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# Florida Medicaid Reform Evaluation Plan

2011 – 2014

## I. Background

### A. Synopsis of the Waiver

Florida's Medicaid Reform program is a comprehensive demonstration that seeks to improve the value of the Medicaid delivery system. The program is operated under an 1115 Research and Demonstration Waiver initially approved by the Centers for Medicare and Medicaid Services (Federal CMS) on October 19, 2005. State authority to operate the program is located in section 409.91211, Florida Statutes (F.S.), which authorizes a statewide pilot program with implementation that began in Broward and Duval counties on July 1, 2006. The program expanded to Baker, Clay, and Nassau counties on July 1, 2007.

On June 30, 2010, the Agency for Health Care Administration (Agency) submitted a 3-year waiver extension request to maintain and continue operations for the period July 1, 2011 through June 30, 2014. Federal CMS approved the 3-year waiver extension request on December 15, 2011. The waiver extension period is December 16, 2011 through June 30, 2014.

Under the Medicaid Reform Demonstration, most Medicaid eligibles are required to enroll in a managed care plan as a condition for receiving Medicaid. Participation is mandatory for TANF-related populations and the aged and disabled with some exceptions. The Demonstration allows health plans to offer customized benefit packages and reduce cost sharing, although each plan is required to cover all mandatory services and all State plan services for children and pregnant women.

### B. Key Components and Objectives of Medicaid Reform

Under the Demonstration, Florida expects to gain valuable information about the effects of allowing market-based approaches to assist the State in its service to Medicaid recipients. Key components of the Medicaid Reform Demonstration include:

- Comprehensive Choice Counseling,
- Customized benefit packages,
- Enhanced benefits for engaging in healthy behaviors,
- Risk-adjusted premiums based on enrollee health status, and
- Low Income Pool.

As described in Special Terms and Conditions (STCs) #30 - #34 of the Reform Demonstration renewal, Choice Counseling services are to provide enrollees with full and complete information about managed care plan choices, including information on

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benefits and benefit limitations, cost-sharing requirements, network information, contact information, performance measures, results of consumer satisfaction reviews, and data on access to preventive services. Choice counseling and enrollment information are available on the Agency website and by phone.

Special Terms and Conditions #35 - #39 describe the requirements and standards for customized benefit packages. While fee-for-service Provider Service Networks (PSNs) are required to provide all benefits for all enrolled beneficiaries as are available under the State plan, capitated plans may provide customized benefit packages for Demonstration enrollees. Customized benefit packages are required to include all mandatory services specified in the State plan for all populations but may alter the amount, duration, and scope of optional services to reflect the needs of the plan's target population. Plans may also offer additional services and benefits not available under the State plan. Customized benefit packages are required to include all State plan services available under the State plan for pregnant women and children, including all EPSDT services for children under age 21.

As described in STCs #40-#46, the Enhanced Benefits Account Program provides incentives to Medicaid Reform enrollees for participating in particular activities that promote healthy behaviors, such as health screenings, preventive care services, disease or weight management, and smoking cessation programs. Enrollees may earn up to \$125.00 in credits per state fiscal year and may use those credits to purchase approved health-related products and supplies at Medicaid-participating pharmacies. Individuals who lose Medicaid eligibility or are no longer enrolled in a Reform plan retain access to any unspent credits for a maximum of one year, unless the Demonstration or the Enhanced Benefits Account Program is terminated.

The Low Income Pool (LIP), described in STCs #51-#59, is a pool of funds that supports safety net providers that furnish uncompensated care to the Medicaid, underinsured, and uninsured populations. The LIP has a maximum annual allotment of \$1 billion for each year of the Demonstration extension. Federal CMS has established Tier-One and Tier-Two Milestones for the LIP during the Demonstration extension, which are outlined in STCs #60-#62. Both Tier-One and Tier-Two Milestones are to be aligned with the overarching goals of CMS' Three-Part Aim: better care for individuals including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity; better health for populations by addressing areas such as poor nutrition, physical inactivity, and substance abuse; and reducing per-capita costs.

- Tier-One Milestones include the development and implementation of a State initiative that requires Florida to allocate \$50 million in total LIP funding in Demonstration Years 7 and 8 to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. Other Tier-One Milestones include the State's timely submission of LIP reconciliations and Demonstration deliverables, as well as the development and annual submission of a "Milestone Statistics and Findings Report" and a "Primary Care and Alternative Delivery Systems Expenditure Report."

