analytic approaches for the evaluation questions related to 12-month continuous eligibility, while controlling for other factors in the models as necessary and feasible. These approaches allowed us to characterize trends and identify the impact of the demonstration while minimizing threats to the internal validity of our estimates. Note that, because of the delay in data access, the results of our analysis of the 12-month continuous eligibility policy are not available yet, so we present the methodologies only for Domain 2, Goal 2.

Domain 1, Component 1: Managed Long-Term Care

Table 2 describes the study design, data, and analytic approaches for each of the research questions under Domain 1, Component 1. Medicaid member-level data are ideal to answer research questions on patient safety, quality of care, and consumer satisfaction, and thus were requested by the RAND team. The RFP for this independent evaluation specifies that NYS DOH would provide only data aggregated to the state level and plan level for analysis. As a result, the statistical power of our analysis has been reduced by the absence of individual-level data.

Table 2. Study Design for Domain 1, Component 1: Managed Long-Term Care

Goal	Research Question	Measure	Data Source	Study Design and Analytic Approach
1. Expand access to Managed Long-Term Care for Medicaid enrollees in need of long-term services and supports	1. Enrollment into MLTC will continue to grow and then stabilize as the program is mandatory across the state. At what time point in the demonstration did the population stabilize in size?	The time needed for the incremental enrollment due to the mandate to stabilize	2010–2018 NYS DOH Monthly MLTC Enrollment Data, 2010–2018 American Community Survey	A quasi-experimental design: Used a difference-in-differences approach by leveraging the fact that the mandate was rolled out gradually across 13 regions
2. Demonstrate stability or improvement in patient safety	1. Is the percentage of the MLTC population having an emergency room visit in the last 90 days stable or improving over the course of the demonstration?	Percentage without emergency room visit in the last 90 days	2010–2019 UAS-NY Community Health Assessment Data	A quasi-experimental design: Used a difference-in-differences approach by leveraging the fact that the mandate was rolled out gradually across 13 regions
	2. Is the percentage of the MLTC population having a fall requiring medical intervention in the last 90 days stable or improving over the course of the demonstration?	Percentage without falls that required medical intervention in the last 90 days	2014–2019 UAS-NY Community Health Assessment Data	
3. Demonstrate stability or improvement in quality of care	1. Are enrollees' perceived timely access to personal, home care, and other services such as dental care, optometry, and audiology stable over time or improving?	Percentage of members who received dental care in a timely manner [Note: the data for other services were not available]	2009–2019 MLTC Satisfaction Data	A quasi-experimental design: Used a difference-in-differences approach by leveraging the fact that the mandate was rolled out gradually across 13 regions
	2. Is the percentage of the MLTC population accessing preventive care services, such as the influenza vaccination and dental care, consistent or improving?	Percentage of members who received an influenza vaccination in the last year; percentage of members who received a dental exam in the last year	2010–2019 UAS-NY Community Health Assessment Data	A quasi-experimental design: Used a difference-in-differences approach by leveraging the fact that the mandate was rolled out gradually across 13 regions
4. Stabilize or reduce preventable acute hospital admissions	1. Is the MLTC population experiencing stable or reduced rates of potentially avoidable hospitalization?	The number of potentially avoidable hospitalizations per 10,000 member days	2013–2017 SPARCS Data	A quasi-experimental design: Used a difference-in-differences approach by leveraging the fact that the mandate was rolled out gradually across 13 regions

Goal	Research Question	Measure	Data Source	Study Design and Analytic Approach
5. Demonstrate stability or improvement in consumer satisfaction	1. What is the percentage of members who rated their managed long-term care plan within the last six months as good or excellent? Has this percentage remained stable or improved over the demonstration?	Percentage of members who rated their managed long-term care plans as good or excellent	2007–2019 MLTC Satisfaction Data	A quasi-experimental design: Used a difference-in-differences approach by leveraging the fact that the mandate was rolled out gradually across 13 regions
	2. What is the percentage of members who rated the quality of care manager/case manager services within the last six months as good or excellent? Has this percentage remained stable or improved over the demonstration?	Percentage of members who rated the quality of care manager/case manager services within the last six months as good or excellent		
	3. What is the percentage of members who rated their home health aide/personal care aide/personal assistant, care manager/case manager, regular visiting nurse, or covering/on-call nurse services within the last six months as usually or always on time? Has this percentage remained stable or improved over the demonstration?	Percentage of members who rated their home health aide/personal care aide/personal assistant, care manager/case manager, regular visiting nurse/registered nurse or covering/on-call nurse services within the last six months as usually or always on time	2007–2019 MLTC Satisfaction Data	A quasi-experimental design: Used a difference-in-differences approach by leveraging the fact that the mandate was rolled out gradually across 13 regions
	4: What is the percentage 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? Has this percentage remained stable or improved over the demonstration?	Percentage 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	2007–2019 MLTC Satisfaction Data	A quasi-experimental design: Used a difference-in-differences approach by leveraging the fact that the mandate was rolled out gradually across 13 regions

NOTE: SPARCS = Statewide Planning and Research Cooperative System.

Goal 1: MLTC Enrollment

Research Question

- Goal 1, Research Question 1: Enrollment into MLTC will continue to grow and then stabilize as the program is mandatory across the state. At what point in the demonstration did the population stabilize in size?

Study Population and Data Sources

We used the 2010–2018 NYS DOH’s MLTC monthly enrollment data to examine expanded access to MLTC for Goal 1. These data cover all individuals who were enrolled into MLTC during the time period. In addition, we used the New York Statewide Managed Long-Term Care Implementation Timeline to delineate the rollout schedule. The 2010–2018 American Community Survey data provide five-year moving average population estimates for each county for individuals who were age 65 or above and living in poverty. We used these estimates to approximate the size of the population eligible for MLTC, which we used as the denominator of MLTC enrollment rates. More details on the data sets used for this evaluation are in the appendix. We included data for the two years before and the five years after implementation of the demonstration. This provides a time series of sufficient length to observe the transition from pre-implementation to post-implementation.

Outcome Measures

The outcomes of interest for this analysis are the number of individuals enrolled in MLTC plans and enrollment rates among eligible individuals. Enrollment rates were calculated by dividing enrollment at the county and month level by the number of individuals who were age 65 or above and living in poverty, which we used to approximate the number of individuals eligible for MLTC.

Analytic Approach

For descriptive analysis, we delineated the time trends in MLTC enrollment by rollout region and month for the years 2009–2018. But a time point at which the total MLTC enrollment stabilized in descriptive trends could be the result of factors other than the MLTC mandate that are associated with the general time trend. To address the research question, therefore, we specified a multivariable model that identified a general time trend in addition to the post-mandate enrollment growth.

A key feature of the MLTC mandate is that it was rolled out at different times across the state. For example, the mandate was implemented first in New York City. During that time, the other regions in the state served as a comparison. Similarly, as more regions implemented the mandate, the rest of the state became a comparison. This staged rollout allows for the identification of a general underlying time trend separately from the impact of the mandate on the MLTC enrollment.

During the implementation, an announcement letter was sent to eligible individuals about two to three months prior to the official mandate start date for a given region. In our analysis, we chose the announcement letter date as the starting point, because many eligible individuals began to enroll before the official start date. For example, in New York City, the announcement letter was sent in June 2012, but the official start date was September 2012. Individuals could enroll any time prior to the mandate for a given region.

In the multivariable analysis, we examined the enrollment rate at the rollout region level using a variant of the well-known difference-in-differences approach. The models include a series of indicators for calendar months, as well as for the time since the mandate, which varies across rollout regions. We allowed the general time trend to vary across rollout regions, but we identified a common mandate effect across the regions, reflected by the coefficients of the indicators for the time since mandate. Note that because the 13 rollout regions differ substantially in population size, we modeled enrollment rates of each region using the number of individuals eligible for MLTC as the denominator, which was approximated by the number of individuals eligible both for Medicare and Medicaid. Thus, the dependent variable in our model is the rate of enrollment rather than the enrollment level in each county. In addition, we used the population aged 65 or above and living in poverty as analytic weights in the model, so that our results are representative of the state and not just averages across the 13 regions. The full methods for the regression analysis are in the appendix.

Because MLTC plans expected the mandate to be implemented on a specific date, there might be an anticipatory effect due to the competition among MLTC plans. That is, existing MLTC plans tried to enroll as many individuals as possible on a voluntary basis before the mandate started. Therefore, as a secondary analysis, we re-estimated the model with the inclusion of the ten months preceding the mandate rollout in each region (based on the descriptive trends) to capture such a potential anticipatory effect on enrollment.

To identify whether and when the mandate's effect stabilized, we visually examined the mandate's effect over time, and we conducted statistical tests to identify when enrollment increases were no longer statistically significantly greater than zero. That is, starting from the fourth month after implementation, and for each of the following rolling three-month periods, we tested whether the current three-month average of enrollment rate was statistically significantly larger than that of the previous three months, using a significance level of 5 percent. For example, we compared the average rate of enrollment in months 1–3 to that of months 4–6, months 2–4 to months 5–7, and so on. We consider the mandate's effect as stabilized at the point at which three-month average enrollment increases were no longer statistically significant.

Goals 2–4: Patient Safety and Quality of Care Among the MLTC Population

Research Questions

- Goal 2, Research Question 1: Is the percentage of the MLTC population without any emergency room visits in the last 90 days stable or improving over the course of the demonstration?
- Goal 2, Research Question 2: Is the percentage of the MLTC population without any falls requiring medical intervention in the last 90 days stable or improving over the course of the demonstration?
- Goal 3, Research Question 1:⁷ Are enrollees' perceived timely access to personal, home care, and other services, such as dental care, optometry, and audiology, stable over time or improving?
- Goal 3, Research Question 2: Is the percentage of the MLTC population accessing preventive care services, such as influenza vaccination and dental care, consistent or improving?
- Goal, 4 Research Question 1: Is the MLTC population experiencing stable or reduced rates of potentially avoidable hospitalization?

Study Population and Data Sources

We analyzed the data for individuals enrolled in an MLTC plan during 2009–2018 across the four different MLTC plan types: Partial Capitation, MAP, PACE, and FIDA. The NYS DOH provided aggregate MLTC plan-level performance data for five outcome measures: without emergency room visits, without falls requiring medical intervention, influenza vaccinations, dental exams, and potentially avoidable hospitalizations. Specifically, for the years 2010, 2012, and 2013, we used annual MLTC performance reports produced by NYS DOH, which contain MLTC plan-level outcome measures derived from the Semi-Annual Assessment of Members (SAAM) data (NYS DOH, 2010, 2012b, 2013c). For the years 2014–2018, we downloaded semi-annual MLTC plan-level outcome data from Open Data NY (NYS DOH, 2020a). The five outcome measures, except for potentially avoidable hospitalizations, were derived from the Uniform Assessment System for New York (UAS-NY) Community Health Assessment (CHA) data. Potentially avoidable hospitalization rates for each MLTC plan were calculated by NYS DOH using the 2014–2018 Statewide Planning and Research Cooperative System (SPARCS) data, an all-payer hospital discharge database in New York State (NYS DOH, 2013a, 2020a, 2020b).⁸

⁷ Because Goal 3, Research Question 1, uses the survey data, its study design is described in the study design section for Goal 5.

⁸ The MLTC rollout schedule is described in the appendix.

Outcome Measures

In this analysis, we examined the following measures for each of the evaluation goals listed below:

- Goal 2: Demonstrate stability or improvement in patient safety
 1. Percentage of MLTC enrollees without any emergency room visits in the last 90 days
 2. Percentage of MLTC enrollees without any falls requiring medical intervention in the last 90 days
- Goal 3: Demonstrate stability or improvement in quality of care
 1. Percentage of MLTC enrollees receiving an influenza vaccination in the past year
 2. Percentage of MLTC enrollees receiving a dental exam in the past year
- Goal 4: Stabilize or reduce preventable acute hospital admissions
 1. Annual rate of potentially avoidable hospitalizations per 10,000 MLTC enrollee days.⁹

Significant changes in how each outcome was measured over time required manipulations to define a consistent measure; as a result, comparison over time should be made with caution. For example, in 2014, the measure instrument changed from the SAAM to the UAS-NY CHA instrument for reported outcomes, and this led to differences in how measures were calculated. Starting with outcomes reported in 2014, plans in each of the four MLTC programs conducted individual assessments every six months, as well as after a significant event such as discharge from a hospital, return from a facility, and a significant change in health status. Also, starting in 2014, the reference period for without emergency room visits and without falls requiring medical intervention changed from six months to 90 days. We discuss below the changes for each of the outcome measures.

Emergency room visits were based on items in the SAAM in the 2010 Annual MLTC Performance Report and included any emergent care in any setting (hospital, physician's office, or outpatient department) since the last MLTC assessment. Starting with the 2012 annual report, the without emergency room visits measure only included hospital emergent care since the last assessment, and this reported measure was risk-adjusted. In the 2013 annual report, this measure was reported as the percentage with no emergent hospital care since the last assessment. We reverse-coded this for our analyses. Starting with 2014 reported outcomes, this measure was based on items in the UAS-NY CHA data and used a 90-day lookback period.

The falls measure was based on items in the SAAM in the 2010, 2012, and 2013 Annual MLTC Performance Reports and initially included any fall since the last assessment. This

⁹ Potentially avoidable hospitalizations are in-patient hospitalizations that could potentially have been avoided with timely care, including those with a SPARCS primary diagnosis of respiratory infection, urinary tract infection, congestive heart failure, anemia, sepsis, or electrolyte imbalance. The rate is determined by dividing the number of such diagnoses by the total plan days for members with more than three months of plan enrollment and then multiplying by 10,000.

measure was not restricted to falls requiring medical intervention until 2014. Starting in the 2012 report, this plan-level measure was risk-adjusted using a statewide statistical model. In the 2013 annual report, there are two measures based on SAAM: any falls and falls not resulting in medical intervention. Each measure is risk-adjusted separately, so we cannot cleanly identify falls that require medical intervention by subtracting one from the other. Starting with 2014 reported outcomes, the measure is based on items in the UAS-NY CHA data and used a 90-day lookback period. In our analysis, we therefore included only the data reported in 2014 and afterwards.

The measure of potentially avoidable hospitalizations was calculated for each plan starting with the 2013 Annual MLTC Performance Report. A potentially avoidable hospitalization is an inpatient admission that might have been avoided if the patient had received proper outpatient care in a timely manner. Potentially avoidable hospitalizations are identified by analyzing health care encounter data in SPARCS data for plan enrollees who have a hospital admission with an admitting diagnosis of respiratory infection, urinary tract infection, congestive heart failure, anemia, sepsis, or electrolyte imbalance during the measurement period. The plan's reported potentially avoidable hospitalization rate is the number of potentially avoidable hospitalizations per 10,000 enrollee days and is risk-adjusted. We did not use the January 1, 2013, data point in our analysis because it is about one third of that of other measurement periods.

Two of the outcome measures did not change over time: the percentage of members who received an influenza vaccine in the past year and the percentage of members who received a dental exam in the past year. The percentage of members who received an influenza vaccine in the past year is available in the 2010, 2012, and 2013 Annual MLTC Performance Reports and in the 2014–2018 semi-annual MLTC plan-level outcome data. Even though the instrument changed from SAAM to UAS-NY in 2014, the item on the influenza vaccine did not change. The percentage of members who received a dental exam in the past year is only available in the 2014–2018 semi-annual MLTC plan-level outcome data.

Starting with the 2012 Annual MLTC Performance Report, selected plan-level outcome measures were risk-adjusted by NYS DOH to account for differences among plan enrollee populations. Risk adjustment accounts for variation in demographics and health status among plan enrollee populations and is designed to create a more equal comparison across plans within a measurement period. Plans that have more frail enrollees may have poorer outcome scores than plans with healthier enrollees because they have sicker enrollees, not because they are performing poorly. Risk adjustment is an attempt to address these differences in plan populations. NYS DOH calculates the expected rates for a plan for each of the risk-adjusted outcomes that would occur if the plan's enrollee population matched the total enrollee population in the state in that year. The expected rate reflects how a plan would perform with an average enrollee population. A plan's risk-adjusted rate is the ratio of the observed rate to the expected rate, multiplied by the state average rate.

The risk adjustment is calculated for each measurement period, and the demographic and health status measures that were used have changed over time, so individual plan scores are not comparable over time. In the 2012 Annual MLTC Performance Report, risk adjustment was based on a number of factors, including demographics, major medical conditions, physical function, cognitive function, and living arrangement. Starting with 2014 reported measures, risk adjustment was based on health status information available on the CHA. The set of risk adjusters has also changed slightly over time. For example, enrollee race/ethnicity was included for the 2012 and 2013 annual reports but not in later reports. Even for the same risk adjusters, definitions could change during the study period. For instance, cognitive functions were measured differently in reports prior to 2014 than they were in later reports; this is due to the change of the data collection instrument from SAAM to UAS-NY CHA.

Measure Reference Period Adjustment

Starting with data reported in 2014, the reference period changed from six months to 90 days for without emergency room visits and without falls requiring medical intervention due to the change of the assessment tool from SAAM to UAS-NY CHA. In our analysis, we adjusted these measures from earlier reports so that they reflect the same 90-day reference period and are therefore comparable over time. To make the adjustment, we assumed that the likelihood of each outcome occurring was the same for each month during the six-month time period, and we calculated the expected value for the outcome over a 90-day period.

Analytic Approach

Because outcome definitions evolved over time and were risk-adjusted, we were not able to directly estimate the impact of the MLTC mandate on absolute changes in outcomes. Instead, we calculated the difference in each outcome measure between each MLTC plan and the statewide average in each year. That is, we “re-centered” each outcome measure around the statewide average of the outcome across plans, such that the sum of the re-centered measure across plans in each year was zero. Although the outcome measures themselves are not comparable over time because of risk adjustment or definitional changes, the re-centered measures are comparable over time unless the definitions of outcome measures changed over time. The re-centered outcome measures allow for a fair comparison over time between a plan’s performance and all other plans. Our strategy was to then determine whether a plan’s relative performance improved or worsened with increased mandated enrollment, using each of the five re-centered plan outcomes.

Mandatory enrollment was rolled out at different times for different regions in the state between September 2012 and July 2015. Typically, identification of the mandate’s effect would be done using outcome measures by rollout region. However, we had only statewide plan-level outcome data, and plans operated in multiple regions. To overcome this limitation, for each MLTC plan, we calculated the fraction of its enrollees residing in the regions under the mandate using monthly MLTC enrollment data, and we estimated its association with the re-centered

outcomes. The assumption was that, on average, plan enrollees contributed equally to plan-level outcomes across mandated enrollment status. The identification of the mandate's effect comes from the variation in this fraction across plans and over time. The full statistical model is in the appendix.

Goal 5: Consumer Satisfaction Among the MLTC Population

Research Questions

- Goal 5, Research Question 1: What is the percentage of members who rated their managed long-term care plan within the last six months as good or excellent? Has this percentage remained stable or improved over the demonstration?
- Goal 5, Research Question 2: What is the percentage of members who rated the quality of care manager/case manager services within the last six months as good or excellent? Has this percentage remained stable or improved over the demonstration?
- Goal 5, Research Question 3: What is the percentage of members who rated their home health aide/personal care aide/personal assistant, care manager/case manager, regular visiting nurse, or covering/on-call nurse services within the last six months as usually or always on time? Has this percentage remained stable or improved over the demonstration?
- Goal 5, Research Question 4: What is the percentage 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? Has this percentage remained stable or improved over the demonstration?

Study Population and Data Sources

The target population of our analysis consists of all MLTC enrollees for the years 2007–2019. The data for this secondary analysis originated from the customer satisfaction survey administered to MLTC plan enrollees. The data for the years 2007, 2011, and 2013 came from the annual MLTC performance reports produced by NYS DOH (NYS DOH, 2010, 2012b, 2013c), which contained MLTC plan-level outcome measures. For the years 2015, 2017, and 2019, the MLTC plan-level outcome data were downloaded from Open Data NY (NYS DOH, 2020a). Statewide data were not generated; these data came directly from the reports or the Open Data NY.

The demographic information for the enrollees, available from Open Data NY, remained fairly consistent during 2015–2019. Approximately 30 percent were male and 70 percent were female. Race and ethnicity also remained consistent, with 32 percent white non-Hispanic, 25 percent Hispanic, and 18 percent African American; the remaining enrollees (25 percent) marked “other.” Persons under 65 years of age represented only 16 percent of enrollees, while those 65 to 74 years old represented 24 percent, those age 75 to 84 represented 33 percent, and those age 85 plus represented 27 percent.

The customer satisfaction survey was developed by NYS DOH along with Island Peer Review Organization (IPRO), an external quality review organization, with the aim of evaluating

the satisfaction of services provided by the MLTC plans, including the quality, accessibility, and timeliness of services. The first customer member satisfaction survey of New York State’s MLTC population was field-tested and administered by IPRO beginning in 2007 and then in two-year intervals starting in 2011 (NYS DOH, 2010).

Survey items explored health plan satisfaction; satisfaction with select providers and services, including timeliness of care and access; and self-reported demographic information. To maximize response rates, IPRO satisfaction surveys were offered in English, Spanish, Russian, and Chinese and included a follow-up mailing to nonresponders within three months post the initial distribution. The survey underwent periodic revisions over the years, with survey items being added or modified (see details in the “Outcome Measures” section below).

In 2007 and 2011, the results of the survey were provided in unadjusted prevalence rates at the MLTC plan level (no individual respondent-level data were available for the analysis); beginning in 2013, the results of four of the five items were risk-adjusted to allow for a fairer comparison among the MLTC plans. In addition, beginning in 2015, to account for unequal plan size, statewide survey data were weighted by plan-eligible population. This allowed larger plans to contribute more—and smaller plans to contribute less—to the statewide average, thus yielding more-representative statewide results (NYS DOH, 2015). As seen in Table 3, the number of surveys mailed during each year of the survey administration has increased with increased MLTC enrollment over time; however, except for 2017, response rates have been trending downward.

Table 3. Number of Surveys Mailed and Response Rate, by Year

Year	Surveys Mailed	Completed Surveys	Response Rate
2007	4,518	1,403	31.1%
2011	5,742	1,845	32.1%
2013	9,346	2,533	27.0%
2015	17,804	4,592	25.8%
2017	20,047	5,559	27.7%
2019	20,007	4,639	23.2%

NOTE: The data came from various annual New York State MLTC reports. (NYS DOH, 2010, 2012b, 2015, 2017a).

Outcome Measures

For this analysis, we examined data pertaining to the questions listed below. Since Goal 3, Research Question 1, uses the survey data, its study design is described in this section.

Goal 3: Demonstrate stability or improvement in quality of care

1. Percentage of MLTC enrollees who reported timely access to dental care within the last six months

The outcome measure that most closely aligns with the research question pertains to dental care, and no reported measures on access to optometry and audiology are available in the data.