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- Tier-Two Milestones apply to the 15 hospitals which are allocated the largest annual amounts in LIP funding. Each of the 15 hospitals is required to select and participate in three initiatives focusing specifically on: infrastructure development; innovation and redesign; and population-focused improvement. In order to receive 100 percent of allocated LIP funding, participating hospitals must implement new, or enhance existing, health care initiatives, investments, or activities aimed at meaningfully improving the quality of care and the health of populations served (including low income populations) and meet hospital-specific targets. If a facility does not meet its tier-two milestones or components of its tier-two milestones, the State must assess a penalty of 3.5 percent of the facility's annual LIP allocation.

Under the extension of the Demonstration, Florida seeks to continue building upon the following objectives:

- Introduce more individual choice, increase access, and improve quality and efficiency while stabilizing cost;
- Increase the number of individuals in a capitated or premium-based managed care program and reduce the number of individuals in a fee-for-service program;
- Improve health outcomes and reduce inappropriate utilization;
- Demonstrate that by moving most recipients into a coordinated care-managed environment, the overall health of Florida's most vulnerable citizens will improve;
- Serve as an effective deterrent against fraud and abuse by moving from a fee-for-service to a managed care delivery system;
- Maintain strict oversight of managed care plans including adapting fraud efforts to surveillance of fraud and abuse within the managed care system;
- Provide managed care plans with flexibility in creating benefit packages to meet the needs of specific groups; and
- Provide plans the ability to substitute services and cover services that would otherwise not be covered by traditional Medicaid.

### **C. Populations Covered**

Participation in Medicaid Reform is mandatory for two eligibility groups currently covered by Florida Medicaid—(1) those eligible under Section 1931 of the Social Security Act and related groups, referred to as the TANF (Temporary Aid to Needy Families) and TANF-related group and (2) the Aged and Disabled group.

#### Mandatory Population

- 1) TANF and TANF-related group
  - a. Families whose income is below the TANF income limit (20% of the Federal Poverty Level (FPL) or \$303 per month for a family of 3, with assets less than \$2,000.
  - b. Children whose family income exceeds the TANF limit as follows:

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- i. Infants under age one, income up to 150% FPL;
  - ii. Children 1-5, income up to 133% FPL; and,
  - iii. Children 6-18, income up to 100% FPL.

- 2) Aged and Disabled group
  - a. Aged/Disabled adults receiving Supplemental Security Income (SSI) whose eligibility is determined by the Social Security Administration (SSA).
  - b. Blind/Disabled children eligible under SSI.

Infants under age one, with family income between 151% and 185% FPL, make up an Optional State Plan Group that is also required to participate in the Demonstration.

#### Voluntary Participants

The following individuals are not required to participate in the Demonstration, but may choose to be voluntary participants:

- 1) Foster care children;
- 2) Individuals with developmental disabilities;
- 3) Individuals residing in an institution such as a nursing home, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an ICF-DD;
- 4) Individuals receiving hospice services;
- 5) Pregnant women with incomes above the 1931 poverty level;
- 6) Dual eligible individuals;
- 7) Medikids under Title XXI; and
- 8) Children under age 1 with family income 186%-200% FPL under Title XXI.

#### Excluded Populations

The following groups of Medicaid eligibles are excluded from participation in the Demonstration:

- 1) Individuals whose immigration status is as a refugee eligible;
- 2) Individuals eligible as Medically Needy;
- 3) Individuals residing in State mental facilities (over age 65);
- 4) Family Planning waiver eligible; and
- 5) Individuals eligible as women with breast or cervical cancer.

#### Enhanced Benefits Reward\$-related Expansion Population

Individuals who have participated in the Reform Demonstration and lose eligibility for Medicaid will continue to have limited eligibility under the Demonstration for one year. This eligibility is limited to access to any funds that the individual may have accrued in their individual Enhanced Benefits account while participating in the Demonstration.

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## II. Evaluation of Medicaid Reform

### A. Evaluation of the initial Reform Demonstration period

During the initial waiver period, the Agency contracted with an independent entity, the University of Florida (UF), to conduct the evaluation. The three primary components of the evaluation were: Organizational Analysis; Utilization and Payment Analysis; and Quality of Care, Outcomes, and Patient Satisfaction Assessment. The evaluation research questions were in five key areas: Patient Involvement; Access to Care; Quality of Care; Coverage; and Costs.