There was a slight change in how the measure was constructed: Prior to 2015, it was the percentage of MLTC enrollees who reported that within the last six months that they waited less than one month for access to routine dental care; from 2015 on, it became the percentage of members who reported that within the last six months they always got a routine dental appointment as soon as they thought they needed one. The item on the 2011 and 2013 satisfaction surveys that corresponded to the research question: “In the last 6 months, when you called for a regular appointment, how long did you generally have to wait between making an appointment and seeing providers?” This item used the following response categories: “Less than 1 month,” “1 to 3 months,” or “Longer than 3 months.” The questions and response categories for this item changed in 2015 to “In the past 6 months, when you called for a regular appointment, how often did you get an appointment as soon as you thought you needed one?” The new response categories were: “Always,” “Usually,” “Sometimes,” or “Never” (IPRO Corporate Headquarters Managed Care Department, 2011). The measure is available for the years 2011, 2013, 2015, 2017, and 2019, and no risk adjustment was made to the measure.

Goal 5: To demonstrate stability or improvement in consumer satisfaction

1. Percentage of MLTC enrollees who rate their health plan as good or excellent

The survey item is, “Overall, how would you rate your managed long-term care plan?” The response categories are “Excellent,” “Good,” “Fair,” or “Poor.” The measure is available for all the survey years and was risk-adjusted starting in 2013.

2. Percentage of MLTC enrollees who rate their care manager as good or excellent

The survey item is, “Please rate the providers and services you receive or have received within the last 6 months—even if the service is not covered, or paid for, by your health plan.” The response categories are “Excellent,” “Good,” “Fair,” “Poor,” or “Not Applicable.” The measure is available for all the survey years and was risk-adjusted starting in 2013.

3. Percentage of MLTC enrollees who reported that within the last six months the home health aide/personal care aide/personal assistant, care manager/care manager, regular visiting nurse/registered nurse, or covering/on-call nurse services were usually or always on time

This composite measure included four survey items: “In the past 6 months, please rate how often the following services were on time or if you were able to see the provider at the scheduled time: Home health aide, personal care aide (aide that comes to your house to take care of you); Care Manager/Case Manager (person who prepares your plan of care); Regular Visiting Nurse/Registered Nurse (comes to your house for regular visits); and Covering/On-call Nurse (comes to your house when regular nurse can’t come.” The response categories changed in 2015 from “Less than 1 month,” “1 to 3 months,” or “Longer than 3 months” to “Always,” “Usually,” “Sometimes,” “Never,” or “Not Applicable” (IPRO Corporate Headquarters Managed Care Department, 2011). The measure is available for all the survey years except 2007 and 2011 and was risk-adjusted for all years.

4. *Percentage of MLTC enrollees who rate the quality of home health aide/personal care aide/personal assistant services within the last six months as good or excellent*

The survey item is, “Please rate the providers and services you receive or have received within the last 6 months—even if the service is not covered, or paid for, by your health plan.” The response categories are: “Excellent,” “Good,” “Fair,” “Poor,” or “Not Applicable.” The measure is available for all the survey years and was risk-adjusted starting in 2013.

As stated above, the outcome measure under Goal 3 was an unadjusted prevalence measure. Beginning in 2013, all the plan outcome measures under Goal 5 were risk-adjusted, meaning they were adjusted by NYS DOH for age, education, and self-reported health status, as these were found to be important satisfaction survey control variables that are widely accepted and used in satisfaction survey analysis (NYS DOH, 2015).

Analytic Approach

Descriptive statistics, specifically means, were generated for the three types of MLTC plans: Partial Capitation MLTC plans, PACE plans, and MAP plans. Satisfaction survey data for FIDA plans were not available. Means were calculated for each type by adding the outcome measure for each of the plans and then dividing the total by the number of plans under each type.¹⁰

We used the same multivariable modeling strategy as that for Goals 2–4; please refer to that section for details. The full statistical model is in the appendix.

Domain 1, Component 2: Individuals Moved from Institutional Settings to Community Settings for Long-Term Services and Supports

Goals 1–3: Individuals Moved from Institutional Settings to Community Settings

Research Questions

- Goal 1, Research Question 1: For those who transition from an institutional setting to the community, did the percentage enrolling in MLTC increase over the demonstration?
- Goal 2, Research Question 1: Is the percentage of the HCBS expansion population without any emergency room visits in the last 90 days stable or improving over the course of the demonstration?
- Goal 2, Research Question 2: Is the percentage of the HCBS expansion population without any falls, as defined by the department’s fall measure, stable or improving over the course of the demonstration?
- Goal 3, Research Question 1: For the HCBS expansion population who entered MLTC after transitioning from an institutional setting, what percentage return to the nursing home within a year of discharge, what was their average level of care need, and for those who return within a year, how long on average did they reside in the community?

¹⁰ The MLTC satisfaction survey uses a similar sample size across plans: 600 enrollees from each plan are selected for each survey year.

- Goal 3, Research Question 2: Is the percentage of the HCBS expansion population accessing preventive care services such as the flu shot and dental care consistent or improving?

In Table 4, we summarize the measures, data sources, study design, and analytic approaches for each of the research questions under Domain 1, Component 2.

Table 4. Study Design for Domain 1, Component 2: Individuals Moved from Institutional Settings to Community Settings for Long-Term Services and Supports

Goal	Research Question	Measure	Data Source	Study Design and Analytic Approach
1: Improve Access to MLTC for those who transitioned from an institutional setting to the community	1. For those who transition from an institutional setting to the community, did the percentage enrolled in MLTC increase over the demonstration?	Percentage of the MFP population who enrolled in MLTC within one year post discharge	2015–2018 UAS-NY Community Health Assessment Data, 2015–2018 MFP Master Data, 2014–2018 MDS Data	A single group, post-intervention design: Delineated annual trends in the percentage of the MFP population who enrolled in an MLTC plan
2: Stability or Improvement in Patient Safety	1. Is the percentage of the HCBS expansion population having an emergency room visit in the last 90 days stable or improving over the course of the demonstration? 2. Is the percentage of the HCBS expansion population having a fall, as defined by the Department’s fall measure, stable or improving over the course of the demonstration?	Percentage of the HCBS expansion population who did not have an emergency room visit in the last 90 days Percentage of the HCBS expansion population who did not have a fall that required medical intervention or resulting in major or minor injuries in the last 90 days	2015–2018 UAS-NY Community Health Assessment Data, 2015–2018 MFP Master Data	A single group, post-intervention design: Delineate annual trends in the percentage of the HCBS expansion population who did not have an emergency room visit or a fall
3: Stability or Improvement in Quality of Care	1. For the HCBS expansion population who entered MLTC after transitioning from an institutional setting, what percentage return to the nursing home within a year of discharge, what was their average level of care need and, for those who return within a year, how long on average did they reside in the community?	Percentage of the HCBS expansion population who remained in the community for one year post-discharge; average residence time in the community for those who returned to a nursing home within one year	2015–2018 UAS-NY Community Health Assessment Data, 2015–2018 MFP Master Data, 2014–2018 MDS Data	A single group, post-intervention design: Describe annual rates stratified by level of care and delineated the trends in the percentage of the HCBS expansion population who remained in the community after one

Goal	Research Question	Measure	Data Source	Study Design and Analytic Approach
	2. Is the percentage of the HCBS expansion population accessing preventive care services such as the flu shot and dental care consistent or improving?	Percentage of the HCBS expansion population who received an influenza vaccination in the last year; percentage of the HCBS expansion population who received a dental exam in the last year		year post-discharge; average amount of time in the community among those who returned to a nursing home; and percentage of the HCBS expansion enrollees who received an influenza vaccination or a dental exam in the last year

Study Population and Data Sources

The study population for this analysis—that is, the HCBS expansion population—consists of individuals who were discharged from a nursing facility to the community and enrolled in MFP and MLTC during 2015–2018. To identify this population, the NYS DOH merged three data sets: the MFP master data, the MDS data, and the UAS-NY CHA data. In the MFP master data, there were 1,443 unique client identification numbers (CINs) with an MFP-start date in the years 2015–2018, after excluding 16 individuals discharged from a hospital or an intermediate care facility. From these 1,443 unique CINs, a total of 1,420 were found in the 2014–2018 MDS data,¹¹ among whom 1,314 were matched using MDS discharge assessments, 38 using non-discharge assessments, and 68 using names and birthdates. The 23 unmatched CINs were excluded from further analysis. Among the 1,420 unique CINs that were in both the MFP master data and the MDS data, 755 were matched to the 2015–2018 UAS-NY CHA data. The remaining 665 CINs without any MLTC assessment were considered not to have been enrolled in MLTC at any time between 2015 and 2018 because MLTC enrollees are required to have an assessment at least every six months.

Of the 755 unique CINs that exist in all three data sets, 629 unique CINs were associated with at least one MLTC assessment conducted either in the 45 days prior to the MFP enrollment date or after MFP enrollment during 2015–2018.¹² After limiting the population to those who had at least one MLTC assessment within 45 days before enrollment or 365 days after the MFP start date, there were 589 unique CINs. Finally, after removing multiple enrollment records for the same individual, there were 583 unique individuals who participated in the MFP program for the first time during 2015–2018 and who were enrolled in an MLTC plan either 45 days prior to MFP start or within 365 days post-MFP start date.

¹¹ NYS DOH also included the 2014 MDS data to identify individuals who were in a nursing home prior to 2015 and transitioned to the community in 2015 and onward. However, MLTC assessments should be done within 45 days prior to MFP participation and during

¹² The previous assessment instrument, the Semi-Annual Assessment of Members (SAAM), was valid for six weeks for MLTC enrollment (see NYS DOH MLTC Policy 13.09(b)). The window was later changed to 45 days.

In addition, for Goal 3, those who remained in the community one year post-discharge were identified using the MDS. First, the 589 unique CINs who had MLTC assessments between 45 days prior to and 365 days post-MFP start date were matched to the MDS data using nursing home discharge assessments based on CIN. To ensure that the MFP days overlapped to a large extent with the calendar days post-discharge, the sample was further limited to those with an MFP start date within 90 days of the discharge date. From this process, 421 participants were identified. For research questions that utilized assessment data, the sample was limited to 368 individuals with one or more assessments conducted after MLTC enrollment.

Outcome Measures

In this analysis, we examined the following measures for each of the evaluation goals listed below for the HCBS population as described in the previous section. The MFP master data and the UAS-NY CHA data were used to construct Goal 1 measures, and the UAS-NY CHA data were used to construct the Goal 2 measures. The MDS data were primarily used to construct Goal 3 measures, supplemented with UAS-NY CHA data to construct the Goal 3 measures. In cases where an individual had multiple MLTC assessments in the UAS-NY CHA data within a 12-month period, the most recent assessment was used to produce aggregate data; all initial assessments around the time of MLTC enrollment were excluded because our aim was to examine the events that occurred *after* MLTC enrollment.

Goal 1: Improve access to MLTC for those who transitioned from an institutional setting to the community

1. Percentage of MFP participants who were enrolled in MLTC within 365 days post-MFP start date, by calendar year
2. Percentage of MFP participants who were enrolled in MLTC any time during 2015–2018, by calendar year

Goal 2: Stability or improvement in patient safety

1. Percentage of the HCBS expansion population without any emergency room visits in the last 90 days
2. Percentage of the HCBS expansion population without any falls that required medical intervention or resulted in major or minor injuries in the last 90 days (The measure was defined as falls requiring medical intervention in the 2015–2017 UAS-NY CHA data. The assessment question on falls changed in 2018, which is now defined as falls that result in major or minor injuries.)

Goal 3: Stability or improvement in quality of care

1. Percentage of HCBS expansion population who remained in the community for one year post-discharge from a nursing facility, overall and by level of care (Re-institutionalization was defined as an entry date into a nursing home either on or after the MFP start date.)
2. Average level of care among those who returned to a nursing home within a year post discharge

3. Average residency time in the community for HCBS expansion population who returned to a nursing home within one year post discharge
4. Percentage of HCBS expansion population who received an influenza vaccination in the last year
5. Percentage of HCBS expansion population who received a dental exam in the last year.

Analytic Approach

The data analysis for this evaluation was descriptive in nature. Because of constraints on data sharing, NYS DOH completed the data merge and compiled the aggregate-level data with RAND's input. Descriptive statistics and figures were then generated based on the aggregate-level data. Pearson's χ^2 tests were used to examine the trends in the measures (Manitoba Centre for Health Policy, 2008). Two-tailed Student's t-tests were used to compare continuous outcomes between two subgroups of the HCBS expansion population.

In some cases, the trend test was not conducted for either 2015 or 2018 because of small sample sizes and incomplete data, respectively, as noted. For example, because we examined whether an individual enrolled in MLTC within 365 days post-MFP start date, the data for 2018 participants did not include the new MLTC enrollment that occurred in the second half of 2019; the average residency time in the community and the return to a nursing home may be biased because of such incomplete data.

Because there were 28 individuals who died without re-entering a nursing facility, we conducted sensitivity analyses by excluding these individuals from the numerator, or both the numerator and denominator when examining the percentage of HCBS expansion population who remained in the community for one year post-discharge.

Domain 2: Mainstream Medicaid Managed Care

Goal 1: Express Lane Eligibility

Research Questions

- Goal 1, Research Question 1. How many recipients are enrolled in Express Lane eligibility?
- Goal 1, Research Question 2: Are there differences in the demographic and clinical characteristics of Medicaid beneficiaries enrolled through Express Lane-like eligibility as compared to those not enrolled through this mechanism?
- Goal 1, Research Question 3: What portion of the beneficiaries enrolled through Express Lane-like eligibility were later deemed not eligible for this coverage?

New York State did not make use of the Section 1115 authority related to Express Lane Eligibility, which determines temporary assistance for Medicaid. Express Lane Eligibility was instead implemented through a State PLAN amendment. Thus, these three questions for Domain 2, Goal 1, were dropped from this 1115 program evaluation. As a replacement, four new research

questions have been added to Domain 2, Goal 2. The four new research questions are aligned with the original evaluation design and Domain 2, Goal 2 (see below for details).

Goal 2: 12-Month Continuous Eligibility

Research Questions¹³

- Goal 2, Research Question 1: What is the distribution of enrollees within select continuous enrollment categories, i.e., 12 months, 24 months, etc.?
- Goal 2, Research Question 2: Does the continuous enrollment differ by demographic or clinical characteristics?
- Goal 2, Research Question 3: Did Medicaid’s average months of continuous enrollment increase following the implementation of continuous eligibility as compared to pre-implementation?
- Goal 2, Research Question 4: Was there an increase in the percentage of Medicaid beneficiaries continuously enrolled for 12 months following the implementation of continuous eligibility as compared to pre-implementation?
- Goal 2, Research Question 5: How do outpatient, inpatient, and emergency department visits compare pre- and post-implementation of this policy? How have costs been impacted because of the change in utilization?
- Goal 2, Research Question 6: How many of the beneficiaries covered under continuous eligibility would have been ineligible for coverage if not for the waiver?
- Goal 2, Research Question 7: Is overall fee-for-service (FFS) enrollment decreasing over time? (New Question 1)
- Goal 2, Research Question 8: Is short-term FFS enrollment decreasing over time? (New Question 2)
- Goal 2, Research Question 9: What percentage of Medicaid managed care (MMC) enrollees remain in the same MMC plan after 12-month recertification? (New Question 3)
- Goal 2, Research Question 10: What percentage of MMC enrollees are auto-assigned to any health plan? (New Question 4)

Study Population and Data Source

For questions 1–6, the population of interest will be the individuals who became newly covered by the 12-month continuous eligibility, including (1) individuals who were eligible for Medicaid prior to 2014 but were not covered by the 12-month continuous eligibility and (2) individuals who became eligible for Medicaid and the 12-month continuous eligibility after 2014. For questions 7 and 8, the analysis will cover all Medicaid enrollees. Questions 9 and 10 are about MMC enrollees only. The 2012–2018 Medicaid Data Warehouse will be used to answer all research questions under Domain 2, Goal 2 (Table 5). The Medicaid Data Warehouse

¹³ Research Questions 7–10 were added later and do not aim to measure the impact of the 12-month continuous eligibility.

provides information on eligibility, enrollment, managed care enrollment status, medical conditions, utilization, and cost.

Outcome Measures

- Goal 2, Research Question 1: The distributions of enrollment duration in months, by the year in which enrollment starts; percentages of enrollees with at least 12, 18, or 24 months of continuous enrollment.
- Goal 2, Research Question 2: Percentages of enrollees with at least 12, 18, or 24 months of continuous enrollment; the average number of continuous enrollment months, by enrollee characteristics such as sociodemographics and chronic medical conditions at the time of enrollment.
- Goal 2, Research Question 3: The average number of continuous enrollment months, by the year in which enrollment starts.
- Goal 2, Research Question 4: The fraction of enrollment episodes that last at least 12 months, by the year in which enrollment starts.
- Goal 2, Research Question 5: Annualized per member rates for inpatient, outpatient, and emergency room visits; annualized total health care cost per member.
- Goal 2, Research Question 6: The percentage of enrollment months in which enrollees would have been ineligible had the 12-month continuous eligibility been removed, by the year in which enrollment starts.
- Goal 2, Research Question 7: The count of individuals who were enrolled in FFS by month; the proportion of total Medicaid enrollment that was FFS by month.
- Goal 2, Research Question 8: The total count and the proportion of individuals enrolled in FFS for two or fewer months, among those with any MMC coverage in a year.
- Goal 2, Research Question 9: The proportion of MMC enrollees who remain in the same MMC plan after 12-month recertification, among individuals with at least 13 consecutive months of Medicaid enrollment and who are enrolled in MMC in the 12th month, by the year in which enrollment starts.
- Goal 2, Research Question 10: The proportion of MMC enrollees who are auto-assigned to any health plan at the start of MMC enrollment, by the year in which enrollment starts,

Table 5. Study Design for Domain 2, Goal 2: To Limit Gaps in Medicaid Eligibility Due to Fluctuations in Recipient Income

Research Question	Measure	Data Source	Study Design and Analytic Approach
1. What is the distribution of enrollees within select continuous enrollment cohorts (i.e., 12 months, 24 months, etc.)?	Percentages of enrollees with at least 12, 18, or 24 months of continuous enrollment	2012–2018 Medicaid Data Warehouse	A pre-post design: Describe the distributions of enrollment months by enrollment start year and test for differences between the pre- and post-policy periods using the Kolmogorov-Smirnov test or a c^2 test as appropriate
2. Does continuous enrollment differ by demographic or clinical characteristics?	Percentages of enrollees with at least 12, 18, or 24 months of continuous enrollment; average number of continuous enrollment months	2012–2018 Medicaid Data Warehouse	A cross-sectional design: Describe the distributions of enrollment months by enrollee characteristics and test for differences using the Kolmogorov-Smirnov test or a c^2 test as appropriate
3. Did Medicaid’s average months of continuous enrollment increase following the implementation of continuous eligibility as compared to pre- implementation?	Average number of continuous enrollment months	2012–2018 Medicaid Data Warehouse	A quasi-experimental design: Apply a difference-in-differences approach using a concurrent comparison (children who were enrolled with 12-month continuous eligibility both before and after the expansion of continuous eligibility)
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?	Percentage of enrollees continuously enrolled for at least 12 months	2012–2018 Medicaid Data Warehouse	A quasi-experimental design: Apply a difference-in-differences approach using a concurrent comparison (children who were enrolled with 12-month continuous eligibility both before and after the expansion of continuous eligibility)
5. How do outpatient, inpatient and emergency department visits compare pre- and post-implementation of this policy? How have costs been impacted because of the change in utilization?	Annualized per member rates for inpatient, outpatient, and emergency room visits; annualized total health care cost per member	2012–2018 Medicaid Data Warehouse	A quasi-experimental design: Apply a difference-in-differences approach using a concurrent comparison (children who were enrolled with 12-month continuous eligibility both before and after the expansion of continuous eligibility)
6. How many of the beneficiaries covered under continuous eligibility would have been ineligible for coverage if not for the waiver?	Percentage of enrolled months in which enrollees would have been ineligible for coverage had the 12-month continuous eligibility been removed	2012–2018 Medicaid Data Warehouse	A quasi-experimental design: Use the analysis results for Research Questions 3 and 4 to simulate what would have happened to enrollment had it not been for the 12-month continuous eligibility
7. Is overall FFS enrollment decreasing over time? (NEW)	Percentage of individuals who were enrolled in FFS by month	2012–2018 Medicaid Data Warehouse	A cross-sectional design: Describe the trends over time and test them using Pearson’s χ^2 test

Research Question	Measure	Data Source	Study Design and Analytic Approach
8. Is short-term FFS enrollment decreasing over time? (NEW)	Percentage of individuals enrolled in FFS for two or fewer months, among those with any MMC coverage in a year	2012–2018 Medicaid Data Warehouse	A cross-sectional design: Describe the trends over time and test them using Pearson's χ^2 test
9. What percentage of MMC enrollees remain in the same MMC plan after 12-month recertification? (NEW)	Percentage of MMC enrollees remaining in the same MMC plan after 12-month recertification, among those with at least 13 consecutive months of MMC coverage by enrollment start year	2012–2018 Medicaid Data Warehouse	A cross-sectional design: Describe the trends over time and test them using Pearson's χ^2 test
10. What percentage of MMC enrollees are auto-assigned to any health plan? (NEW)	Percentage of MMC enrollees who are auto-assigned to any health plan at the start of MMC enrollment by MMC enrollment start year	2012–2018 Medicaid Data Warehouse	A cross-sectional design: Describe the trends over time and test them using Pearson's χ^2 test

NOTE: Research Questions 7–10 do not aim to measure the impact of the 12-month continuous eligibility.

Analytic Approach

Research Questions 1–6

We will use a difference-in-differences study design and use a concurrent comparison group to measure the policy’s impact on enrollment. For enrollment-related research questions, we will apply survival analysis techniques; for questions related to utilization, we will apply generalized linear models as appropriate. We will specify cost models as suggested by Manning and Mullahy, who outline a strategy for addressing the skewness and heterogeneity typical of health care cost data (Manning and Mullahy, 2001).

It is of paramount importance to define the policy intervention at a granular level to separate the intervention group from the comparison group. The state implemented the 12-month continuous eligibility for children in the Medicaid program prior to 2014—that is, children were covered by 12-month continuous eligibility in both the pre- and post-policy periods. We will differentiate individuals who were newly covered by the 12-month continuous eligibility starting in January 2014 from those who were previously covered and could therefore act as concurrent controls.

Specifically, we will use a comparison group consisting of children who were eligible for 12-month continuous eligibility both before and after the policy implementation. We acknowledge that the labor force and employment status of the parents of potential enrollees are likely very different from those of adult potential enrollees, which makes children a less than ideal control group. We did not consider non-MAGI individuals enrolled in Medicaid as a comparison group because these individuals are often very different populations—for example, those who are disabled or in foster care.

We will also address some specific issues about eligibility recertification and enrollment below and specify models that are sufficiently flexible to characterize the “fuzzy” eligibility period; alternatively, we will perform sensitivity analyses around the length of continuous eligibility (e.g., from 12 to 15 months). For instance, new Medicaid enrollees may be retroactively enrolled to cover medical bills for as many as three months prior to the month of the Medicaid application. Those months do not count against the 12-month period of continuous eligibility. Thus, the recertification month could be as late as the 15th month (that is, up to three months of retrospective eligibility followed by 12 months of continuous eligibility). In addition, individuals who submit recertification materials late, or for whom eligibility is not determined by the end of month 12, will not be dropped from coverage until eligibility is adjudicated. Thus, some may be enrolled for several months after the 12-month continuous eligibility period has ended.

Research Questions 7–10

For Research Questions 7–10, we will generate the measures and describe their trends during 2012–2018. Pearson’s χ^2 tests will be used to test such trends (Manitoba Centre for Health Policy, 2008).

4. Discussion OF Findings and Conclusions

Domain 1, Component 1: Managed Long-Term Care

Goal 1, Research Question 1: MLTC Enrollment

Enrollment into MLTC will continue to grow and then stabilize as the program is mandatory across the state. At what point in the demonstration did the population stabilize in size?

MLTC Mandate Rollout

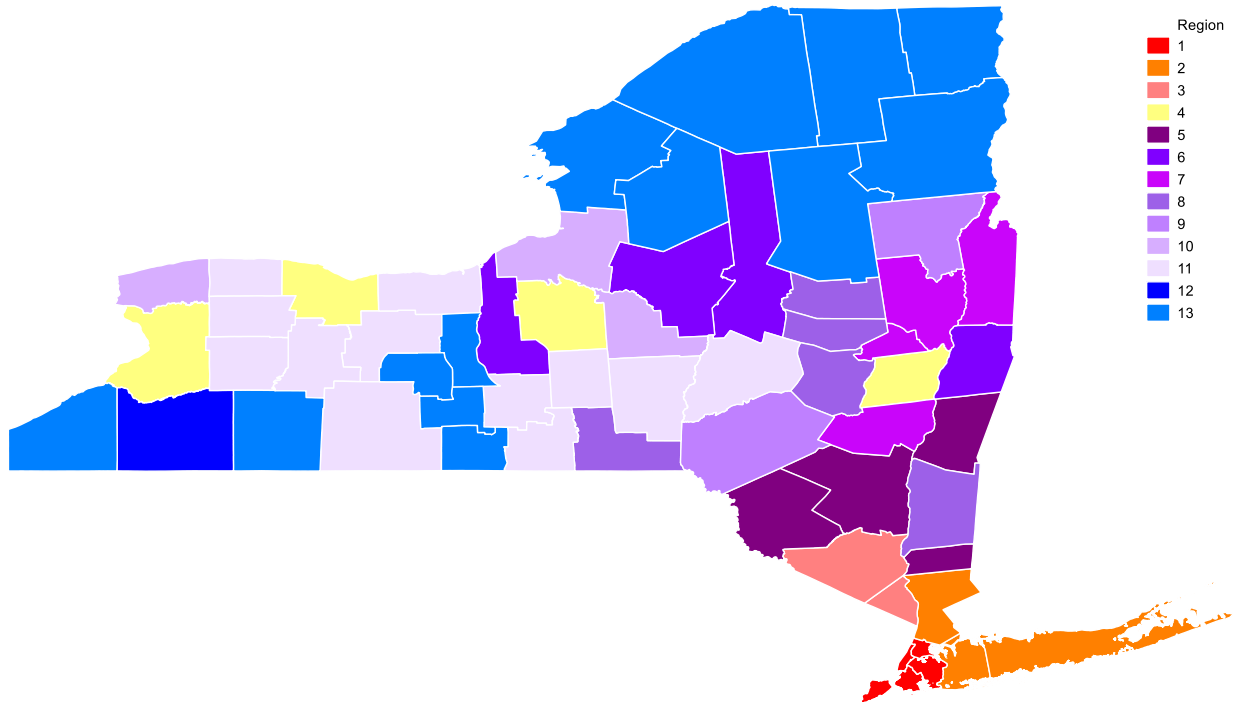
Table 6 presents the rollout region, the counties in each region, and the announcement letter date for each region. The rollout regions are also illustrated in Figure 1. The mandate started in New York City (Region 1), followed by three more populated regions (Regions 2–4), and then the remaining regions. The majority of regions (Regions 5–11) implemented the mandate in 2014. The last two regions (Regions 12–13) are less populated than the rest of the state.

Table 6. List of Counties and the MLTC Mandate Rollout Dates

Region	Counties in Region	Announcement Letter Date
1	New York City (Bronx, Kings, New York, Queens, Richmond)	June 2012
2	Nassau, Suffolk, Westchester	January 2013
3	Orange, Rockland	June 2013
4	Albany, Erie, Monroe, Onondaga	December 2013
5	Columbia, Putnam, Sullivan, Ulster	April 2014
6	Cayuga, Herkimer, Oneida, Rensselaer	May 2014
7	Greene, Saratoga, Schenectady, Washington	June 2014
8	Broome, Dutchess, Fulton, Montgomery, Schoharie	August 2014
9	Delaware, Warren	September 2014
10	Madison, Niagara, Oswego	October 2014
11	Chenango, Cortland, Genesee, Livingston, Ontario, Orleans, Otsego, Steuben, Tioga, Tompkins, Wayne, Wyoming	December 2014
12	Cattaraugus	March 2015
13	Allegany, Chautauqua, Chemung, Clinton, Essex, Franklin, Hamilton, Jefferson, Lewis, Schuyler, Seneca, St Lawrence, Yates	June 2015

NOTE: The MLTC mandate was formally launched in September 2012. For our analytic purposes, we used the announcement letter date as the start date since some beneficiaries started to enroll in MLTC under the mandate after the letter date.

Figure 1. The MLTC Mandate Rollout Regions by Announcement Letter Date

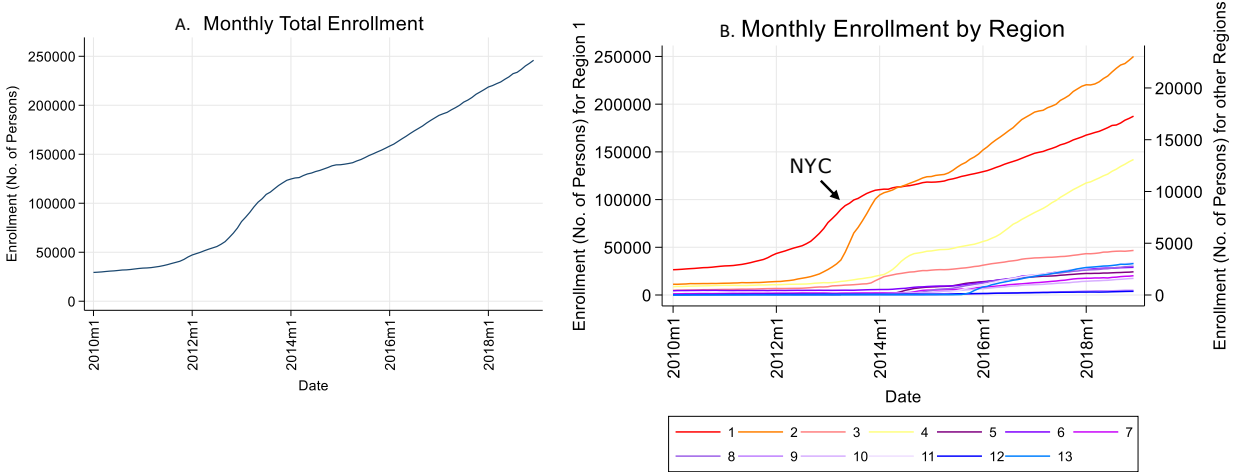


NOTE: This map depicts the clusters of counties by Announcement Letter date. Region numbers correspond to those in Table 6.

MLTC Enrollment

The total enrollment over calendar time is presented in Figure 2A. MLTC enrollment increased rapidly from 54,479 in mid-2012 to 124,757 at the beginning of 2014, at which point the curve flattens slightly before resuming a continuing trend of increased enrollment compared to the pre-mandate period. The total enrollment reached 245,973 in December 2018. We also looked at enrollment by each region, over time. Most of the growth was driven by Region 1 (New York City), where enrollment accounted for 76 percent of total enrollment at the end of 2018; this is clearly presented in Figure 2B, in which the total enrollment trend mirrors that of New York City. The next two regions that contributed most to the total enrollment, but to a much lesser extent, are Regions 2 (Nassau, Suffolk, Westchester) and 4 (Albany, Erie, Monroe, Onondaga), accounting for 9 percent and 5 percent of the total enrollment in December 2018, respectively.

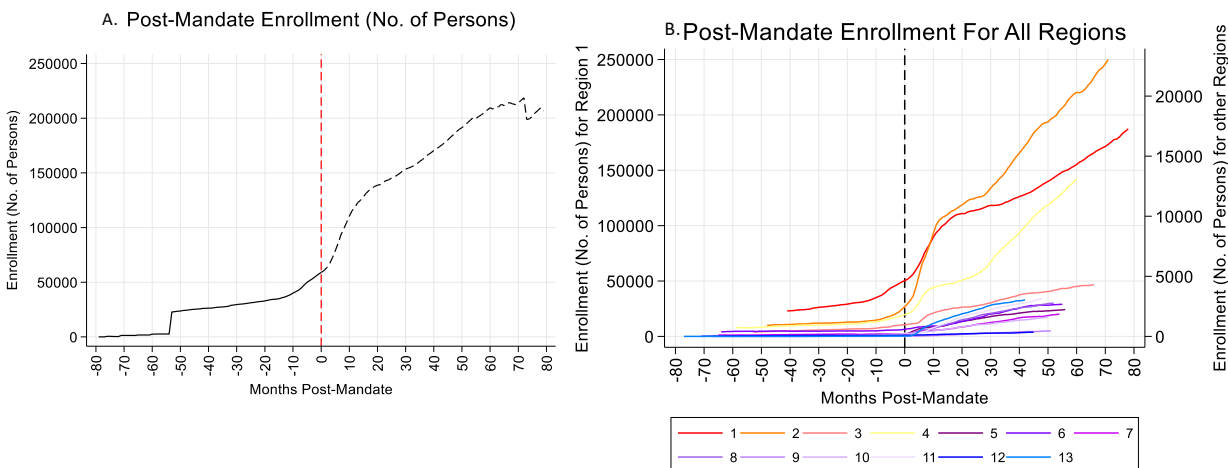
Figure 2. Total MLTC Enrollment Over Calendar Time, Statewide and by Rollout Region



The calendar time enrollment trend is confounded by the fact that the mandate started at different times. Each region has a different number of months in the pre- and post- mandate periods, depending on when the mandate was rolled out in that region. For example, Region 1 (New York City) has the fewest number of months (29 months) in the pre-period and the greatest number of months (79 months) in the post-period. As a result, we observed an upward calendar time trend simply because a few regions newly started to implement the mandate at that time. We therefore examined the trend by resetting a region-specific time index to 0 for the month during which each region implemented the mandate (i.e., “re-centering” the data).

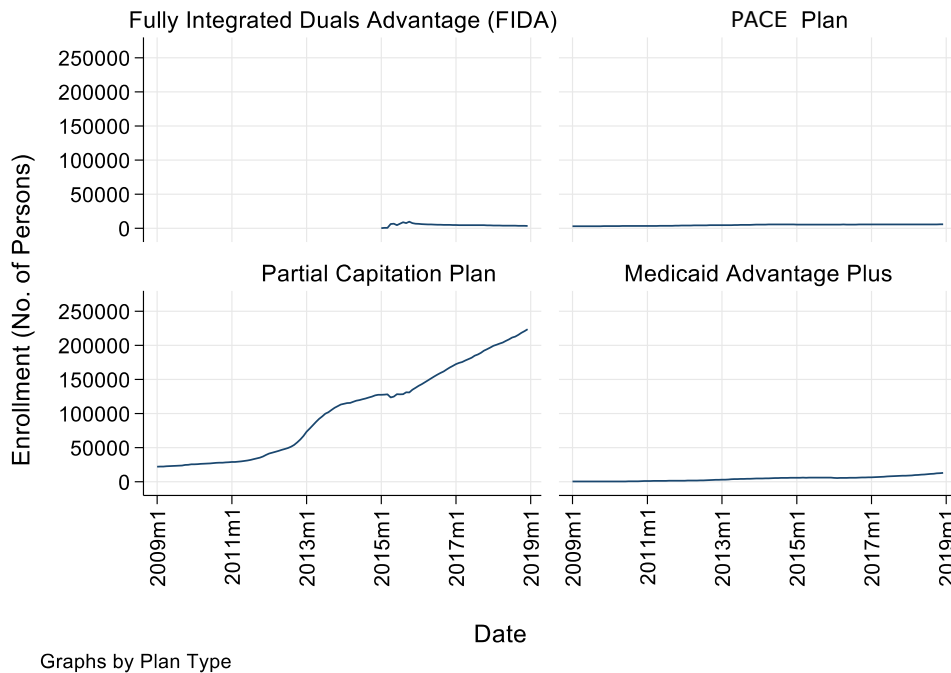
Once the data were re-centered, we find that the increases observed in the ten months prior to the mandate and those in the post-mandate period are more pronounced (Figure 3A) than those in calendar time trends (Figure 2A). The post-mandate enrollment trend increased very rapidly until month 19, at which point it started to flatten and stabilize. Note that, due to re-centering the data for each region, the total enrollment (213,852) at month 79, reflecting the enrollment in New York City in December 2018, is different from the statewide enrollment (245,973) in December 2018, as illustrated in Figure 2A. Similar to the enrollment trend by calendar time, Figure 3B shows the greatest enrollment (188,872 at month 79) in Region 1 (New York City), followed by Region 2 (Nassau, Suffolk, Westchester) and Region 4 (Albany, Erie, Monroe, Onondaga), 24,980 at month 79 and 14,786 at month 72, respectively.

Figure 3. Total MLTC Enrollment Over Time Since Mandate, Statewide and by Rollout Region



We next examined the enrollment by MLTC plan type. Four plan types were included in the analysis: Partial Capitation, PACE, MAP, and FIDA plans. The FIDA plans were part of a five-year demonstration and were limited to Regions 1 (New York City) and 2 (Nassau, Suffolk, Westchester); the program closed December 31, 2019. Figure 4 describes the number of MLTC enrollees by plan type. We find that most members enrolled in Partial Capitation plans (223,568, or 91 percent, in December 2018), followed by MAP (5 percent), PACE (2 percent), and FIDA (1 percent). The trends in Partial Capitation enrollment mirror that of the statewide enrollment presented in Figure 2A. MAP and PACE plans have a limited increase in enrollment over time and do not mimic the Partial Capitation trend curve.

Figure 4. Total MLTC Enrollment by Calendar Time and Plan Type



MLTC Enrollment Rate

We next performed a similar descriptive analysis of enrollment rates. Figure 5 presents the statewide (A) and region-specific (B) rates. The statewide enrollment rate increased rapidly from 10–18 percent in the second half of 2012 to 35 percent in December 2013, after which it slowed. But the enrollment rate increased again in 2016 (Figure 5A) and reached 65 percent by 2018. The statewide enrollment rate is driven by Region 1 (New York City), with a rate of 88 percent in December 2018. Regions 2 (Nassau, Suffolk, Westchester) and 3 (Orange, Rockland) have the second-highest rates, with a similar pattern to that of Region 1 (Figure 5B), 62 percent and 66 percent at the end of 2018, respectively. The enrollment rates in other regions varied between 27 percent and 42 percent as of December 2018.

Figure 5. MLTC Enrollment Rates over Calendar Time, Statewide and by Rollout Region

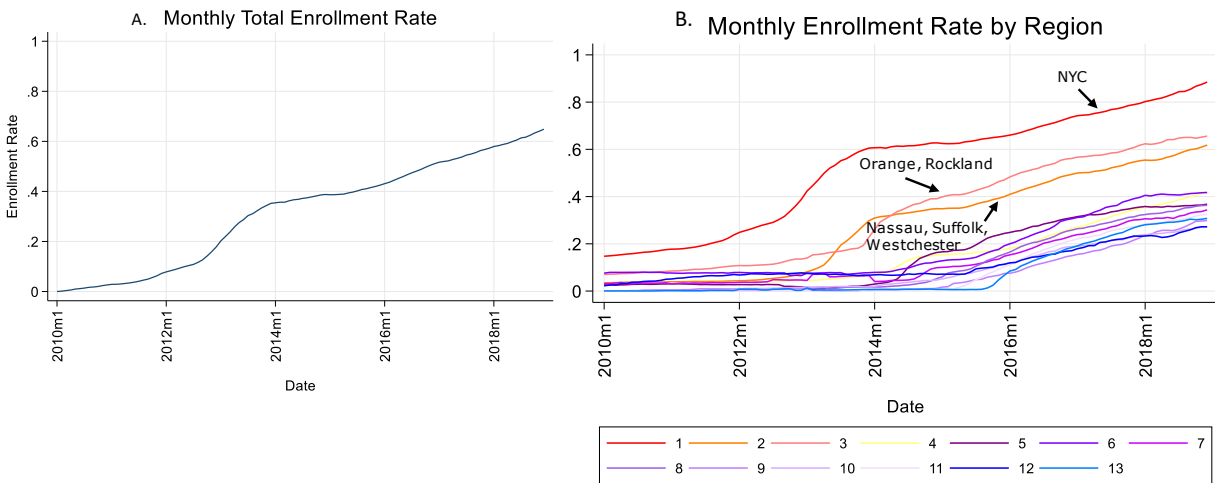
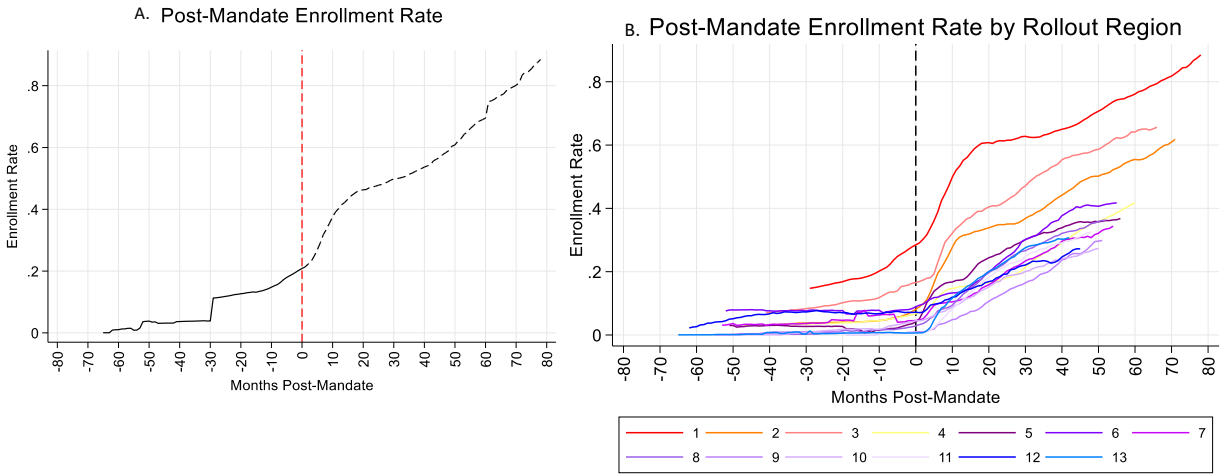


Figure 6 shows that, after the data are re-centered around the mandate start for each rollout region, the trend curves continued to increase during the post-mandate period, from 20 percent at month 0 to 88 percent at month 79, and are much steeper than calendar time trends as depicted in Figure 5. In particular, the ten months prior to the start of the mandate appear to have a marked increase in statewide enrollment rates compared to earlier months (Figure 6A). Note that, due to the re-centering of the data for each region, the overall rate in Figure 6A is different from that in Figure 5A.

A close examination of enrollment rates by region (Figure 6B) shows the highest rate at month 40 (65 percent) in Region 1 (New York City), followed by Regions 2 (44 percent) and 3 (55 percent). But even prior to the mandate, the enrollment rate in Region 1 was about 20 percent, much higher than in other regions. The acceleration in enrollment rates just prior to the mandate start was primarily driven by Regions 1 (New York City) and 3 (Orange, Rockland). Other than Regions 1, 2, and 3, rates in the remaining regions appear to have similar trends with similar values, varying between 24 percent and 38 percent at month 40.

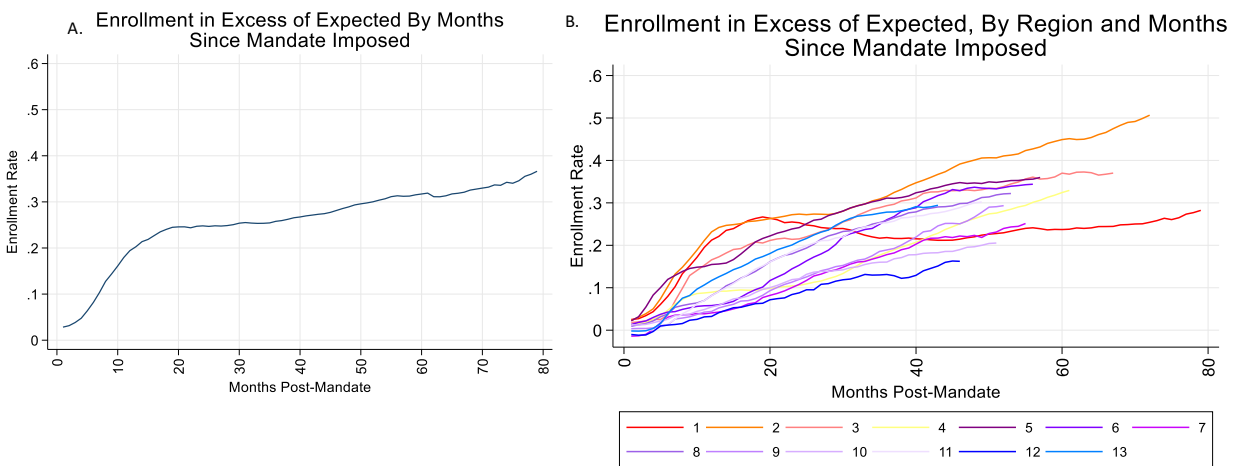
Figure 6. MLTC Enrollment Rates over Time Since Mandate, Statewide and by Rollout Region



MLTC Mandate’s Effect on Enrollment Rate

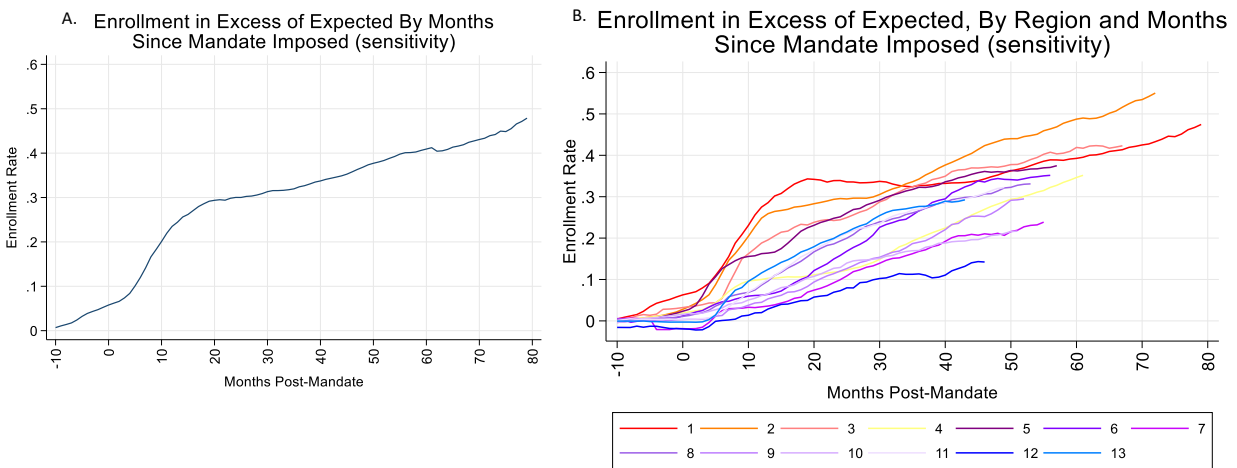
For the regression analysis, we determined the enrollment rate increase in excess of the expected rate based on prior trends in the data (Figure 7); that is, we controlled for the region-specific baseline calendar time trends that are assumed to continue regardless of the mandate. The MLTC mandate is associated with an increase of 37 percentage points in enrollment rates during the first 79 months post-mandate, with about two-thirds of the impact (a 24-percentage point increase) occurring in the first 19 months post-mandate (Figure 7A). Since month 20, the mandate’s impact stabilized at about 0.21 percent per month, or 2.4 percent per year. Not surprisingly, the mandate’s effect differs across regions. In New York City, the mandate’s effect (28 percentage points) was largely realized in the first 19 months, and Regions 3 (Orange, Rockland), 5 (Columbia, Putnam, Sullivan, Ulster), and 6 (Cayuga, Herkimer, Oneida, Rensselaer) seem to stabilize at Month 42, 46, and 45, respectively. But in other regions, the mandate continued to increase its impact. At month 40, Regions 3, 5, and 2 seem to experience the largest impact from the mandate, with enrollment rates in excess of what was expected reaching 31 percent, 32 percent, and 35 percent, respectively.