The Final Evaluation Report, *Evaluating Florida's Medicaid Reform Demonstration Pilot: 2006 – 2011 Summary Report*, was submitted to Federal CMS on December 15, 2011. This report summarized evaluation findings across the five years of the initial waiver. It included a description of the managed care organizations (MCOs) participating in the demonstration, enrollee experiences with the demonstration, the fiscal impact of the demonstration, the Low Income Pool, and mental health services under the demonstration. A few key findings of the evaluation were:

- The percentage of enrollees reporting that they do have a personal doctor and that they did not have a problem finding a personal doctor/health care provider with whom they were happy increased significantly from the benchmark year to Demonstration Year 1 and was maintained in Demonstration Years 2 and 3.
- There were statistically significant improvements from the benchmark year to Demonstration Years 1, 2, and 3 regarding rating of communication with a personal doctor.
- There were statistically significant improvements from the benchmark year to the Demonstration Years regarding ratings of always getting care right away, in terms of both urgent care and routine care.
- The demonstration resulted in reductions in Per Member Per Month (PMPM) expenditures for SSI and TANF enrollees. A multivariate analysis controlling for age, gender, and race also included a variable capturing change over time and confirmed a downward trend in expenditures over time in the demonstration counties compared to the control counties.
- The shift from the Special Medicaid Payments (SMP) program to the Low Income Pool (LIP) program resulted in increased funding for safety-net providers and the extension of this funding to non-hospital providers, in addition to hospitals.

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- Analyses of mental health-related services found that implementation of the demonstration was not associated with significant changes in rates of Baker Act examinations, arrests, or juvenile justice encounters.

## **B. Goals of the Evaluation of the Reform Demonstration renewal period**

The Agency for Health Care Administration is in the process of contracting with two public state universities as independent evaluators to conduct various pieces of the Medicaid Reform Evaluation during the Demonstration renewal period. The broad goals of the evaluation are to:

- Measure the extent to which the Medicaid Reform Demonstration achieves its objectives;
- Capture lessons learned as a result of the Demonstration;
- Determine in what ways, and to what extent, experiences and outcomes for enrollees, providers, and payers changed as a result of the Demonstration; and
- Determine whether the reallocation of resources in the demonstration provided greater “value” than under traditional State Medicaid expenditures.

Special Term and Condition (STC) #80 of the waiver extension specifies that, in the evaluation design, the State must propose at least one research question that it will investigate within nine Domains of Focus. With respect to the last three domains, the State must propose two research questions under each domain, one related to LIP Tier-One milestones and one related to LIP Tier-Two milestones.

The Domains of Focus are:

- 1) The effect of managed care on access to care, quality and efficiency of care, and the cost of care;
- 2) The effect of customized benefit plans on beneficiaries’ choice of plans, access to care, or quality of care;
- 3) Participation in the Enhanced Benefits Account Program and its effect on participant behavior or health status;
- 4) The impact of the Demonstration as a deterrent against Medicaid fraud and abuse;
- 5) The effect of LIP funding on the number of uninsured and underinsured, and rate of uninsurance;
- 6) The effect of LIP funding on disparities in the provision of health care services, both geographically and by population groups;
- 7) The impact of Tier-One and Tier-Two milestone initiatives on access to care and quality of care (including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity);
- 8) The impact of Tier-One and Tier-Two milestone initiatives on population health; and
- 9) The impact of Tier-One and Tier-Two milestone initiatives on per-capita costs (including Medicaid, uninsured, and underinsured populations) and the cost-effectiveness of care.

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### III. Proposed Methodologies

Consistent with STC #80, the State has proposed research questions for each of the required Domains of Focus. This section of the Evaluation Plan details the research questions to be examined, the proposed data sources to be used, and the proposed methods of evaluation.

#### A. Research Questions by Domain of Focus

- 1) The effect of managed care on access to care, quality and efficiency of care, and the cost of care
  - Are services accessible to enrollees? Have there been changes in the accessibility of services to enrollees over the course of the Demonstration? Has the demonstration resulted in more appropriate use of services by enrollees?
  - Has the quality of care that enrollees receive improved during the demonstration? What have managed care plans done to improve quality of care?
  - How has the demonstration increased timeliness of services?
  - How has the demonstration affected the growth of Medicaid costs?
- 2) The effect of customized benefit plans on beneficiaries' choice of plans, access to care, or quality of care
  - To what extent do health plans offer customized benefits? How much variation is there between plans' benefit packages? Are there plans whose customized benefits are geared to particular populations?
  - When presented the opportunity, do plans provide additional services not previously covered by Medicaid? If so, what types of services? To what extent do enrollees use these additional services?
  - Are there differences in enrollees' satisfaction with and experiences with care between plans with different benefit packages? Between plans that offer additional benefits vs. those that do not?
  - Does access to and quality of care vary between plans with different benefit packages? Between plans that offer additional benefits vs. those that do not?
- 3) Participation in the Enhanced Benefits Account Program (EBAP) and its effect on participant behavior or health status
  - To what extent do enrollees earn Enhanced Benefits? To what extent do they spend their rewards?
  - Is the Enhanced Benefits program associated with increased use of preventive services by enrollees?
  - Is there a difference in services used by enrollees participating in EBAP vs. enrollees who do not in demonstration and non-demonstration counties?

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- Is there variation in the likelihood of participation in certain health care behaviors between enrollees in demonstration and non-demonstration counties?
  - To what extent does participation in EBAP vary by characteristics of enrollees (e.g., race/ethnicity, chronic illness, and plan type)?
  - Is there a difference in rates of avoidable hospitalizations and emergency department use among EBAP users (high, medium, low) and non-users?
- 4) The impact of the Demonstration as a deterrent against Medicaid fraud and abuse
- What are the program integrity-related measures employed by the health plans in the Demonstration related to: deterring fraud and abuse by network and non-network providers; deterring fraud and abuse by recipients; detecting fraud and abuse by network and non-network providers; and detecting fraud and abuse by recipients?
  - How often do health plan compliance officers/teams interact with providers in the health plan networks? What types of contact and interactions do the compliance officers/teams have with providers? How do plans document and track their efforts to deter fraud and abuse?
  - How do health plan compliance officers/teams measure the effectiveness of the health plan policies and procedures related to program integrity?
- 5) The effect of LIP funding on the number of uninsured and underinsured, and rate of uninsurance
- How has LIP funding improved access to care for uninsured/underinsured recipients? That is, how many uninsured and underinsured recipients receive services through LIP funding? What types of services are being provided and in what settings?
- 6) The effect of LIP funding on disparities in the provision of health care services, both geographically and by population groups
- How does LIP funding impact access to and use of services by different population groups? Does it increase access to services in particular areas?
  - How many programs funded by LIP, including Tier-One and Tier-Two initiatives, are focused on reducing disparities in the provision of health care services or health outcomes? What are these programs doing to reduce disparities and how successful are they?
- 7) The impact of Tier-One and Tier-Two milestone initiatives on access to care and quality of care (including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity)
- What are the goals of the Tier-One Milestone programs? What interventions/activities are they using to enhance quality of care and the health of low-income populations? Are they successful? Do hospitals



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participating in Tier-One initiatives have higher quality measure rates than other hospitals?

- What are the goals of the Tier-Two Milestone initiatives? How many of the initiatives are focused on access to care and quality of care? How are the top 15 hospitals working to meet their goals? Are they successful?

8) The impact of Tier-One and Tier-Two milestone initiatives on population health

- How are the Tier-One Milestone initiatives proposing to affect population health? Are they targeting particular groups of recipients or health conditions? Are they successful in achieving their objectives?
- How are the Tier-Two Milestone initiatives proposing to affect population health? Are they targeting particular groups of recipients or health conditions? What interventions/activities are they engaging in to impact population health? Are they successful?

9) The impact of Tier-One and Tier-Two milestone initiatives on per-capita costs (including Medicaid, uninsured, and underinsured populations) and the cost-effectiveness of care

- How do expenditures for services funded through the Tier-One Milestone initiatives differ from other LIP expenditures? How do the services provided under Tier-One milestone initiatives differ from those provided under other LIP funding? That is, do Tier-One Milestone expenditures result in more preventive and outpatient care than emergency department and inpatient visits? Do Tier-One milestone initiatives, including hospital quality initiatives, result in lower expenditures for recipients who are served by them?
- Do the Tier-Two Milestone initiatives impact expenditures for care for the uninsured/underinsured? How are expenditures affected? That is, what initiatives are successful in helping recipients to access the appropriate level of care and prevent the need for emergency or inpatient care?