Figure 7. Trends In Excess of MLTC Enrollment Rates over Time Since Mandate, Statewide and by Rollout Region



We noted that there seemed to be an increase in enrollment in the ten months prior to the mandate start; this trend was observed when looking at the number of enrollees, as well as enrollment rates. We therefore conducted a sensitivity analysis by explicitly modeling these ten months as part of the implementation period (Figure 8); that is, the reference group now becomes the time period of 11 months or more prior to the mandate. We found that both the level and the slope of excessive enrollment rates increased after explicitly modeling the ten months prior to the mandate start. For example, the mandate’s impact on the statewide enrollment rate increases to 30 percentage points by month 19 (over 50 percent of the total impact by month 70, Figure 8A) from 24 percentage points (Figure 7A), and the impact at month 70 is 44 percentage points versus 37 percentage points in the main analysis. Since month 20, the mandate’s impact stabilized at about 0.32 percent per month, or 3.9 percent per year. This change, admitting anticipatory effects, has a large impact on results for Region 1. First, in Figure 8B, we observe enrollment in excess of expected in the ten months prior to the mandate start (in contrast, this effect in Region 3 is small); second, the trend in Region 1 started to increase again at month 45, which is not present in the main analysis. Upon conducting a visual inspection, no other regions had stabilized their enrollment rates by 2018.

Figure 8. Trends in Excess of MLTC Enrollment Rates over Time Since Mandate, Including the 10 Months Prior to the Mandate, Statewide and by Rollout Region



Based on our tests of the changes in three-month average enrollment rates, the mandate’s effect on enrollment rate stabilized statewide at month 19 post-mandate (comparing months 19–21 with months 16–18), and no significant increases are observed after month 19. The testing results are similar to those from the sensitivity analysis, in which the ten months prior to the mandate were included as an anticipatory effect of the mandate. The enrollment rate stabilized at month 20, and no significant increases appeared from that point forward.

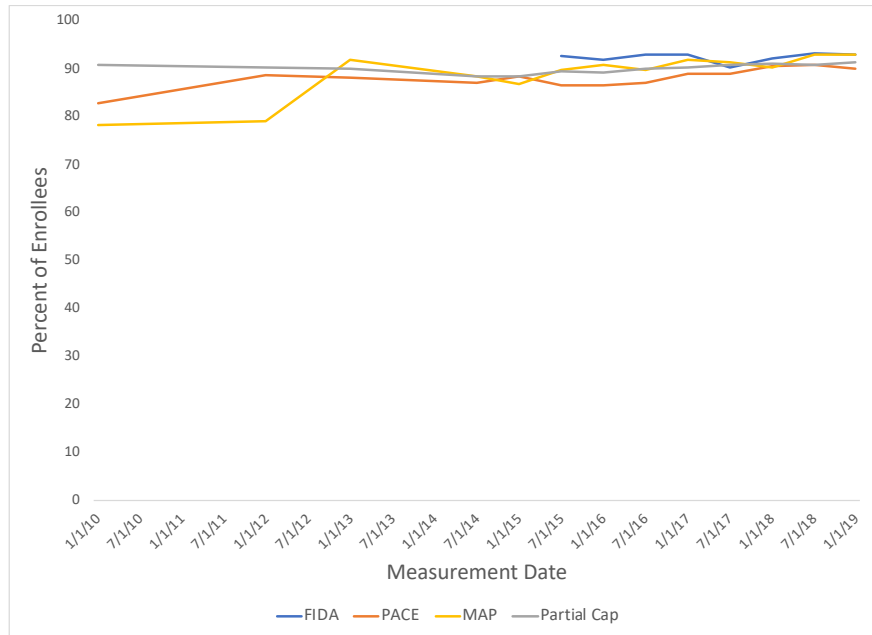
Goal 2, Research Question 1: Emergency Room Visits

Is the percentage of the MLTC population without any emergency room visits in the last 90 days stable or improving over the course of the demonstration?

As illustrated in Figure 9, the percentage of enrollees without any emergency room visits remained largely unchanged¹⁴ during 2010–2019 among Partial Capitation plans, which accounted for 91 percent of total MLTC enrollment in 2018. In comparison, the rates among MAP and PACE plans were lower than among Partial Capitation plans based on the data reported prior to July 2012 but similar in the later reporting years. FIDA plans had a relatively flat trend over the observation period, with a range from 93.1 percent to 90.1 percent of enrollees from July 2015 to January 2019, and FIDA rates were generally higher than those of other plan types. Note that the total enrollment of FIDA plans was relatively small, ranging from 1 to 2,978 during 2015–2019, and accounting for about 1 percent of total MLTC enrollment.

¹⁴ Despite our adjustment for the reference period, rates in percentage without emergency room visits and percentage without falls may not be comparable over time because of measurement definitional issues and risk adjustment. We therefore did not conduct trend tests. But they are comparable within the same time period across different plan types.

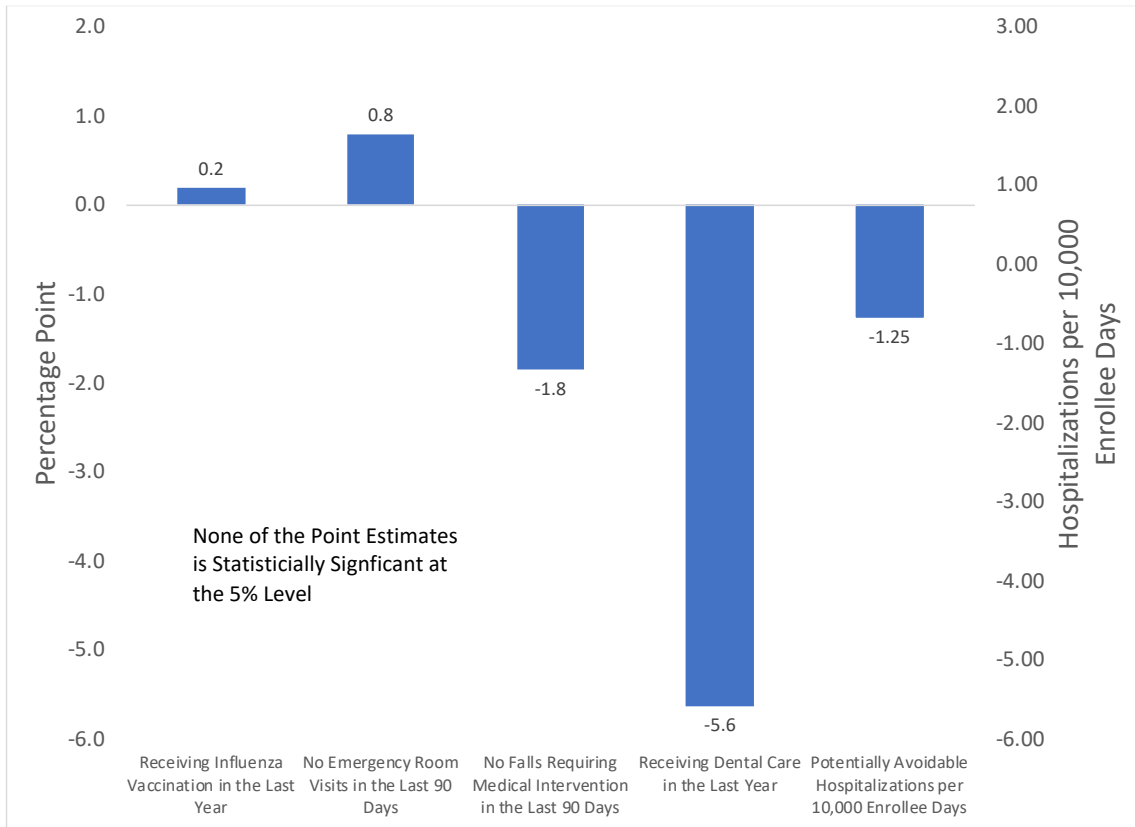
Figure 9. Percentage of MLTC Enrollees without Any Emergency Room Visits in the Last 90 Days



NOTE: The lookback period was adjusted from the last six months to the last 90 days for the 2010, 2012, and 2013 measures. The 2010 measure includes any emergent care received in a hospital emergency room, outpatient department, or physician’s office. Starting in 2012, the measure includes only emergent care received in a hospital emergency room and is risk-adjusted.

Based on the multivariable regression analysis, we did not find a statistically significant association between the MLTC mandate and without emergency room visits (Figure 10).

Figure 10. Effect of the MLTC Mandate on Patient Safety and Quality of Care Measures



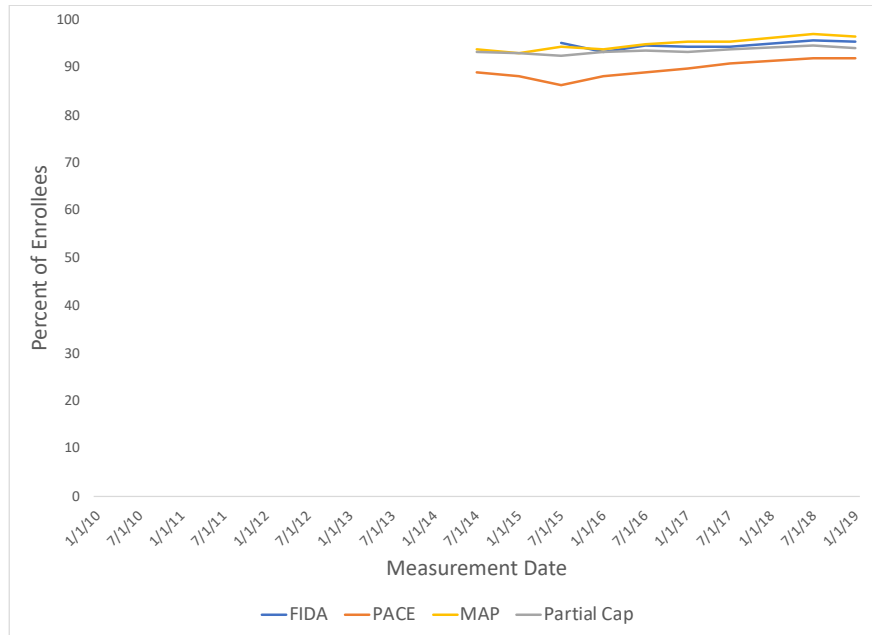
NOTE: The outcome measures for influenza vaccination (N=522), no emergency room visit (N=475), no falls requiring medical intervention (N=403), and dental exam (N=448) are in percentage points (left Y-axis). Potentially avoidable hospitalization rate (N=210) is defined as the number of such events per 10,000 MLTC enrollee days (right Y-axis). None of the estimates is statistically significant at the 5 percent level.

Goal 2, Research Question 2: Falls Requiring Medical Intervention

Is the percentage of the MLTC population without any falls requiring medical intervention in the last 90 days stable or improving over the course of the demonstration?

Figure 11 shows the percentage of enrollees without any falls that required medical intervention in the last 90 days by plan type. Because the measure definition changed significantly in 2014, the data set is limited to July 2014 onward. Enrollee rates of without falls among both PACE and Partial Capitation plans were lowest in July 2015, at 85.4 percent and 92.5 percent, respectively. After an initial drop in the rate of falls, there was a general increase in the trends across all plan types. In 2019, 95.6 percent of FIDA, 91.0 percent of PACE, 94.2 percent of Partial Capitation, and 96.7 percent of MAP enrollees did not have any falls requiring medical intervention in the last 90 days. The multivariable regression analysis did not show a statistically significant association between the MLTC mandate and falls requiring medical intervention (Figure 10).

Figure 11. Percentage of MLTC Enrollees without Any Falls Requiring Medical Intervention or Resulting in Major or Minor Injuries in the Last 90 Days



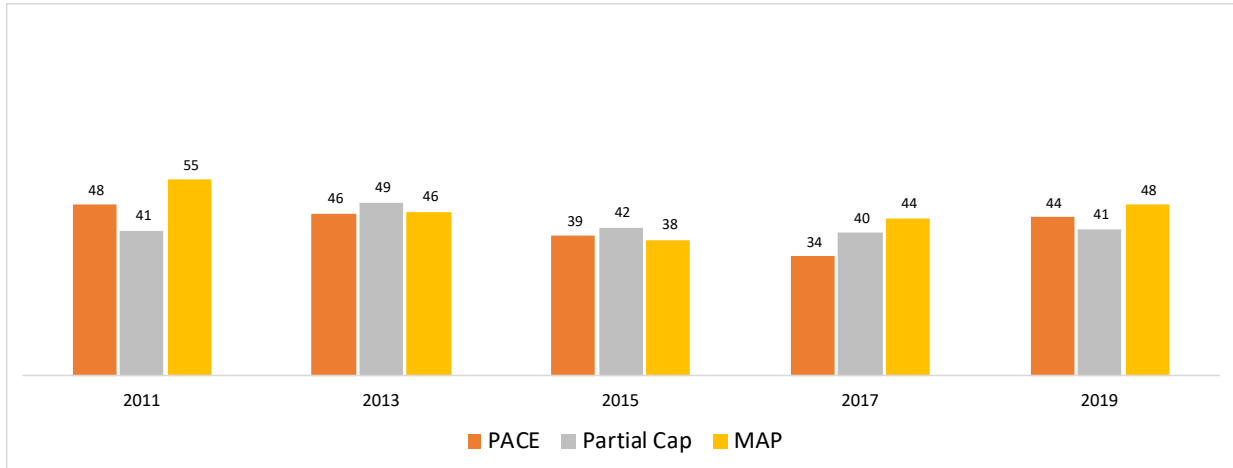
NOTE: The year 2014 is the first reporting period in which the risk-adjusted percentage of enrollees without any falls requiring medical intervention was reported. In 2010, the percentage of enrollees without any falls was reported; in 2012, the risk-adjusted percentage of enrollees without any falls was reported; in 2013, the risk-adjusted percentage of enrollees without any falls and the risk-adjusted percentage of enrollees without falls not requiring medical intervention was reported. We did not analyze the data reported prior to 2014 because the definition changed in 2014, and data were not available for January 1, 2018.

Goal 3, Research Question 1: Timely Access to Care

Are enrollees’ perceived timely access to personal, home care, and other services such as dental care, optometry, and audiology stable over time or improving?

Because of a lack of reported measures on access to optometry and audiology, we present results on access to dental care only. The percentage of enrollees who waited less than a month for routine dental care decreased from 2011 to 2013 for those in PACE and MAP plan types, and it increased slightly for those in the Partial Capitation (Figure 12). In 2015, the outcome definition changed and the percentage of enrollees who received access to routine dental appointments within PACE and MAP plan types increased from 2015 to 2019, while those in the Partial Capitation plans remained largely unchanged. Overall, on a statewide level, the trend is that more enrollees had similar wait times and access to routine dental care.

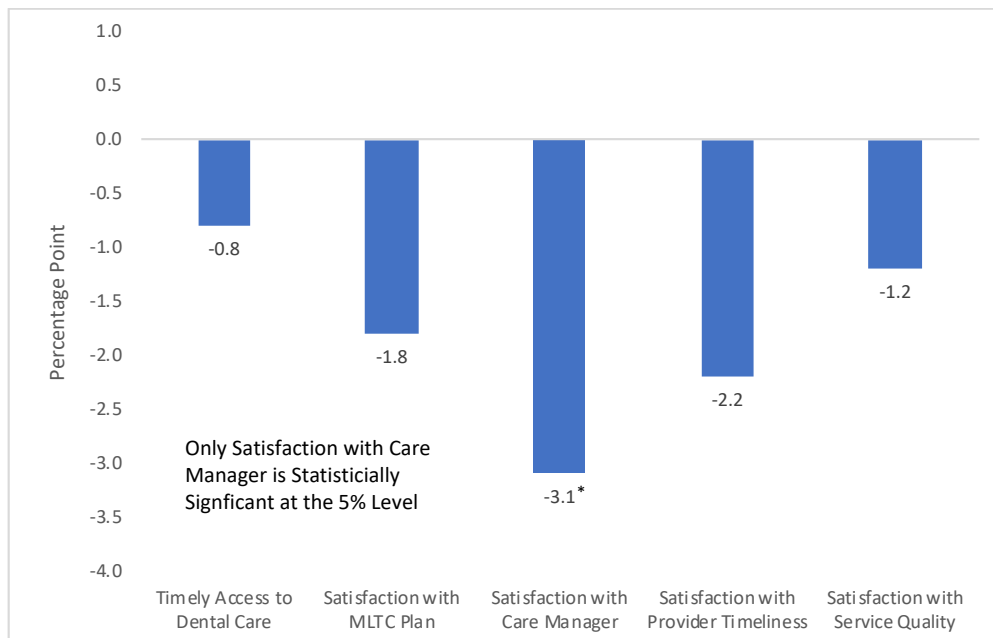
Figure 12. Percentage of MLTC Enrollees Who Received Timely Access to Dental Care



NOTE: The bars represent the percentage of MLTC enrollees who reported that within the last six months they waited less than 1 month for access to routine dental care (2011, 2013) or the percentage of members who reported that within the last six months they always got a routine dental appointment as soon as they thought they needed one (2015, 2017, 2019). Data from 2007 was not available from MLTC reports by individual plan; the outcome definition changed in 2015; the measure is not risk-adjusted.

Based on the multivariable regression analysis, no statistically significant association between the MLTC mandate and timely access to dental care was found (Figure 13).

Figure 13. Effect of the MLTC Mandate on Access and Satisfaction Measures



NOTE: * $p < 0.05$. The sample sizes for timely access to dental care, satisfaction with MLTC plan, satisfaction with care manager, satisfaction with provider timeliness, and satisfaction with service quality are 42, 45, 46, 45, and 47, respectively.

Goal 3, Research Question 2: Preventive Services

Is the percentage of the MLTC population accessing preventive care services, such as the influenza vaccination and dental care, consistent or improving?

Figure 14 shows that the rate of influenza vaccination stayed relatively flat or increased slightly since the pre-mandate period (before 2013), with the exception of MAP enrollees, whose vaccination rate went from 77.1 percent in 2012 to 61.7 percent in 2013. Since 2013, the percentage of MAP enrollees who received an influenza vaccination in the last year increased to 83.5 percent as of the January 2019 measurement period. The percentage of enrollees in FIDA plans who received influenza vaccinations in the last year increased from 76.5 percent in July 2015 to 83.0 percent in January 2019. The percentage of enrollees in FIDA plans who received influenza vaccinations in the last year increased from 76.5 percent in July 2015 to 83.0 percent in January 2019. The percentage of PACE and Partial Capitation plan enrollees who received influenza vaccinations in the last year stayed relatively flat, at 87.2 percent to 86.3 percent and 80.9 percent to 78.8 percent, respectively, from January 2010 to January 2019. This measure is not risk-adjusted at the plan level. The multivariable regression analysis did not show a statistically significant association between the MLTC mandate and influenza vaccinations (Figure 10).

Figure 14. Percentage of MLTC Enrollees Receiving an Influenza Vaccination in the Last Year

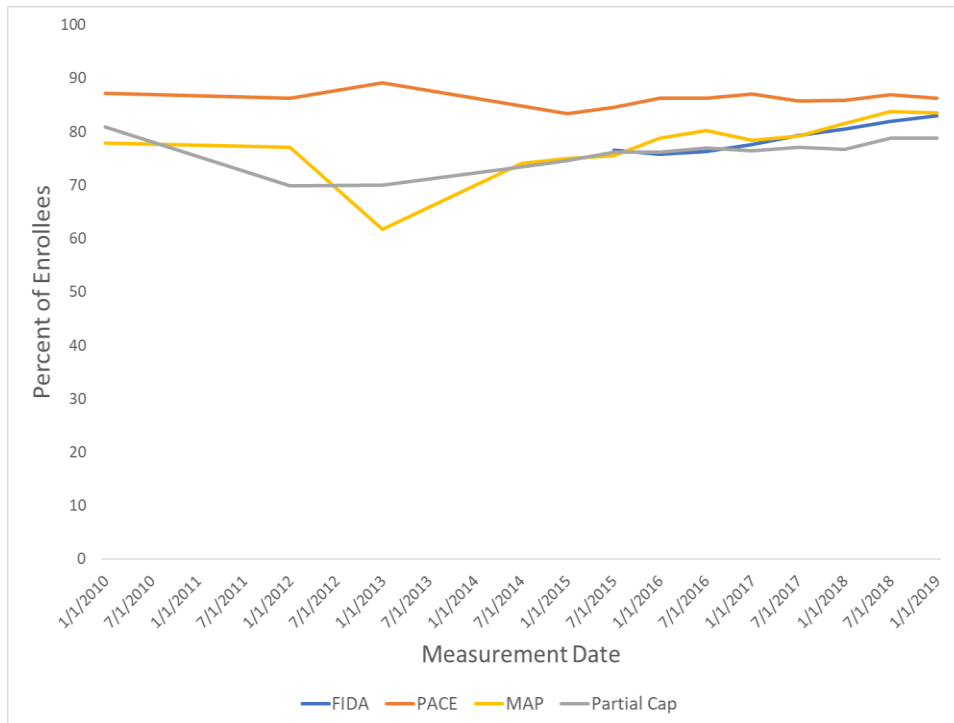
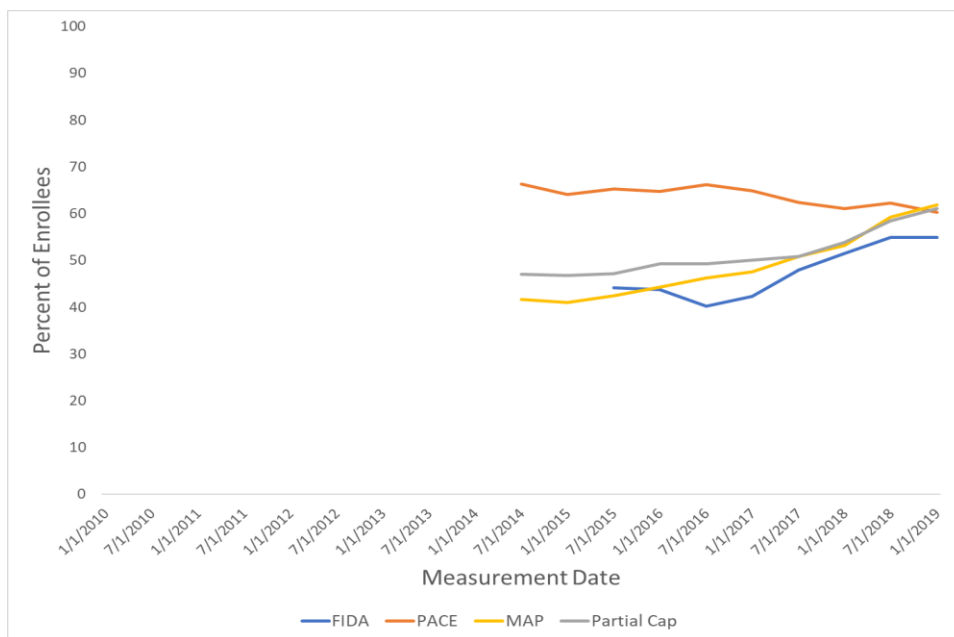


Figure 15 shows the percentage of MLTC enrollees receiving a dental exam in the last year by plan type; the measure was reported starting in July 2014. Overall, there was an upward trend over the available measurements, with the exception of PACE plan enrollees, who had a

downward trend from 66.3 percent in July 2014 to 60.3 percent in January 2019. The percentage of Partial Capitation and MAP plan enrollees receiving a dental exam steadily increased from 47.0 percent to 61.1 percent and from 41.6 percent to 61.8 percent, respectively, over the same time period. The percentage of FIDA plan enrollees who received a dental exam also increased, albeit over a shorter time period, from July 2015 to January 2019. This measure is not risk-adjusted at the plan level. The multivariable regression analysis did not show a statistically significant association between the MLTC mandate and receipt of dental exam (Figure 10), although the point estimate is sizable (−5.6 percentage points).

Figure 15. Percentage of MLTC Enrollees Receiving a Dental Exam in the Last Year

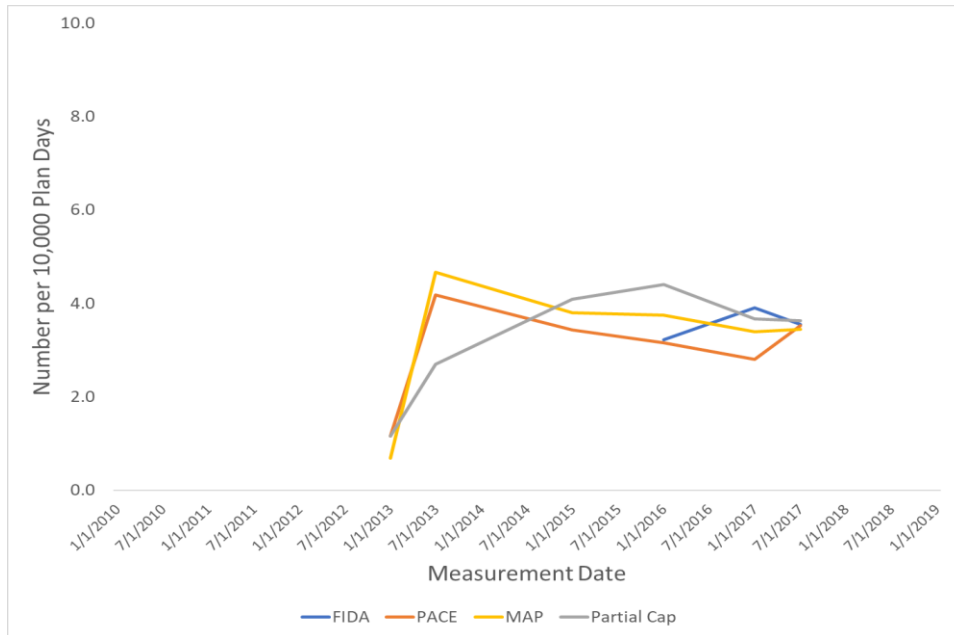


Goal 4, Research Question 1: Potentially Avoidable Hospitalizations

Is the MLTC population experiencing stable or reduced rates of potentially avoidable hospitalization?

We descriptively examine the annual rate of potentially avoidable hospitalizations by plan type (Figure 16), measured as the number of potentially avoidable hospitalizations per 10,000 enrollee days. FIDA plans only reported for three measurement periods, and the rate is relatively flat at 3.219 to 3.910 hospitalizations per 10,000 enrollee days. For the other three plan types, the rates reported in January 2013 were relatively low; rates spiked in either July 2013 (4.176 for PACE, 4.670 for MAP) or January 2016 (4.404 for Partial Capitation), and then remained relatively stable (PACE) or decreased (Partial Capitation and MAP). The multivariable regression analysis did not show a statistically significant association between the MLTC mandate and potentially avoidable hospitalizations (Figure 16).

Figure 16. Annual Rate of Potentially Avoidable Hospitalizations



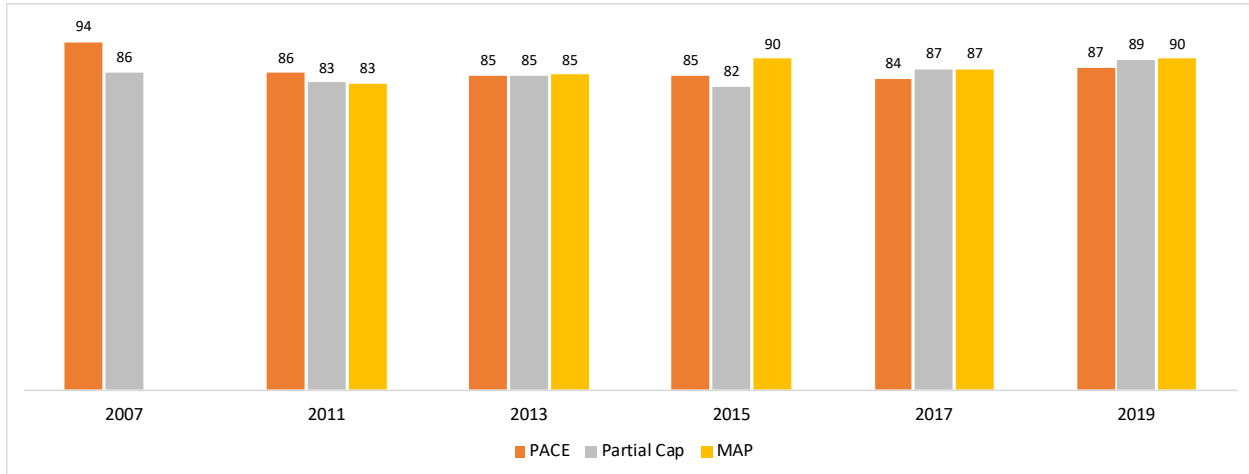
NOTE: SPARCS records were matched using SAAM data (2013) or UAS-NY data (2014 onward). After 2013, eligible enrollees were those with continuous enrollment periods of four months or greater in an MLTC plan. We did not analyze the January 1, 2013, data point in the regression analysis because, for some reason, it is about one-third of other data points.

Goal 5, Research Question 1: Satisfaction with MLTC Plans

What is the percentage of members who rated their managed long-term care plan within the last six months as good or excellent? Has this percentage remained stable or improved over the demonstration?

Figure 17 shows how enrollees rated their health plan, by plan type and survey year. The percentage of participants who rated their health plan as good or excellent was initially quite high in 2011: 85.7 percent, 83.2 percent, and 83.0 percent for PACE, Partial Capitation, and MAP plans, respectively. Among PACE plans, ratings of health plan satisfaction remained rather stable over time except for a decline compared to 2007. Ratings of satisfaction in health plans among Partial Capitation and MAP plan enrollees did not experience the same dip and generally rose each year. The multivariable regression analysis did not show a statistically significant association between the MLTC mandate and satisfaction with MLTC plan (Figure 13).

Figure 17. Percentage of MLTC Enrollees Who Rate Their Health Plan as Good or Excellent



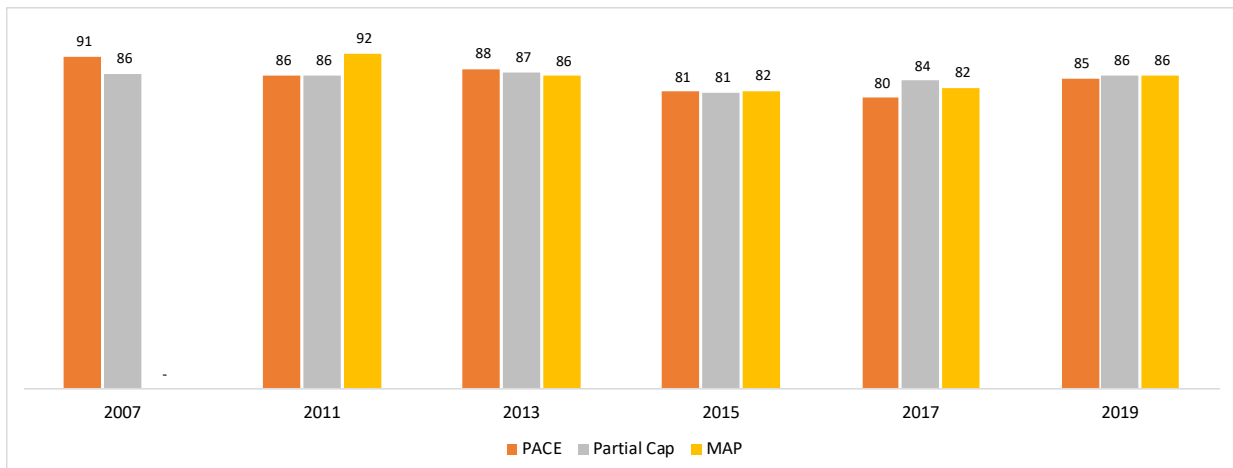
NOTE: The 2007 data for MAP plans are not available.

Goal 5, Research Question 2: Satisfaction with Care Managers

What is the percentage of members who rated the quality of care manager/case manager services within the last six months as good or excellent? Has this percentage remained stable or improved over the demonstration?

Ratings for each plan type showed decreases in care manager satisfaction corresponding to the time that mandatory enrollment was implemented. While satisfaction increased in 2019, it remained below 2011 levels across all plan types (Figure 18). The multivariable regression analysis shows a 3.1 percentage drop in satisfaction with care managers associated with the MLTC mandate (Figure 18).

Figure 18. Percentage of MLTC Enrollees Who Rate Their Care Manager as Good or Excellent

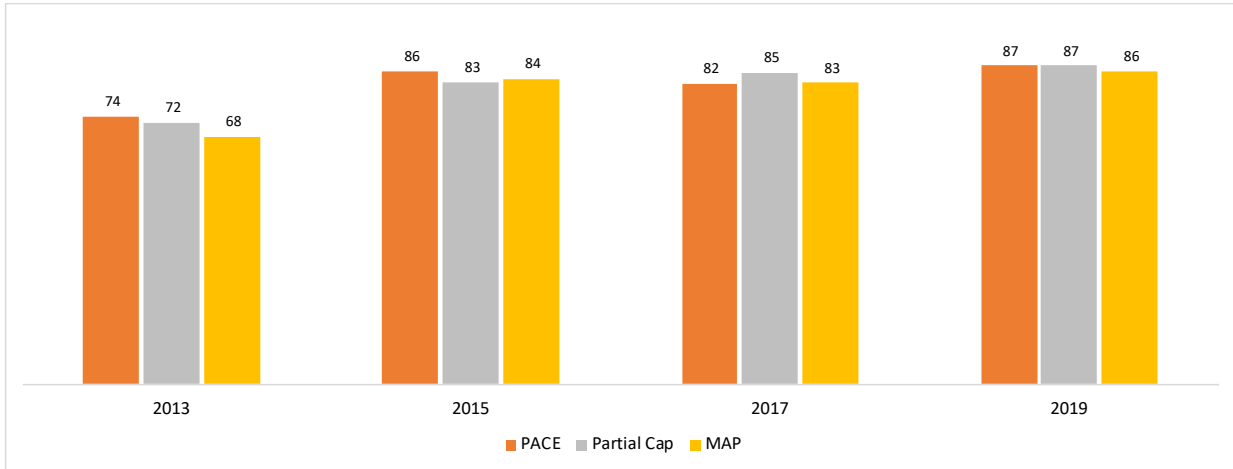


Goal 5, Research Question 3: Satisfaction with Services

What is the percentage of members who rated their home health aide/personal care aide/personal assistant, care manager/case manager, regular visiting nurse, or covering/on-call nurse services within the last six months as usually or always on time? Has this percentage remained stable or improved over the demonstration?

The timeliness composite indicates the percentage of MLTC enrollees who reported that within the last six months the home health aide/personal care aide/personal assistant, care manager/case manager, regular visiting nurse/registered nurse, or covering/on-call nurse services were usually or always on time. The measure was implemented in 2013 and has increased across plan types from 2013 to 2019 (Figure 19). The multivariable regression analysis did not show a statistically significant association between the MLTC mandate and the timeliness of care providers (Figure 19).

Figure 19. Percentage of MLTC Enrollees Who Rate Their Care Providers as Usually or Always on Time



NOTE: The measure reflects the risk-adjusted percentage of MLTC enrollees who reported that within the last six months the home health aide/personal care aide/personal assistant, care manager/case manager, regular visiting nurse/registered nurse, or covering/on-call nurse services were usually or always on time. The outcome measure for this measure was not included on the survey in 2007 or 2011.

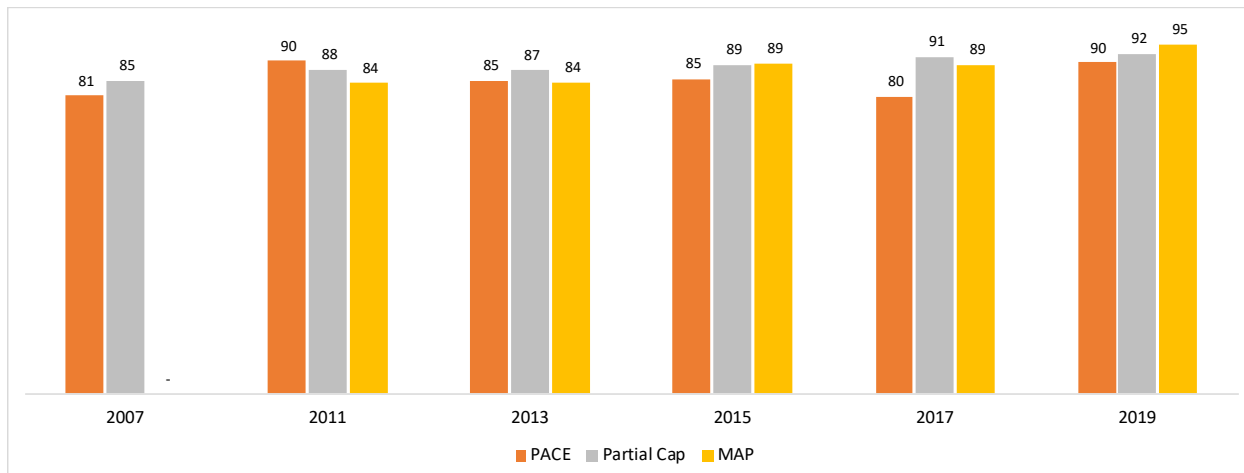
Goal 5, Research Question 4: Satisfaction with Service Quality

What is the percentage 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? Has this percentage remained stable or improved over the demonstration?

Satisfaction with home health aides for PACE plans showed an initial increase and then a dip in ratings; by 2019, satisfaction with home health aides had returned to 2011 levels (Figure 20). In contrast, Partial Capitation and MAP plan participant satisfaction increased from 2011 levels, 87.6 percent and 84 percent to 92 percent and 94.5 percent, respectively, in 2019. The

multivariable regression analysis did not show a statistically significant association between the MLTC mandate and the quality of LTSS (Figure 20).

Figure 20. Percentage of MLTC Enrollees Who Rate Service Quality as Good or Excellent



Domain 1, Component 1: Managed Long-Term Care—Discussion and Conclusions

MLTC Enrollment

The statewide MLTC enrollment increased rapidly after the mandate implementation, particularly during mid-2012 to 2014, reaching about 250,000 by 2018. The enrollment trend was dominated by New York City (Region 1), whose enrollment accounted for 76 percent of the statewide total enrollment in 2018. This is consistent with the size of New York City’s population, which is over 40 percent of the state’s population (calculated from the American Community Survey data using total population by county for New York). In addition, New York City had a much higher baseline enrollment rate even prior to the mandate start; this may reflect the enrollment capacity and/or a better awareness among New York City beneficiaries eligible for MLTC. By December 2018 (month 79 post mandate), New York City achieved an enrollment rate of 88 percent. Regions 2 (Nassau, Suffolk, Westchester) and 3 (Orange, Rockland) had the largest enrollment other than New York City: 62 percent and 66 percent in 2018, respectively.

Based on the descriptive results, it is not apparent that enrollment had stabilized by 2018. However, when controlling for the underlying time trend, and by identifying enrollment in excess of what was expected, we estimated that about two-thirds of the mandate’s impact, a 24-percentage-point increase in enrollment rates, had materialized by month 19, and the overall trend in enrollment rates stabilized by month 19 post-mandate based on our statistical tests contrasting consecutive three-month average enrollment rates. Since month 20, the mandate’s impact stabilized at about 0.2 percent per month, or 2.4 percent per year.

There was large regional variation in the mandate’s impact on enrollment. Region 1 (New York City) dominated statewide trends and stabilized faster (month 19), driving the overall trend

for statewide stability by month 19. The enrollment in Regions 3 (Orange, Rockland), 5 (Columbia, Putnam, Sullivan, Ulster), and 6 (Cayuga, Herkimer, Oneida, Rensselaer) seemed to have stabilized by months 42 to 46. The mandate's impact in other regions had not stabilized by 2018. In addition, the magnitude of the mandate's impact also differs across regions. For example, Regions 2, 3, and 5 achieved a higher impact from the mandate in terms of enrollment rates by month 40 than the rest of the state, including New York City.

There are several possible explanations for this large regional variation. First, some regions may not have had long enough post-mandate horizons for enrollment to stabilize. For instance, Regions 7–13 had a horizon of 42 to 55 months post-mandate. Nonetheless, the post-mandate time required for enrollment rates to stabilize varied across regions. Regions 2 and 4 had 72 and 61 months post-mandate, respectively, but the mandate's impact continued to increase in each region, whereas enrollment rates in Regions 3, 5, and 6 stabilized by month 46. It is also possible that enrollment in regions with higher pre-mandate enrollment rates may have stabilized more quickly. Regions 1 and 3 are two such examples. A higher pre-mandate enrollment rate may also be associated with a smaller total mandate effect, at least in part because enrollment may be approaching a ceiling. New York City may be such an example. The mandate's impact there is lower than in many other regions, even though its post-mandate enrollment rate is high. Another possible explanation may lie in a region's MLTC enrollment capacity. Regions 1, 3, 5, and 6 may have leveraged the mandate better using their existing institutions and infrastructure.

We observe an increase in enrollment rate in the ten months prior to the mandate start. This trend was linear in nature and largely driven by Region 1 (New York City) and, to a lesser extent, Region 3 (Orange, Rockland). The MLTC program enrollment was largely concentrated in New York City prior to the mandate, and there may have been an anticipatory effect as MLTC plans prepared for the rollout and actively competed with each other to gain a larger market share. If we consider this anticipatory effect as part of the mandate's impact, as modeled in the sensitivity analysis, the overall impact becomes larger for Regions 1 and 3, but particularly for Region 1. It is very likely that enrollment capacity caused both the pre-mandate acceleration in enrollment and the more rapid stabilization of the mandate's impact.

There are limitations to our analysis. First, the denominator we used to calculate enrollment rates is not ideal. It is only a gross approximation of the actual eligible population. We will update this using Medicare and Medicaid dual eligible data in the final interim report. Second, we controlled for the underlying calendar time trend and consider the residual post-mandate trend as the impact of the mandate. There could be other omitted time-varying factors that coincide with the timing of the mandate's implementation, which could bias our estimates of the mandate's effect either up or down. The variation in the timing of the mandates across the state mitigates this concern but does not eliminate it.

Patient Safety and Quality of Care

Our results show that during the study period, on average by plan type, about 87 to 93 percent of MLTC plan enrollees did not have any emergency room visits; 86 to 96 percent did not have falls requiring medical intervention; 60 to 90 percent received an influenza vaccination in the last year; 40 to 70 percent received a dental exam in the last year; and there were 3 to 5 potentially avoidable hospitalizations per 10,000 enrollee days. For the four outcomes measured in percentage points, the difference between an MLTC plan's outcome measure and the statewide average varied from -0.27 to 0.32 percentage points, whereas for potentially avoidable hospitalizations the difference varied from -3.4 to 9.3 hospitalizations per 10,000 enrollee days. Based on multivariable analyses, we found no statistically significant differences between MLTC mandatory enrollment and any of the outcomes.