**B. Research Projects, Data Sources , and Methods**

Domains 1 and 2: Studying the effect of managed care and customized benefit plans on beneficiaries' choice of plans, access to care, quality of care, and cost of care

**Hypotheses:** It is expected that the Demonstration will result in improved access to and quality of care, and that the utilization of preventive services and engagement in healthy activities will increase. It is expected that the Demonstration will result in significant cost containment. That is, it is hypothesized that the per-enrollee cost by eligibility group in the Demonstration will be less than the non-Demonstration program's projected growth.

**Data Sources:** To answer the research questions related to domains 1 and 2, the following data sources will be used:

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- 1) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey data: Surveys of a sample of each plan's enrollees will be fielded on a rolling basis. To answer questions related to access, quality, and efficiency of care, overall ratings variables related to health care, health plan, personal doctor, and satisfaction with specialists will be analyzed. Analyses of survey results related to getting needed care, ease in getting care, getting care quickly, and length of time with the same personal doctor will be conducted as well.
  - 2) HEDIS and Agency-defined performance measures: HMOs and PSNs are required to submit performance measures to the Agency annually. Plans are required to certify, through independent audit, that the data have been "fairly and accurately reported" and plans must attest to the accuracy of their performance measure data. The Agency has four years of performance measure data (calendar years 2007-2010) that will be analyzed for changes over time and that will be compared to the performance measures submitted for calendar years 2011, 2012, and 2013 moving forward. To answer questions related to access and quality of care, measures related to use of preventive services and management of chronic conditions will be analyzed.
  - 3) Performance Measure Action Plans (PMAPs) and Performance Improvement Projects (PIPs): HMOs and PSNs are contractually required to conduct a set number of PIPs and are required to have two of them validated by the State's External Quality Review Organization (EQRO) each year. Plans must report on their PIPs according to Federal CMS protocols, and the EQRO provides technical assistance to the plans as well as preparing an annual report on the status of the health plans' PIPs. In addition to PIPs, the Agency requires HMOs and PSNs to develop PMAPs for any HEDIS measures where the plan's performance falls below the 50<sup>th</sup> percentile, according to the National Medicaid Means and Percentiles issued by the National Committee for Quality Assurance (NCQA). Health plan PMAP and PIP submissions will be analyzed to look at what measures the health plans have taken to improve quality of care for enrollees during the Demonstration. EQRO reports on the status of health plan PIPs may be analyzed as well.
  - 4) Medicaid claims, eligibility, enrollment, and encounter data: these data will be used to look at service utilization and expenditures during the Demonstration. Data for Demonstration and non-demonstration counties will be included.
  - 5) Health plan contracts and Agency quarterly and annual reports to Federal CMS: these data sources will be used to identify customized benefit plans and any expanded/additional services they cover.

**Analyses will include:**

- Descriptive statistics and tests of significance for standard measures and composites of the CAHPS survey, looking at the Demonstration as a whole as well as comparing plans and plan types (e.g., by varying benefit packages);
- Comparison of Demonstration and non-demonstration means to Medicaid National Means and Percentiles for HEDIS measures;

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- Examination of trends in individual health plan performance on HEDIS and Agency-defined measures;
  - Descriptions of Performance Measure Action Plans and Performance Improvement Projects, including their objectives, interventions, and outcomes;
  - Descriptive statistics of plan benefits over time, including the number of expanded or optional benefits offered per plan as part of customized benefit packages, as well as the average number of expanded benefits offered across plans; and,
  - Difference-in-difference statistical analysis with both bivariate and multivariate controls to assess utilization and expenditures before and after and compared to non-Demonstration counties. Control counties will be identified for each Reform county and differences between the Reform and control counties will be described. Trends in utilization and expenditures over time will also be examined. Multivariate controls will include age, gender, and race/ethnicity.

Domain 3: Studying participation in the Enhanced Benefits Account Program (EBAP) and its effect on participant behavior or health status

**Hypotheses:** It is expected that the availability of the Enhanced Benefits Account Program will be associated with an increase in the utilization of select preventive services and healthy activities. It is anticipated that participants in the EBAP may have lower rates of emergency department visits and inpatient hospitalizations.