The fact that we found no evidence of associations between mandated enrollment and the outcomes is particularly important given that such associations could have arisen because of changes in practice among existing MLTC plans or better management among new MLTC plans. In addition, MLTC creates financial incentives for plans. For example, to the extent that MLTC plans are responsible for health care costs not covered by Medicare, such as PACE, MAP, and FIDA plans, they have an incentive to minimize those health care events. The consequences of such incentives would have been captured by our key independent variable, the fraction of enrollees subject to the mandate. In our analysis, we applied plan-level fixed effects to control for time-invariant plan-level factors; to a large extent, this allowed us to capture a plan's underlying clinical management capabilities. But this approach did not address the time-varying plan-level factors that were not under the control of MLTC plans, such as concurrent policy or environmental changes during the mandate rollout period.

The fact that new enrollees under the mandate may differ from existing plan members who enrolled voluntarily in MLTC is another factor that may confound the association between the mandate and the outcomes. For example, if enrollees under mandatory enrollment are healthier in ways not captured by risk adjustment, then we might expect to observe an improvement in outcomes—for example, a decrease in emergency room visits or falls requiring medical intervention. Whether this is the case depends on the performance of the risk adjustment methodology employed by NYS DOH for its annual MLTC performance reports. The methodology utilizes enrollee demographics, chronic medical conditions, and physical and mental functions. If there are important unobserved factors that predict both clinical outcomes and individuals' enrollment in MLTC, the differences in outcome measures could potentially arise from those factors.

We did not find a significant association between the mandate and without emergency room visits, without falls requiring medical intervention, or potentially avoidable hospitalizations. Although these can be costly events, Partial Capitation plans do not cover medical costs, and for other plan types the costs are borne primarily by Medicare. As a result, MLTC plans may not have large financial incentives to improve the management of costly medical events. Financial

incentives associated with influenza vaccinations are mixed, with the costs of the vaccinations being offset by reductions in costs associated with influenza, many of which are also covered by Medicare. Dental services are covered by MLTC, so there may be a direct financial incentive to reduce visits, and we did find a negative association between MLTC mandatory enrollment and dental visits, but it was not statistically significant.

There are limitations to our analyses. First, we had to rely on the risk adjustment embedded in the outcome measures, and the data and risk adjustment methodology changed over time. In addition, influenza vaccinations and dental exams were not risk-adjusted. As a result, we were not able to control for risk selection that may have affected the outcomes. For example, the population of new enrollees under the mandate may have differed in ways that affect the outcomes, and those differences were not accounted for with risk adjustment.

Furthermore, there are several challenges in measuring outcomes over time. Without emergency room visits, without falls requiring medical intervention, and receiving an influenza vaccine were reported throughout our study period, but the definitions of emergency room visits and falls changed over time. These changes reflect decisions to improve the value of these measures, but they make it difficult to evaluate changes over time. In addition, annual risk adjustment may yield a fairer comparison of plans each year, but it also results in plan-level measures that are not comparable from year to year. We addressed these challenges by limiting our evaluation of changes to time periods for each outcome that are measured consistently and by focusing on each plan's performance relative to the statewide average each year.

Consumer Satisfaction

This analysis examined customer satisfaction, or the extent to which customer's needs were fulfilled, namely accessibility of dental care and satisfaction in the overall health plan, care manager, and home health aide, and the timeliness of care provided. Overall, customer satisfaction, as measured by the outcomes of this analysis, is high among the respondents regardless of plan type across the years of the survey. While consumer satisfaction measures may have dipped slightly during the years of the implementation of the mandate, only satisfaction of quality of care manager/case manager services had a statistically significant decrease associated with the mandate.

This analysis had several limitations. First, there were many Partial Capitation plans but very few PACE and MAP plans. The small and uneven sample size likely reduced the statistical power, limiting our ability to detect the overall impact of the mandate, as well as our ability to make comparisons between plan types (PACE, MAP, and Partial Capitation). The ability to detect the mandate's impact was further compromised by the low variability in the outcome measures themselves. There was a high degree of satisfaction at the start of the survey in 2007 that remained relatively high throughout the years.

Another limitation of the analysis was the lack of comparability of data between different survey administrations. Areas of concern include changes in the survey items and inconsistent

implementation procedures. As mentioned earlier, the survey item for the measured outcome in Goal 3 changed the wording and response categories. In addition, in 2011, the survey was mailed in two waves, the first in February and the second in April, whereas in 2015, the first wave was mailed in December and the second in March. Ideally, the survey should have been administered on the same date each year to reduce possible confounders or impact on response rates.

Finally, the survey response rate fell over each of the years it was implemented, from 32.1 percent in 2011 to 23.1 percent in 2019, and thus may have increased potential bias in responses. It is also possible that satisfied MLTC enrollees were more likely to respond to the survey or, conversely, that dissatisfied enrollees were less likely to do so.

Data Limitations

There are several limitations associated with the lack of individual-level data, as well as data for some study years. Individual-level data were not included within the RFP and not made available as part of the evaluation. To the extent that such data would have been requested and made available, it would have permitted us to be able to utilize a larger number of observations in the analysis, control for individual-level characteristics, apply risk adjustment directly to allow for comparisons over time, and, most importantly, identify outcomes for individuals by mandatory enrollment status.

In the absence of individual-level data, statistical power to detect the effects of MLTC is limited for two reasons. First, the outcome data are at the aggregate plan year level, with a limited number of observations; that is, the sample size for each analysis is small. Second, because of the limitations of existing aggregate data, a majority of available data points are for the time period after July 2015, when the mandate implementation was completed. Thus no variation in the key independent variable (the fraction of plan enrollees under the mandate) is available after July 2015. This further reduces the precision of our estimates of the impact of MLTC on outcomes.

The fact that we did not observe statistically significant results does not mean MLTC had no impact on the outcomes of interest. Because of the lack of statistical power, we are failing to reject the null hypothesis (i.e., no effect), but we are not accepting the null hypothesis either. For example, the 95 percent confidence interval of receipt of dental care includes a reduction of 19.7 percentage points, which is clearly a substantively important reduction, and the point estimate would have to be an increase of 8.6 percentage points in order to reject the null. In other words, the data generated particularly uncertain estimates.

Moreover, given that the aggregate data were risk-adjusted using a different model each year, we had to re-center outcomes in order to make relevant comparisons across years. That is, our approach was to compare how a plan's relative performance compared to all other plans changed each year. Although our approach allowed us to identify how relative plan performance is associated with mandatory enrollment, it prevented us from characterizing how overall quality

evolved over time. We were not able to control for the effect of other state initiatives on the outcomes whose variation could be captured by calendar time indicators.

Finally, to utilize the aggregate data for the causal inference, we were limited to the use of the fraction of enrollees under the mandate for each plan as the intervention variable. This involved an assumption that enrollees contributed uniformly to plan-level outcomes, which may or may not be true.




Summary









Our results show that the MLTC mandate’s effect on enrollment stabilized at month 19 after the mandate start (Table 7). The enrollment trends were dominated by Region 1 (New York City), but there is wide variation across the mandate rollout regions.

We find no evidence of increases or reductions in patient safety and quality of care among enrollees because of the MLTC mandate, as measured by without emergency room visits, without falls requiring medical intervention, potentially avoidable hospitalizations, influenza vaccinations, and dental exams.

Customer satisfaction was high across the years and across the measures, except for access to dental care. We found no evidence of increases or reductions in perceived access to dental care, satisfaction with MLTC plan, timeliness of services, or satisfaction with service quality due to the MLTC mandate. We did find, however, a statistically significant decrease in enrollees’ satisfaction with their care manager associated with the MLTC mandate.

Table 7. Summary of Evaluation Results for Domain 1, Component 1

Domain	Goal	Outcome	Results
Domain 1, Component 1: Managed Long-Term Care (MLTC)	Goal 1: Expand access to MLTC for Medicaid enrollees in need of long-term services and supports (LTSS)	Time for the MLTC mandate’s effect on enrollment to stabilize	 19 months, stabilizing at +2.4 percentage points per year; a 37-percentage point increase in enrollment rates during the first 79 months post-mandate (p<0.05)
	Goal 2: Demonstrate stability or improvement in patient safety	Percentage without emergency room visits	 +0.8 percentage points (p>0.05)
		Percentage without falls requiring medical intervention	 -1.8 percentage points (p>0.05)

Domain	Goal	Outcome	Results
	Goal 3: Demonstrate stability or improvement in quality of care	Receipt of timely care	 -0.8 percentage points (p>0.05)
		Influenza vaccination	 +0.2 percentage points (p>0.05)
		Dental exam	 -5.6 percentage points (p>0.05)
	Goal 4: Stabilize or reduce preventable acute hospital admissions	Potentially avoidable hospitalization	 -1.3 hospitalizations per 10,000 enrollee days (p>0.05)
	Goal 5: Demonstrate stability or improvement in consumer satisfaction	Satisfaction with MLTC plans	 -1.8 percentage points (p>0.05)
		Satisfaction with care managers	 -3.1 percentage points (p<0.05)
		Satisfaction with provider timeliness	 -2.2 percentage points (p>0.05)
		Satisfaction with service quality	 -1.2 percentage points (p>0.05)

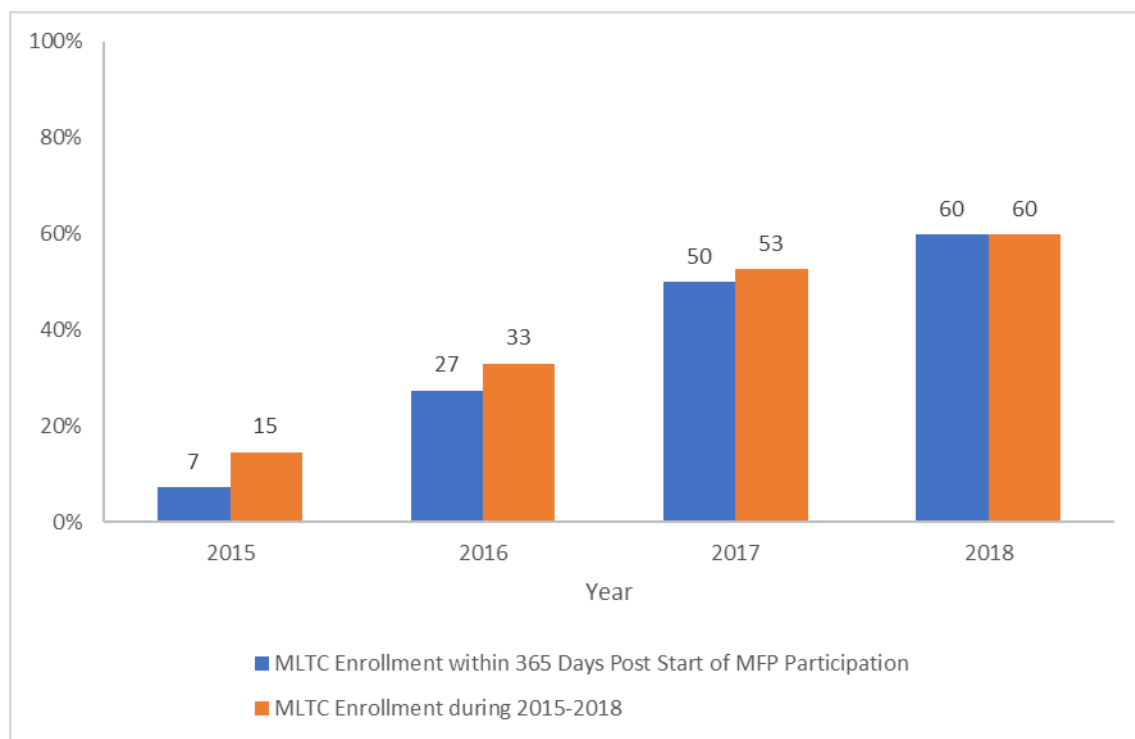
Domain 1, Component 2: Individuals Moved from Institutional Settings to Community Settings for Long-Term Services and Supports

Goal 1, Research Question 1: MLTC Enrollment Among MFP Participants

For those who transition from an institutional setting to the community, did the percentage enrolling in MLTC increase over the demonstration?

The percentage of MFP participants who were enrolled in MLTC, by year, are presented in Figure 21. MLTC enrollment increased rapidly from 2015 to 2018, from 7 percent to 60 percent for enrollment within 365 days of MFP participation, and from 15 percent to 60 percent for enrollment anytime during the study window. For individuals newly participating in MFP during 2015–2017, we found a statistically significant trend in MLTC enrollment among those who enrolled for the first time in MLTC within 365 days post-start of MFP participation ($p < 0.001$) and among those who enrolled in MLTC anytime during 2015–2018 ($p < 0.001$). The sample size of MFP participants was relatively small in 2015 (220). Because some individuals who participated in MFP in 2018 may have enrolled in MLTC in the second half of 2019, for which MLTC enrollment data were not available, 2018 was excluded from the trend tests.

Figure 21. Percentage of the MFP Population Enrolled in MLTC during 2015–2018



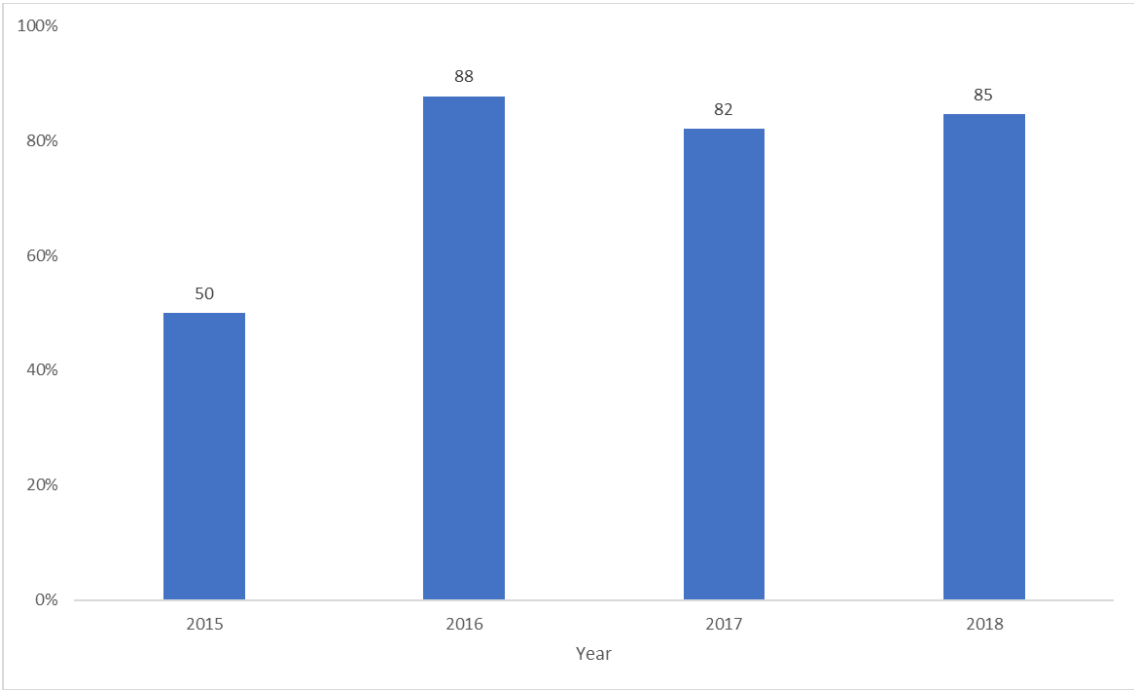
NOTE: The number of new MFP participants by year: 220 (2015), 354 (2016), 368 (2017), 478 (2018). A trend test was performed for 2015–2017 MLTC enrollment within 365 days post-start of MFP participation (Pearson's $\chi^2 = 120.760$, $p = 0.0001$) and MLTC enrollment during 2015–2018 (Pearson's $\chi^2 = 89.384$, $p = 0.0001$).

Goal 2 Research, Question 1: Emergency Room Visits among the HCBS Expansion Population

Is the percentage of the HCBS expansion population without any emergency room visits in the last 90 days stable or improving over the course of the demonstration?

The percentage of the HCBS expansion population who did not have an emergency room visit in the last 90 days was stable at 82 percent to 88 percent in the years 2016–2018 (Figure 22). The 2015 rate was lower, at 50 percent, as was the sample size (4 non-initial assessments). We did not find a statistically significant trend in the percentage of MFP participants who did not have an emergency room visit ($p=0.5892$).

Figure 22. Percentage of the HCBS Expansion Population without Any Emergency Room Visit in the Last 90 Days



NOTE: The number of latest non-initial MLTC assessments among MFP participants for analysis by year: 4 (2015), 57 (2016), 206 (2017), 447 (2018). A trend test for the years 2015–2018 was performed for MFP participants who did not have an emergency room visit (Pearson's $\chi^2 = 0.292$, $p = 0.5892$).

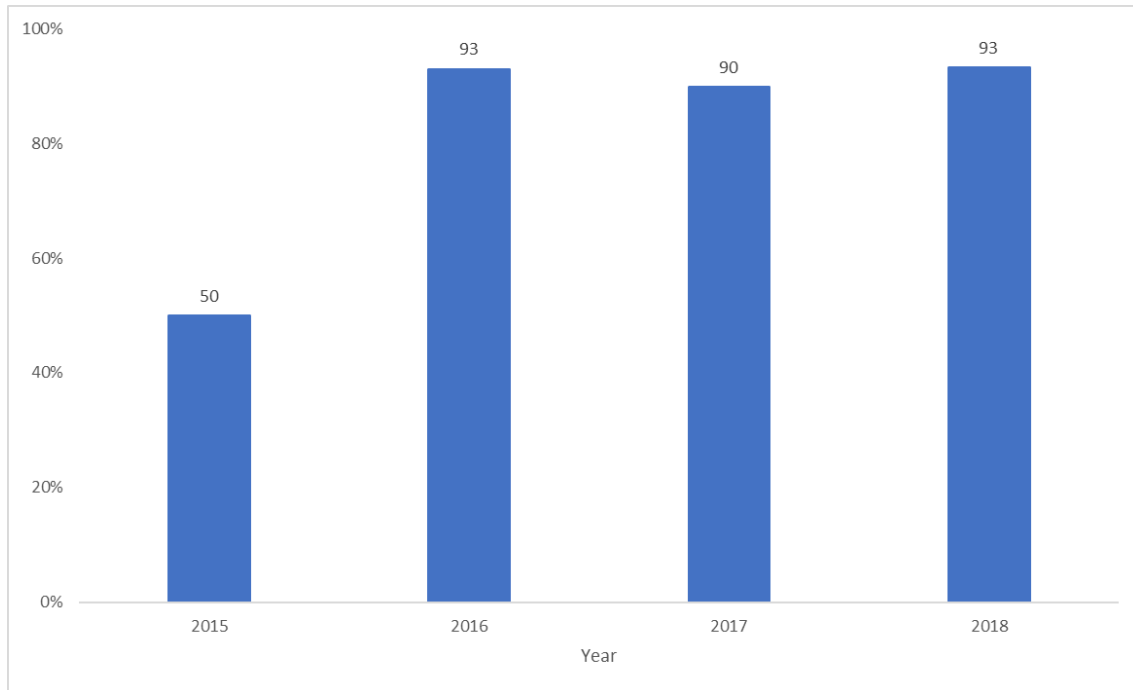
Goal 2, Research Question 2: Falls among the HCBS Expansion Population

Is the percentage of the HCBS expansion population without any falls, as defined by the department's fall measure, stable or improving over the course of the demonstration?

The percentage of the HCBS expansion population who did not have falls requiring medical intervention or resulting in major or minor injuries in the last 90 days followed a similar pattern (Figure 23). The rates were also stable at 90 percent to 93 percent in 2016–2018, with a lower

rate of 50 percent in 2015. Although the measure definition changed from falls requiring medical intervention in the 2018 UAS-NY CHA data to falls resulting in major or minor injuries, we did not observe a significant change in the measure in 2018 compared to 2016–2017. We tested but did not find a statistically significant trend in the percentage of MLTC enrollees who did not have a fall requiring medical intervention or resulting in major or minor injuries ($p=0.0777$).

Figure 23. Percentage of the HCBS Expansion Population without Any Falls Requiring Medical Intervention or Resulting in Major or Minor Injuries in the Last 90 Days



NOTE: The number of latest non-initial MLTC assessments among MFP participants for analysis by year: 4 (2015), 57 (2016), 206 (2017), 447 (2018). A trend test for the years 2015–2018 was performed for MFP participants who did not have a fall requiring medical intervention or resulting in major or minor injuries (Pearson’s $\chi^2 = 3.113$, $p = 0.0777$).

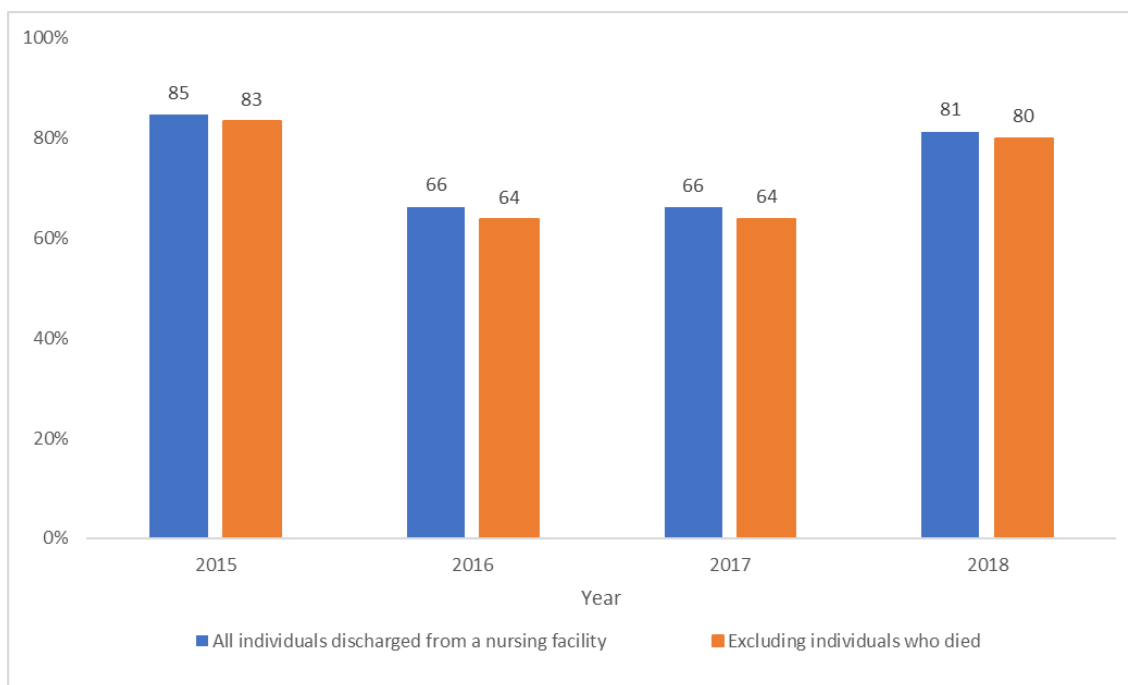
Goal 3 Research Question 1: Community Residence among the HCBS Expansion Population

For the HCBS expansion population who entered MLTC after transitioning from an institutional setting, what percentage return to the nursing home within a year of discharge, what was their average level of care need, and, for those who return within a year, how long on average did they reside in the community?