**Data Sources:** To answer the research questions related to Domain 3, the following data sources will be used:

- 1) Enhanced Benefits Information System (EBIS): This database includes information on the healthy behavior activities in which enrollees have participated (submitted by the health plans), the amount of credits earned by enrollees for those activities, the amount of credits spent by enrollees, and the items purchased using credits.
- 2) Medicaid claims, eligibility, and encounter data: these data will be used to look at service utilization during the Demonstration. Data for Demonstration and non-demonstration counties will be included.
- 3) Agency quarterly and annual reports to Federal CMS: these reports will be used to look at the Agency's quarterly updates on Enhanced Benefits Account Program-related activities.

**Analyses:** This study will compare changes in enrollee participation in the EBAP and utilization of services over time within the Demonstration. Service utilization of non-demonstration enrollees will be analyzed for comparison. An analytic dataset will be formed by combining EBIS data, claims, eligibility, and encounter data. Bivariate and multivariate analyses that control for age, gender, eligibility category, race/ethnicity, length of time in Medicaid, plan type, and Demonstration vs. non-demonstration counties will be conducted. Specifically, general descriptive statistics and active participation rates (e.g., comparison of dollar amounts of credits earned and purchases

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within a month) will be assessed using EBIS data. Claims, eligibility, and encounter data will be used to compare the likelihood of receipt of certain preventive services between Demonstration enrollees and non-demonstration enrollees. Preventive services are those that allow enrollees to earn EBAP credits (e.g., office visits, adult/childhood preventive care visits, dental preventive services, vision exams, pap smears, mammograms, and colorectal screenings). Claims, eligibility, and EBIS data will be used to compare demographic and health status characteristics of high, medium, and low credit earners to individuals who do not earn credits. These data will be linked to encounter data to compare the likelihood of avoidable hospitalizations for ambulatory sensitive conditions (using Prevention Quality Indicators) for high, medium, and low credit earners vs. individuals who do not earn credits.

Domain 4: Studying the impact of the Demonstration as a deterrent against Medicaid fraud and abuse

**Hypotheses:** It is expected that managed care plans in the Demonstration will use a variety of strategies to prevent Medicaid fraud and abuse and to detect fraud and abuse by providers and recipients.

**Data Sources:** To answer the research questions related to Domain 4, the following data sources will be used:

- 1) Health plan policies and procedures (including manuals) related to compliance and to fraud and abuse.
- 2) Interviews of health plan executive leadership and compliance/fraud and abuse directors at health plans.

**Analyses:** This study will review the program integrity-related measures health plans in the Demonstration take to deter and detect fraud and abuse, by both providers and recipients. Analyses will include comparisons of those efforts over time in the Demonstration counties and comparison entities that may include non-demonstration health plans and the Medicaid fee-for-service environment. Descriptions of health plan policies and procedures and manuals related to fraud and abuse and compliance and content analyses of interviews with health plan compliance/fraud and abuse directors will be used to assess the impact of the Demonstration as a deterrent against Medicaid fraud and abuse. The Agency's efforts to assist the health plans in their program integrity-related activities will be reviewed as well.

Domains 5-9: Studying the effect of Low Income Pool (LIP) funding on the provision of health care services to the uninsured and the impact of Tier-One and Tier-Two Milestone initiatives on (a) access to and quality of care, (b) population health, and (c) per capita costs and the cost-effectiveness of care

**Hypotheses:** It is expected that LIP funds to hospital and non-hospital providers will increase access to care for uninsured individuals. Tier-One Milestone programs and

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Tier-Two Milestone initiatives are expected to increase access to and quality of care, improve population health, and impact per capita costs.

**Data Sources:** To answer the research questions related to Domains 5-9, the following data sources will be used:

- 1) Annual Milestone Statistics and Findings Report: This report includes information on the numbers and types of services that are provided by hospital and non-hospital providers, the number of recipients served, and encounters.
- 2) Information on innovative programs funded under Tier-One Milestones (STC #61a): This information will include descriptions, goals, and progress reports of programs that are established (and funded through the \$50 million allocation) to meaningfully enhance the quality of care and the health of low income populations.
- 3) Hospital quality measure scores, for which hospitals are eligible to receive additional LIP distributions based on performing well.
- 4) Primary Care and Alternative Delivery System Report: This report includes descriptions of primary care and alternative delivery systems operating with LIP funds. The report will include descriptions of each program, including the services provided, the populations served, goals of the program, expenditures, and results of the program.
- 5) Tier-Two Milestone Initiative proposals and quarterly progress reports: These documents will contain the descriptions and goals of each of the three initiatives adopted by the 15 hospitals receiving the largest annual allocations of LIP funds. The proposals and quarterly reports will contain information on expected outcomes and targets of the initiatives, specific process and improvement measures related to infrastructure development, innovation, redesign, and population-focused improvement.