Overall, we found that the percentage of the HCBS expansion population who remained in the community in 2015 was higher, at 85 percent, than in 2016 and 2017 (both at 66 percent), and we found another increase in 2018 (see blue bars in Figure 24). The 2015 result has a smaller denominator (13 MFP participants), and the 2018 data are not complete because individuals re-institutionalized in the second half of 2019 were not included in the data. The sensitivity analysis

excluding those who died but were not re-institutionalized showed a similar pattern. We did not find a statistically significant trend in the rates during 2015–2017 for the main analysis ($p = 0.389$) or for the sensitivity analysis excluding those who died but were not re-institutionalized ($p=0.382$). We also examined the results by including those who died but were not re-institutionalized in the denominator but not in the numerator, assuming they re-entered a nursing facility. The results are 77 percent, 59 percent, 60 percent, and 75 percent for each of the four years, respectively (data not shown, $p=0.452$).

Figure 24. Percentage of the HCBS Expansion Population Who Remained in the Community for One Year Post Discharge from a Nursing Facility



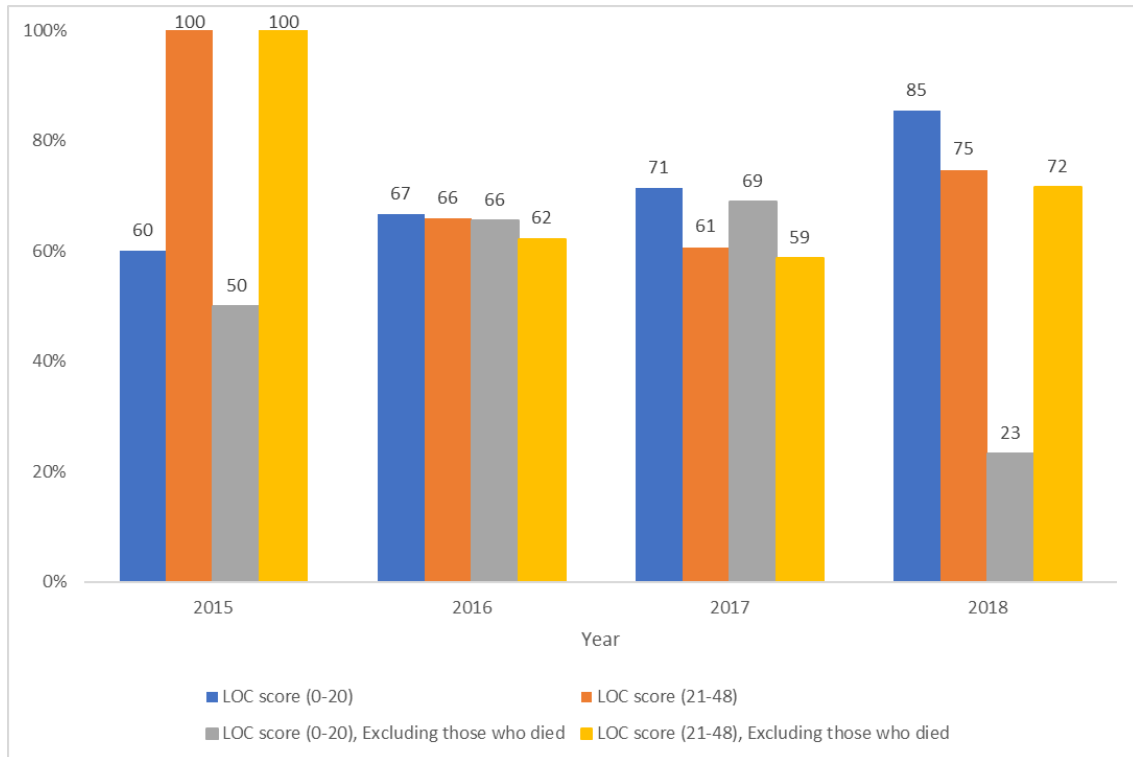
NOTE: The number of MFP participants for analysis by year: 13 (2015), 71 (2016), 124 (2017), 213 (2018), with the number of individuals who died before re-entering a nursing facility being: 1 (2015), 5 (2016), 8 (2017), 14 (2018). Trend test results for all individuals: Pearson's $\chi^2 = 0.805$, $p = 0.3891$; trend test results for the sensitivity analysis excluding those who died but were not re-institutionalized: Pearson's $\chi^2 = 0.765$, $p = 0.3819$. The year 2018 was excluded from trend analysis due to incomplete data.

Next, MFP participants who remained in the community for one year post-discharge were assessed by level of care (Figure 25). Trend tests were performed from 2015 to 2017 (2018 was excluded because of incomplete data) for all participants, as well as for the subgroup of participants excluding those who died prior to re-institutionalization.

MFP participants with a lower level of care score had a higher rate of remaining in the community during the study period, except for 2015; this is consistent in both the main analysis and the sensitivity analysis. There is large variation in the 2015 rates, which is likely due to small denominators. From 2016 to 2018, there may be an upward trend in the likelihood of remaining in the community; however, the 2018 data are incomplete, and this trend may not hold once the

data for the second half of 2019 are included. No statistically significant trends were found for each level of care category in either the main analysis or the sensitivity analysis.

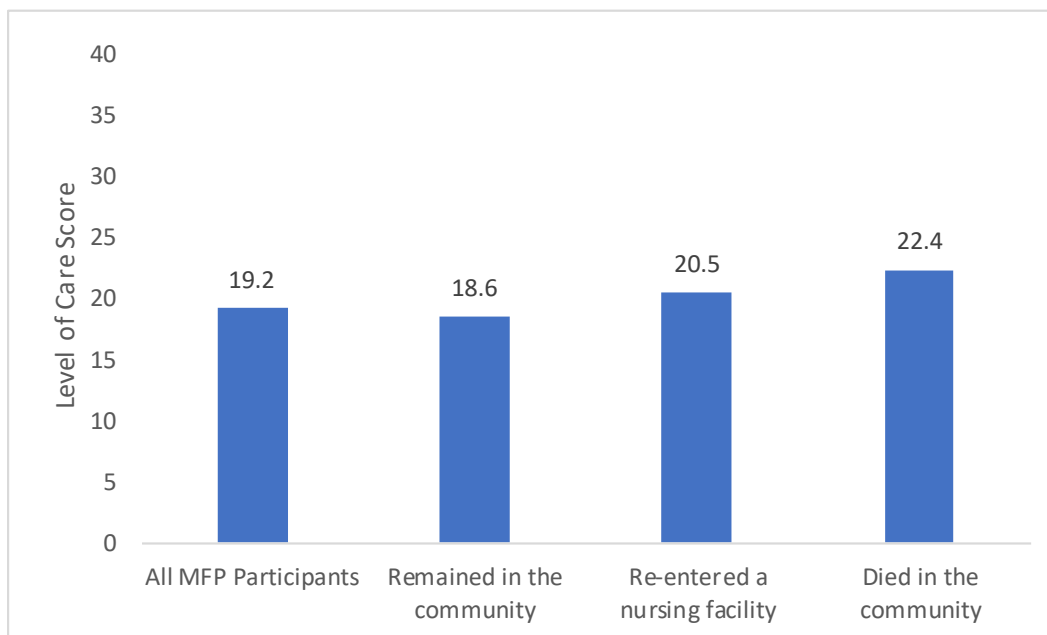
Figure 25. Percentage of the HCBS Expansion Population Who Remained in the Community for One Year Post Discharge from a Nursing Facility, by Level of Care



NOTE: LOC = Level of Care. The number of MFP participants for analysis by year: 13 (2015), 71 (2016), 124 (2017), 213 (2018), with the number of individuals who died before re-entering a nursing facility being: 1 (2015), 5 (2016), 8 (2017), 14 (2018). Trend tests performed for years 2015 through 2017 for LOC score 0–20 (Pearson’s $\chi^2 = 0.667$, $p = 0.5117$); LOC score 21-48 (Pearson’s $\chi^2 = 3.295$, $p = 0.0695$), LOC score 0–20 excluding those who died (Pearson’s $\chi^2 = 0.491$, $p = 0.4836$), and LOC score 21-48 excluding those who died (Pearson’s $\chi^2 = 3.174$, $p = 0.0748$).

As illustrated in Figure 26, overall, MFP participants had an average level of care score of 19.2. Participants who remained in the community for one year post-discharge from a nursing facility had the lowest average level of care score (18.6), whereas those who died but did not re-enter a nursing facility had the highest average level of care score (22.4). MFP participants who were re-institutionalized within one year post-discharge had an average level of care score between these two groups (20.5). The differences between different subpopulations are not statistically significant at the 5 percent level.

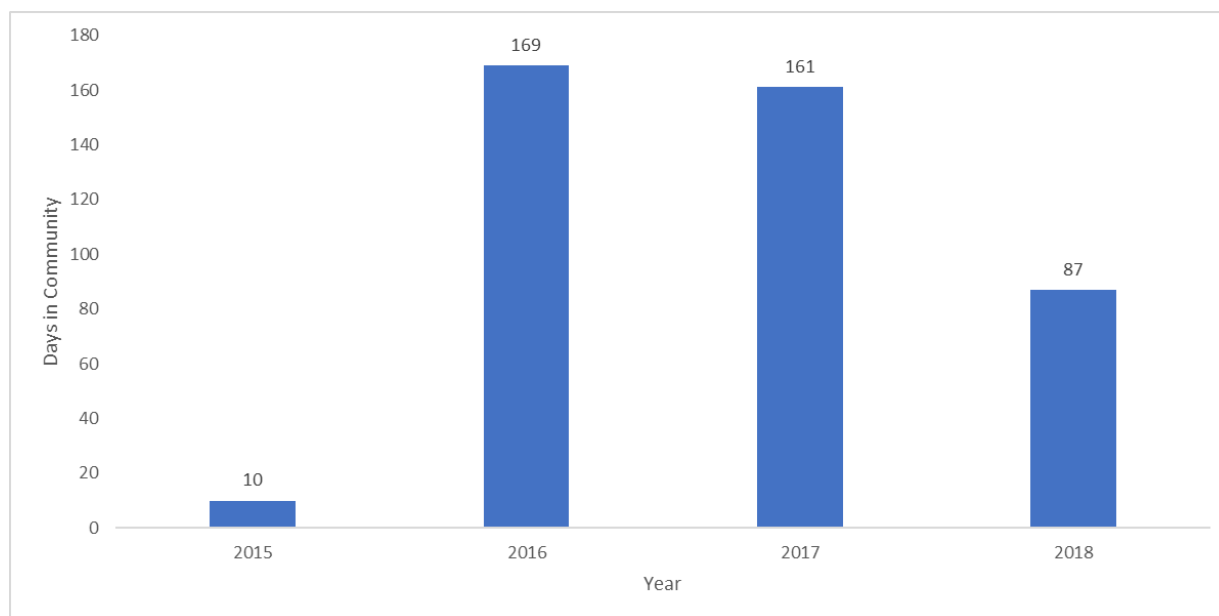
Figure 26. Average Level of Care Score for Those Who Remained in the Community Compared to Those Who Did Not within One Year Post Discharge from a Nursing Facility



NOTE: The number of MFP participants for analysis by group: 421 (all MFP participants), 313 (remained in the community for 365 consecutive days), 80 (re-entered a nursing facility within 365 days post discharge), 28 (died in the community). The standard deviation of level of care score is 8.9, 8.7, 8.6, and 10.6 for each of the four groups, respectively. Student t-tests were performed to compare those who remained in the community with those who re-entered a nursing facility ($t = 1.76$, $p = 0.0811$), those who remained in the community with those who died in the community ($t = 1.84$, $p = 0.0753$), and those who re-entered a nursing facility with those who died in the community ($t = 0.86$, $p = 0.3976$).

The average residency time in the community among MFP participants who were re-institutionalized was very small in 2015; there was only one participant who re-entered a nursing facility. The average residency time was similar between 2016 and 2017, at 169 and 161 days, respectively (Figure 27). The average residency time in the community was 87 days for 2018, but the data for that year were not complete. We tested and did not find a statistically significant trend in average residency time in the community for the years 2016–2017 among participants who returned to a nursing facility within one year post-discharge ($p=0.552$). The trend analysis excluded both 2015, due to sample size, and 2018, due to incomplete data.

Figure 27. Average Residency Time in the Community for the HCBS Expansion Population Who Returned to a Nursing Facility within One Year



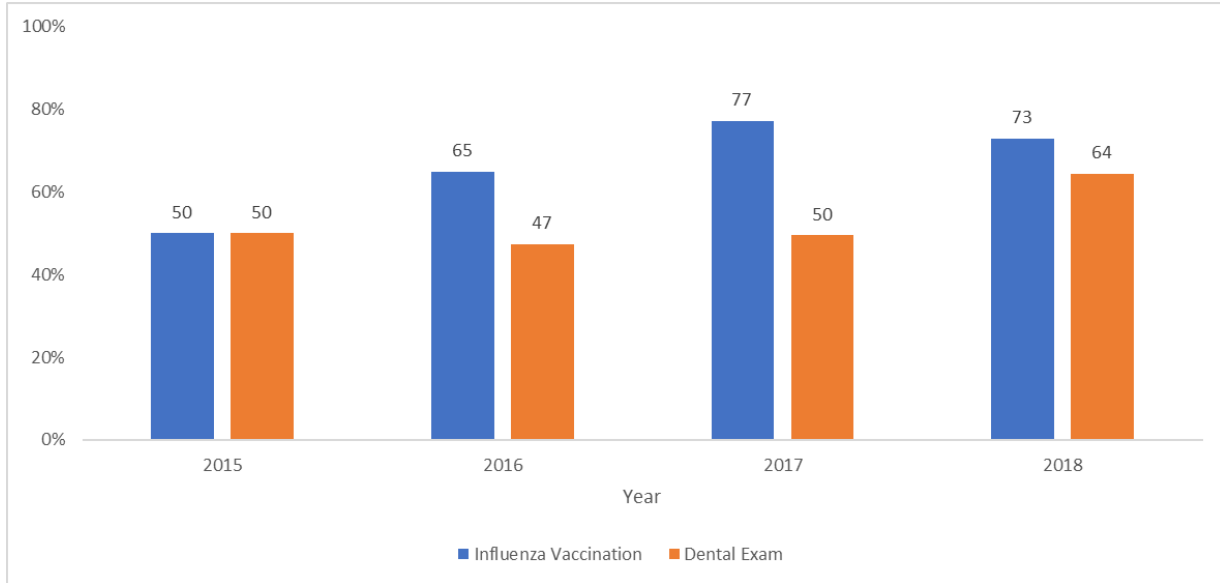
NOTE: The number of MFP participants included for analysis by year: 1 (2015), 19 (2016, standard deviation[SD] = 122 days), 34 (2017, SD = 107 days), 26 (2018, SD = 85 days). A trend test was performed for 2016–2017: Pearson's $\chi^2 = 0.354$, $p = 0.5519$. The year 2015 was excluded from the trend test due to its small sample size, and the year 2018 was excluded due to incomplete data.

Goal 3, Research Question 2: Preventive Services among the HCBS Expansion Population

Is the percentage of the HCBS expansion population accessing preventive care services, such as the flu shot and dental care, consistent or improving?

While there was a general increase in the proportion of the HCBS expansion population who self-reported receiving an influenza vaccination in the past year, from 50 percent in 2015 to 73 percent in 2018, most of that increase occurred by 2016 (Figure 28). Overall, the trend was not statistically significant ($p=0.553$). However, the proportion of the HCBS expansion population who self-reported receiving a dental exam in the last year showed a statistically significant increase from 2015 to 2018, from 50 percent to 64 percent ($p<0.001$).

Figure 28. Percentage of the HCBS Population Who Received an Influenza Vaccination or Dental Exam in the Last Year



NOTE: The number of latest non-initial MLTC assessments among MFP participants for analysis by year: 4 (2015), 57 (2016), 206 (2017), 447 (2018). Trend tests for 2015–2018 were performed for influenza vaccinations (Pearson’s $\chi^2 = 0.351$, $p = 0.5534$) and dental exams (Pearson’s $\chi^2 = 14.083$, $p = 0.0002$).

Domain 1, Component 2: Individuals Moved from Institutional Settings to Community Settings—Discussion and Conclusions

Since 2015, the MFP program has assisted Medicaid beneficiaries with MLTC enrollment. The proportion of MFP participants who were enrolled in an MLTC plan within 365 days post-MFP participation increased rapidly from 7 percent in 2015 to 60 percent in 2018. The actual MLTC enrollment among the individuals newly enrolled in MFP in 2018 was likely larger than 60 percent because some participants may not have enrolled until the second half of 2019.

Of note, additional participants enrolled in MLTC even after the end of the 365 days post-MFP participation, at which point the assistance from MFP ended. This is apparent for new MFP participants in 2015: 7 percent enrolled in MLTC within 365 days, but an additional 8 percent enrolled after the end of MFP assistance. MLTC enrollment increased by 6 and 3 percentage points after 365 days among 2016 and 2017 MFP participants, respectively.

The MFP program’s increasing impact on MLTC enrollment over time may have been a result of increased awareness of MLTC among both MFP transition specialists and Medicaid beneficiaries. It is conceivable that as transition specialists became more familiar with the MLTC program, they knew which individuals they should target. Similarly, individuals eligible for MLTC may have reached out to the MFP program as they became aware of its benefits.

Based on our communication with subject-matter experts on MFP and MLTC within the NYS DOH, aside from the inclusion of managed care as a qualified constituent program for MFP participation in 2015, there were no major policy changes during 2015–2018 regarding the MFP

implementation. But one relevant MLTC policy change could have played a role in the MLTC enrollment increase among MFP participants: the mandatory MLTC enrollment of new nursing home residents, which started in February 2015. From that point on, all individuals who were newly admitted to a nursing home after February 2015 had to enroll in an MLTC plan; when they were subsequently discharged, they were already in MLTC. This policy change could be associated with an increase in the proportion of MFP participants enrolled in an MLTC plan, although more evidence is needed to confirm such a hypothesis.

Overall, we did not observe a statistically significant change in patient safety measures during 2015–2018, including percentage without emergency room visits and percentage without falls that required medical intervention or resulted in major or minor injuries. The proportions of the HCBS expansion population without an emergency room visit or fall were about 85 and 90 percent, respectively, for 2016–2018, although these were lower in 2015, which could simply be due to the small number of members that year. The 2016–2018 results are consistent with our preliminary data for Domain 1, Component 1, of this 1115 Demonstration evaluation, which showed that among the general MLTC population, the proportion without an emergency room visit did not change significantly (89 percent in 2015 to 91 percent in 2018), nor did the proportion without falls (from 93 percent to 94 percent in 2015 and 2018, respectively).

The proportion of the HCBS expansion population remaining in the community seemed to be stable at about 66 percent during 2016–2017, and excluding participants who died without re-entering a nursing facility did not change the conclusions. It is possible that enrollment in MLTC is not necessarily associated with the community residence duration among individuals who transitioned from institutions to communities. Our evaluation has not addressed this, because of a lack of a comparison group and a lack of data prior to the inclusion of MLTC in MFP among this population.

When examining the results by the level of care needs, we found a non–statistically significant trend showing that a smaller percentage of MFP participants with a higher level of care needs stayed in the community compared with participants with a lower level of care needs. Conversely, when examining the level of care needs by subgroups, there was a non–statistically significant trend that MFP participants staying in the community for 365 days had the lowest level of care needs, followed by those re-entering a nursing facility and those who died without re-entering a nursing facility. But, likely due to small sample sizes, our statistical tests of these differences are not statistically significant at the 5 percent level. Compared with those with a lower level of care needs, it is not surprising that participants with a greater level of care needs are often more fragile, have a higher chance of re-entering a nursing facility, and have a higher mortality rate.

MFP participants who re-entered a nursing facility stayed on average slightly less than half a year in the community in both 2016 and 2017. The sample for 2015 MFP participants included only one observation, and the data for 2018 MFP participants were not complete. When the second half of the 2019 data are available, the number of days in the community could double,

reaching a level similar to that of 2016 and 2017. Thus, we found no evidence that the average residency time among the HCBS expansion population re-entering a nursing facility within one year post-discharge varied during the study period.







The proportion of the HCBS expansion population who reported the receipt of influenza vaccination in the last year was relatively stable at 65 percent to 73 percent during 2016–2018, whereas an increasing trend in the receipt of a dental exam was observed for the same time period, from 47 percent to 64 percent. Again, the denominator for 2015 was small, and thus the results are less reliable. The improvement in the dental exam measure may be attributed to the performance improvement project for MLTC enrollees during 2015–2018. This was a quality improvement initiative, implemented during this time period, that covered depression management, pain management, falls, advanced directives, emergency preparedness, and preventive screenings for eye, ear, and dental exams. MLTC plans had the option to choose one of the quality measures covered, but many of them selected preventive screenings for eye, ear, and dental exams. This initiative might be associated with the increased receipt of dental exams among MLTC enrollees.

There are two major limitations of our analysis. First, the results are descriptive in nature. Per the evaluation plan approved by CMS, the data were limited to state aggregated outcomes by plan, and we were therefore not able to estimate multivariable regression models to control for individual-level characteristics such as demographics and health status. Without multivariable analyses, the results we obtained may be biased by potential confounders. For example, we concluded that the proportion of the HCBS expansion population remaining in the community was similar across 2016–2017. If, hypothetically, the MFP participants in 2017 were sicker for some reason, the proportion in 2017 may be higher than what we observed after adjusting for participants' health status. Second, our data did not cover the pre-MLTC mandate period (prior to 2012) or the mandate implementation period (2012–2015). That is, we were not able to draw any conclusions regarding the association between the MLTC mandate and various outcome measures examined here. The results we observed were general time trends only, and they are limited by a small sample size in 2015 and incomplete data for 2018.

Summary

From 2015 to 2018, the proportion of MFP participants enrolled in an MLTC plan increased rapidly, and we found no evidence of a decline in patient safety and quality of care measures (Table 8). These outcomes remained stable except for the significant increase in the proportion of the HCBS expansion population receiving a dental exam, which may be attributed to a quality improvement project with a focus on preventive screenings for eye, ear, and dental exams.

Table 8. Summary of Evaluation Results for Domain 1, Component 2

Domain	Goal	Outcome	Results
Domain 1, Component 2: Individuals Moved from Institutional Settings to Community Settings for LTSS	Goal 1: Improve access to MLTC for those who transitioned from an institutional setting to the community	Enrollment in MLTC within one year post discharge from an institution	 7% in 2015; 60% in 2018 (p<0.05)
	Goal 2: Stability or improvement in patient safety	Percentage without emergency room visits	 50% in 2015; 85% in 2018 (p>0.05)
		Percentage without falls requiring medical intervention or resulting in major or minor injuries	 50% in 2015; 93% in 2018 (p>0.05)
	Goal 3: Stability or improvement in quality of care	Percent in community within one year post discharge from an institution	 85% in 2015; 81% in 2018 (p>0.05)
		Influenza vaccination	 50% in 2015; 73% in 2018 (p>0.05)
		Dental exam	 50% in 2015; 64% in 2018 (p<0.05)

Domain 2: Mainstream Medicaid Managed Care

There has been delay in completing the tasks under Domain 2, Goal 2: 12-month continuous eligibility. We have obtained access to all the data needed to answer the research questions except for health care utilization and cost data, and medical diagnoses required to answer Research Question 5. We are currently in the process of cleaning the data and constructing an analytic file. Domain 2 results will be presented in the final interim evaluation report, a complete draft of which is expected to be delivered in spring 2021.

The delay is mostly due to our inability to access the data. From March 2020 to date, the COVID-19 pandemic in NYS has consumed considerable time, attention, and resources at NYS DOH. As a result, there has been a delay in getting access to relevant data sources to complete the analysis on timelines proposed prior to the COVID-19 pandemic. Working with NYS DOH, we are continuing to make progress toward data sharing, analysis, and interpretation of all the remaining research questions. A proposed timeline to accomplish the remaining data access and analysis tasks is presented below.

Proposed Timeline

November 2020

December 2020

January 2021

February 2021

March 2021

April 2021

Remaining Tasks

Complete data access

Data processing

Data analysis

Draft report to NYS DOH

Quality assurance

Final report to CMS

5. Policy Implications

The broad goals of the Medicaid Section 1115 Waiver are to enroll a majority of Medicaid beneficiaries into managed care, increase access and service quality, and expand coverage to more low-income New Yorkers. Similarly, the MLTC program aims to increase managed care enrollment among individuals eligible for LTSS and improve patient safety and quality of care. Given the rapid increases in MLTC enrollment, there might be concerns over patient safety and quality of care, and this interim evaluation intends to shed some light on relevant questions. In this chapter, we discuss our findings on enrollment, patient safety, and quality of care and their implications for the overall MLTC population and for those who were transitioned from institutions to the community.

MLTC Enrollment

The MLTC mandate increased enrollment with the program rapidly and dramatically. Within 20 months of the implementation of the mandate, its impact on statewide enrollment stabilized at a growth rate of about 0.2 percent per month, or 2.4 percent per year. Increases in enrollment and the time to enrollment stabilization differed across regions, however, suggesting that idiosyncratic factors may have affected implementation across the state. New York City, for which the mandate was implemented first, drove the results. Enrollment increases in each of the other regions occurred more slowly, which could be due to lower pre-mandate enrollment rates in these regions or differences in enrollment capacity across the state.

The very large and rapid increases in enrollment, particularly in New York City, show that the mandate was able to substantially expand MLTC. These large increases in enrollment could have stressed existing or new MLTC plans, raising concerns about the quality of services provided following the mandate. These concerns highlight the importance of the remaining components of the evaluation. Nevertheless, this evaluation found that mandating enrollment in MLTC successfully scaled up the MLTC program to include a large share of the potentially eligible population.

Patient Safety and Quality of Care

Policymakers may have concerns over patient safety and quality of care given the large increases in MLTC enrollment. First, as mentioned above, it could be difficult for MLTC plans to manage the increased number of enrollees and ensure the quality of LTSS. Second, there was a change in the financial incentives as individuals transitioned from FFS to MLTC for LTSS. For example, plans have incentives to reduce the quality of care covered under MLTC, such as the receipt of dental services. Third, there might be spillover effects on medical utilization, such as

emergency room visits, medical interventions for falls, and potentially avoidable hospitalizations: Better management of LTSS may improve safety (e.g., reductions in falls) and health outcomes (e.g., fewer avoidable hospitalizations), but, among MLTC plans that are responsible for health care costs not covered by Medicare (e.g., PACE, MAP, and FIDA plans), there may be an incentive to reduce access to medical care services.

However, our examination of patient safety (without emergency room visits and without falls) and quality of care (influenza vaccinations, dental exams, and potentially avoidable hospitalizations) found no evidence of significant changes in these key measures. Such results may be affected by the annual public reporting of patient safety and quality of care measures by NYS DOH. For branding and reputation reasons—MLTC plans have to compete for enrollees—MLTC plans may want to ensure that their publicly reported measures look good.

The evidence from this evaluation, however, is weakened by important data limitations, which reduced statistical power and precluded stronger designs. For example, risk-adjusted outcomes data aggregated to the plan level by mandated enrollment status would have allowed a direct comparison of outcomes for those who enrolled via the mandate and those who voluntarily enrolled. Our models identified how risk-adjusted outcomes data aggregated to the statewide plan level varied by the percentage of the plan's enrollment that was mandated. Because of the importance of patient safety and quality of care, stronger empirical designs should be considered for future evaluations.

Consumer Satisfaction

Changes in the marketplace resulting from the large increases in MLTC enrollment, including the consequences of altered financial incentives, as well as additional administrative burdens for the plans or for consumers, raise concerns about consumers' ability to obtain timely care and their satisfaction with MLTC plans, case managers, and care providers. Again, the same factors affecting patient safety and quality of care discussed above, including public reporting, can apply to consumer satisfaction as well. Overall, satisfaction measures remained high with MLTC, with little evidence of decline. Only satisfaction with case managers fell statistically significantly, and although each of the other measures declined, none were substantively or statistically significant. Thus, results indicate that MLTC plans were able to accommodate the large increases in enrollment without noticeably compromising consumer satisfaction with care. As above, statistical power and causal inference were limited by data availability for the evaluation. Nevertheless, this evaluation found very limited evidence that the large increase in MLTC due to the implementation of mandatory MLTC enrollment resulted in reductions in patient safety, quality of care, or consumer satisfaction with care.

MLTC for the HCBS Expansion Population

The HCBS expansion population is a subset of MLTC enrollees who were transitioned from institutional to community settings. Because institutional care is often much more expensive than community-based care, this is an important population to examine, especially if the transition to the community can be facilitated by programs such as MFP. Concerns are legitimate over who should be eligible for transition, and whether patient safety and quality of care are affected after transition. In addition, enrollment in MLTC plans after transition adds an additional layer of complexity.

This evaluation only examined the trends among this HCBS expansion population after the policies were implemented and without a comparison group; therefore, our results are only descriptive in nature, and there are several important questions that remain unanswered. There were no significant changes in patient safety measures (without emergency room visits or without falls requiring medical intervention or resulting in major or minor injuries), and a significant majority or more (65–85 percent) of the HCBS expansion population remained in the community within one year post-discharge. Although we are unable to compare these results with those from an appropriate control group, the fact that residents were able to remain in the community for more than five months during 2016 and 2017, for which data were complete, is encouraging. Interestingly, there was a statistically significant increasing trend in receipt of dental exams, which might be a consequence of the performance improvement project for MLTC enrollees during the study period. Questions remain, however, about whether MLTC has affected patient safety and quality of care among this subpopulation of MLTC enrollees; whether such an effect differs from that in the overall MLTC population; the extent to which MFP has played a role in the results we observed; whether the combination of MFP and MLTC improved the efficiency in delivering LTSS; and how the performance improvement project interacted with MLTC.

Policy Implications

An overarching question is whether the Medicaid Section 1115 Waiver Demonstration, specifically the mandatory MLTC enrollment, has achieved its three goals of broadening access, increasing quality, and expanding coverage to more low-income New Yorkers. This interim evaluation assessed the first two goals. We observed a large and rapid increase in MLTC enrollment during 2012–2018, with about two-thirds of the mandate’s effect realized in the first 19 months post-mandate, but we did not find evidence of a decline in patient safety, quality of care, and consumer satisfaction. From a policymaker’s perspective, increasing access without compromising care quality is certainly a win.

A further question is whether the MLTC program has improved efficiencies in spending. Although this third goal is not covered in this interim evaluation, this is an important question to policymakers. It is plausible that MLTC generates efficiencies in spending. Because MLTC

plans are paid on a capitated basis, they are incentivized to keep cost down. In particular, individuals newly admitted to nursing homes were required to enroll in MLTC during 2015–2018. MLTC plans would strive to keep nursing home eligible individuals in the community since nursing home care costs much more than HCBS does. If MLTC were more efficient in spending, the state would have more resources to expand coverage and access.

One possible unintended consequence of managed care is decreased quality of care, and the disclosure of quality measures could be one way to address the concern. In fact, the state publishes annual MLTC reports. Another approach is to utilize quality assurance programs. The performance improvement project is such an example. Every MLTC plan has to participate and work on one of the quality measures selected by NYS DOH. Public reporting of quality of care leverages the market mechanism to ensure the level of quality because plans have to compete for consumers; whether it can improve or stabilize quality of care hinges on the assumption that consumers need quality information to choose a plan and know where to find such information. In contrast, quality assurance programs utilize administrative processes, the success of which depends on their implementation. Of course, both public reporting of care quality and quality assurance programs could increase MLTC plans' operating cost. It is unclear to what extent public reporting of quality and quality assurance programs have affected patient safety and quality of care. Future evaluations may examine this question and give a definitive answer.

Summary

Our analyses suggest that the MLTC program under the demonstration has achieved its goal of increasing access to LTSS via MLTC, as illustrated by the rapid expansion of MLTC across the state from 2012–2018. There is little evidence suggesting that the rapid expansion has led to a significant change in patient safety, as measured by without emergency room visits and without falls requiring medical interventions or resulting in major or minor injuries, and quality of care, as measured by timeliness of care access, preventive screenings, potentially avoidable hospitalizations, and consumer satisfaction. It is important to note, however, that the evidence from this evaluation's Domain 1 objectives is weakened by important data limitations, which reduced statistical power to detect the impacts of the MLTC mandate on outcomes.

In brief, the state has achieved the demonstration's first goal—expanding access. We did not find evidence to support the second goal—improving quality of care—but increasing access without compromising quality of care is a success in its own right. Questions remain about whether the MLTC mandate has achieved the third goal of the demonstration—generating efficiencies in spending—and the extent to which public reporting and quality assurance programs have affected quality of care. Future evaluations may be conducted to answer these questions to guide state policies.

6. Interactions with Other State Initiatives

Other State Initiatives

The Performance Improvement Project for MLTC Plans

The Quality Strategy for the New York State MMC program is a requirement of New York State's 1115 Waiver to ensure the quality of care of Medicaid managed care plans (NYS DOH, 2018). As part of the Quality Strategy Program, starting in 2015, each year, all MLTC plans are required to participate in the Performance Improvement Project (PIP). Plans can choose one of the approved PIP topics, work with an external quality review organization as well as NYS DOH, develop and conduct an intervention to improve the quality of care on the chosen topic, collect data, and submit a final report. PIP topics include both clinical and non-clinical areas. For example, the 2015–2016 PIP topics included depression management, pain management, falls, advanced directives, emergency preparedness, and preventive screenings such as eye, ear, and dental exams. Influenza and pneumonia immunizations, emergency room visit and hospitalization reduction, and diabetic care were added to 2017–2018 PIP topics, but pain management and emergency preparedness were dropped.

The Federal Money Follows the Person Rebalancing Demonstration Program

In 2007, the federal Money Follows the Person Demonstration grants, authorized first by the 2005 Deficit Reduction Act and then by the 2010 Affordable Care Act, were secured by the state to shift LTSS delivery from institutional services to HCBS. This program helps Medicaid beneficiaries transition from institutions to communities by providing information about options for living in the community, identifying services and supports available in the community, and checking in with beneficiaries on a regular basis after the transition. See more details in Chapter 2 of this interim report.

The Long-Term Home Health Care Program

The Long-Term Home Health Care Program is a 1915(c) waiver to provide HCBS to individuals who would otherwise stay in a nursing facility (NYS DOH, 2012a). The goal was to allow eligible individuals to stay in the community, prevent institutionalizations, and avoid costly medical events. The waiver was initially approved by CMS in 1983 and needed to be renewed every five years. The most recent renewal required new policies and procedures in place to improve care planning, participant choice and satisfaction, and quality of care, and to provide case management by registered nurses.

To qualify for the program, individuals were required to be eligible for Medicaid, need a nursing facility level of care, and obtain physician approval that they would be able to remain at home medically. The program was terminated in 2013, and all non-dually eligible participants in the program were required to be transitioned to a mainstream MMC or an MLTC plan if available (NYS DOH, 2013b). The dually eligible participants who were 21 years or older and needed LTSS for more than 120 days were required to join an MLTC plan.

Other HCBS-Related Initiatives

There are several other HCBS-related state initiatives, including the Nursing Home Transition and Diversion Medicaid Waiver, the Traumatic Brain Injury Waiver, the Office for People with Developmental Disabilities Comprehensive Waiver, and the Community First Choice Option. The first three initiatives are 1915(c) waivers. The Nursing Home Transition and Diversion Medicaid Waiver provides HCBS services, including community transitional services, moving assistance, and home-delivered meals, to individuals 65 years and older or those age 18–64 with physical disabilities; the goal is to help beneficiaries transition to and stay in the community or avoid institutional services (diversion) (NYS DOH, 2008). The Traumatic Brain Injury Waiver provides HCBS to help individuals, age 18–64, upon application, with a traumatic brain injury transition from institutional care or stay in the community (NYS DOH, 2009). The Office for People with Developmental Disabilities Comprehensive Waiver provides community habilitation, live-in caregiving, and other supports to individuals with autism, intellectual disabilities, or developmental disabilities (NYS DOH, 2020c). However, the populations covered under these 1915(c) waivers are excluded from MLTC.

The Community First Choice Option was authorized by the Affordable Care Act and provides HCBS services to individuals eligible for the state plan, such as assistance with activities of daily living, improving and maintaining individual skills to accomplish activities of daily living, and care management (Centers for Medicare and Medicaid Services, 2015). Participants must need an institutional level of care and be eligible for HCBS under the state plan. Participants are not excluded from receiving services from other HCBS programs, but they should not receive duplicative services. So far, New York State has implemented only part of the waiver.¹⁵

Initiatives That May Affect Patient Safety, Quality of Care, and Consumer Satisfaction

There are initiatives under the Affordable Care Act or the Medicare Access and CHIP Reauthorization Act that have likely affected patient safety and quality of care among individuals enrolled in MLTC, such as provisions that incentivize providers or insurers to improve quality of care. In particular, the state launched the Delivery System Reform and Incentive Payment Initiative, authorized by CMS as part of the state's Medicaid Section 1115 Waiver in 2014

¹⁵ Based on our communication with NYS DOH as of October 23, 2020.

(Weller et al., 2019). The initiative aimed to invest \$6.4 billion to reduce avoidable hospital use by 25 percent during 2014–2019. The initiative uses incentive payments to promote delivery system transformation and improve clinical quality of care and population health.

Interactions with Other State Initiatives

All MLTC plans are required to participate in the PIP initiative, and these plans conduct various interventions to improve their operation through improving care coordination, increasing the utilization of assessment and home visits, and educating care managers (NYS DOH, 2018). These interventions could potentially affect the outcomes of interest in this evaluation. For example, during 2017–2018, according to our communication with NYS DOH, 6 (16 percent), 8 (22 percent), and 9 (24 percent) out of 37 plans selected falls, preventive screenings (eye, ear, and dental exams), and emergency room visit and hospitalization reduction, respectively. In other words, the PIP initiative could contribute to the data we observed. A visual inspection of the descriptive figures in Domain 1 does not indicate a significant trend in the improvement of outcome measures, except the dental exam among the HCBS expansion population, and neither do our regression results.

The MFP program provides assistance to individuals transitioning from an institution to the community and helps eligible individuals enroll in an MLTC plan or other qualified constituent programs. In this regard, the MFP program could increase MLTC enrollment. However, given the relatively small number of beneficiaries served (3,259 during 2009–2020)¹⁶ and the large MLTC enrollment (245,973 as of 2018), the overall impact on MLTC might not be significant.

Since the MLTC mandate implementation started in September 2012—and the Long-Term Home Health Care Program was terminated in 2013, and all dually eligible participants in the program were required to transition to MLTC—we do not expect it to have affected the data we observed, except that MLTC enrollment increased during the transition period. Similarly, other 1915(c) waivers are unlikely to affect MLTC because the populations served do not overlap with that of the MLTC program. The Community First Choice Option initiative is unlikely to have affected MLTC because it has been implemented partially.¹⁷

Finally, the value-based care initiatives under the Affordable Care Act, the Medicare Access and CHIP Reauthorization Act, and the Delivery System Reform and Incentive Payment Initiative could have impacted outcomes related to patient safety and quality of care. For example, emergency room visits, potentially avoidable hospitalizations, and influenza vaccination could be part of value-based payment initiatives, although the impact of these initiatives on outcomes among the MLTC population is difficult to quantify. Given the MLTC data limitations, we were not able to tease out the effect of these initiatives in our estimates.

¹⁶ Based on the unpublished materials provided by NYS DOH in June 2020.

¹⁷ Based on our communication with NYS DOH in October 2020.

Appendix

Data Sources

Data Source	Description
MLTC enrollment data	The data contain 2010–2018 MLTC enrollment by county, by month, and by plan name and plan type. ¹⁸
American Community Survey population estimates	The American Community Survey provides 5-year rolling average population estimates for 2010–2018. To construct the denominator for the MLTC enrollment analysis, we used the population aged 65 and older living below 100% of the federal poverty level generated from the 5-year pooled files. ¹⁹
Medicaid Data Warehouse ²⁰	This data set includes Medicaid eligibility data, managed care enrollment, and encounter and payment data. In addition, it includes Clinical Risk Group that reflects an individual’s clinical risk.
Minimum Data Set (MDS 3.0)	MDS 3.0 is a federally required standardized, comprehensive assessment for all residents of long-term care facilities. It includes demographic information, as well as measures of health status and functional capability.
MLTC satisfaction data	In 2007, NYS DOH, in consultation with the MLTC plans, developed a satisfaction survey of MLTC enrollees. The survey was field tested and is now administered by NYS DOH’s external quality review organization, Island Peer Review Organization. NYS DOH sponsors the biennial MLTC satisfaction survey, which contains three sections: health plan satisfaction; satisfaction with select providers and services, including timeliness of care and access; and self-reported demographic information.
Money Follows the Person (MFP) master data	In January 2007, CMS approved New York’s application to participate in the MFP 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, such as nursing facilities and intermediate care facilities, into qualified community-based settings.

¹⁸ 2009–2011 files: NYS DOH, 2013a. 2012–2018 enrollment files: NYS DOH, 2020b.

¹⁹ U.S. Census Bureau, 2019.

²⁰ Descriptions are from the RFP for this work (NYS DOH, 2019a) Redesign Team, Section 1115 Demonstration.

Data Source	Description
Semi-Annual Assessment of Members (SAAM) ²¹	The MLTC plans were required to collect and report to the NYS DOH information on enrollees' levels of functional and cognitive impairment, behaviors, and clinical diagnoses. SAAM is a modified version of the Federal (Medicare) Outcome and Assessment Information Set (OASIS-B) and was utilized from 2005 to 2013. This information was collected at enrollment and then semi-annually thereafter or following any significant event. Effective October 1, 2013, the UAS-NY CHA replaced the SAAM.
Statewide Planning and Research Cooperative System (SPARCS)	SPARCS is an all-payer hospital database in NYS. UAS-NY records can be matched to SPARCS data.
Uniform Assessment System for New York (UAS-NY) Community Health Assessment Data (CHA)	MLTC plans are required to collect and report to NYS DOH information on enrollees' levels of functional and cognitive impairment, behaviors, and clinical diagnoses. The UAS-NY CHA is based on the InterRAI suite of assessment instruments. It is administered to MLTC enrollees in both facilities and in the community. This information is collected at enrollment and then semi-annually thereafter.

Regression Methods

Domain 1, Component 1, Goal 1: MLTC Enrollment

For the regression analysis of the MLTC enrollment, we specified the following model. Let Y_{jt} denote the enrollment for county j in month t , where

$$Y_{jt} = \alpha_j I_j + q(t; \beta) + S(s; \gamma) \quad \text{Equation (1)}$$

In the above equation, Y_{jt} is the MLTC enrollment rate in region j in month t ; I is a vector of indicator variables that identify regions, and the parameters α are the region-level fixed effects estimates; $q(t; \beta)$ is a flexible function of calendar time (t) and parameters (β). In our specification, calendar time was specified in months, which is a natural choice to delineate non-parametric trends given the nature of our data. $S(s; \gamma)$ is a function of time in months since MLTC enrollment became mandatory (s) and parameters (γ), allowing us to characterize the transition period from implementation until the policy's full effect (or steady state) is achieved. Note that the time at which MLTC became mandatory varied across the state, so s and t are not linearly dependent and the effects of each can be identified. For example, if t is specified in months and the mandate became effective in a region in $t = 4$, then $s = 1$ in month 4 for that region, $s = 2$ in month 5, and so on. Note that indicators for mandatory regions vs. non-mandatory regions and for the post-mandate time period are not needed in Equation (1), because they are absorbed in I and $S(s; \gamma)$, respectively. The parameter vector γ characterizes the difference-in-differences estimate of the mandate's effect on the MLTC enrollment in s . By

²¹ Description adapted from the NYS DOH webpages on MLTC Policy 13.09 (NYS DOH, 2019c) and 13.09(a) (NYS DOH, 2019d).

specifying $S(s; \gamma)$ as a flexible function of s , γ can characterize the policy effect smoothly over time since implementation, allowing us to derive the length of time it took (on average) for the enrollment to stabilize.

Domain 1, Component 1, Goal 2–5: Patient Safety, Quality of Care, and Consumer Satisfaction Among the MLTC Population

The statistical model for the analysis of patient safety, quality of care, and consumer satisfaction was specified as

$$Y_{jt} = \beta_M M_{jt} + \gamma_j + \epsilon_{jt} \quad \text{Equation (2)}$$

where Y_{jt} is the difference between a risk-adjusted outcome for plan j in time-period t and the statewide average outcome across all plans in time-period t ; M_{jt} is a measure of the fraction of a plan's total enrollment that is subject to mandatory enrollment in the six months prior to t ; γ_j is a fixed effect for plan j ; and ϵ_{jt} is an error term.

Because Y_{jt} was constructed as the difference between the statewide average score across plans and a plan's score for each outcome and for each year, the mean of Y_{jt} across plans in each year is zero by construction. Thus a meaningful time-effect cannot be identified in any comparisons of Y_{jt} over time. In addition, we did not use analytic weights based on the plan size in terms of the number of enrollees. We aimed to examine how the variation in the fraction of enrollees under the mandate is associated with outcomes. Most of the enrollees are in the New York City region and plans in the region are large, so using analytic weights that account for the number of enrollees in each plan would lead to the dominance of New York City plans. Instead, the same weight for each of the observations should be used to allow the variation in the fraction of enrollment under the mandate in order to identify the mandate's effect on outcomes. One concern of not using analytic weights may be heteroskedasticity in the error term, which could result in incorrect standard error estimates. To resolve this concern, we estimated Huber-White standard errors, clustered at the plan level (Huber, 1964).

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