**Analyses:** The analytic strategy of this study will be a review of the innovative programs and services funded by the LIP. Analyses will include examinations of those efforts over time among LIP recipients in the Demonstration counties and the non-demonstration counties. Descriptive analyses of the entities receiving LIP funds, the number of recipients served, the types of services obtained, and any changes over time will be conducted. Analyses of the Tier-One and Tier-Two initiatives will include content analyses of proposals/plans and progress reports, identifying which prong or prongs of the Three-Part Aim are addressed by the initiatives, describing the strategies being implemented for each initiative, and whether those strategies result in the intended outcomes. The entities conducting Tier-One and/or Tier-Two initiatives will be reviewed individually, though if there are several entities conducting similar initiatives, differences and similarities between those projects and their levels of success may be analyzed. The final evaluation report will include a summary of lessons learned through the LIP projects.

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## Appendix I: Reform Evaluation Project Time Lines

Delivery dates and other key activities are identified in ranges, as they may be impacted by the contracts' execution dates.

### August – December 2012

- Obtain university IRB approval (August and September)
- Prepare and submit comprehensive evaluation work plan for each project for the evaluation period ending December 2014 (September)
- Receive and analyze EBIS, claims, eligibility, and encounter data for dates of service through June 30, 2011 (September and October)
- Receive and analyze CAHPS survey data – Benchmark year through Year 4 (August and September)
- Receive and analyze HEDIS and Agency-defined performance measure data submissions 2008-2011 (August and September)
- Receive and analyze Performance Measure Action Plans and Performance Improvement Projects for 2011 (August and September)
- Review health plan policies, procedures, and manuals related to compliance and fraud and abuse for Year 6 (State Fiscal Year 2011-12) (September and October)
- Review information on Tier-One and Tier-Two Milestone initiative proposals submitted in Year 6 (September and October)
- Conduct and analyze interviews with health plan compliance/fraud and abuse directors (September and October)
- Review Agency quarterly and annual reports (September and October)
- Receive and analyze HEDIS and Agency-defined performance measure data submitted in 2012 (October)
- Receive and analyze Year 6 LIP Milestone data from the Agency for the Milestone Statistics and Findings report (December – February 2013)
- Submit preliminary annual reports of analyses related to domains 1-4 (December)

### January – June 2013

- Receive and analyze claim, eligibility, and encounter data through June 30, 2012 (February)
- Submit preliminary report of LIP Milestone Statistics and Findings Report for DY 6 to the Agency (2/28)
- Submit final LIP Milestone Statistics and Findings Report for DY 6 to the Agency (3/31)
- Submit final annual reports of analyses related to domains 1-4 (March)
- Submit preliminary annual report of analyses related to domains v-ix to the Agency (April)
- Receive and analyze CAHPS survey data through Year 5 (June)
- Receive and analyze PMAPs and PIPs for 2012 (June)
- Submit final annual report of analyses related to domains v-ix to the Agency (June)

### July – December 2013

- Receive and analyze EBIS data through June 30, 2012 (July)
- Review health plan policies, procedures, and manuals related to compliance and fraud and abuse for Year 7 (State Fiscal Year 2012-13) (July)

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- Review information and quarterly progress reports for Tier-One and Tier-Two initiatives for Year 7 (September)
  - Conduct and analyze interviews with health plan compliance/fraud and abuse directors (September and October)
  - Review Agency quarterly and annual reports (September and October)
  - Receive and analyze HEDIS and Agency-defined performance measure data submitted in 2013 (October)
  - Receive and analyze data for the Primary Care and Alternative Delivery Systems Expenditure Report for Year 7 (SFY 2012-13) (September and October)
  - Submit preliminary Primary Care and Alternative Delivery Systems Expenditure Report for Year 7 to the Agency (November 1)
  - Submit preliminary annual reports of analyses related to domains 1-4 (December)
  - Receive and analyze LIP Milestone data for the Milestone Statistics and Findings report for Year 7 (December – February 2014)
  - Submit final Primary Care and Alternative Delivery Systems Expenditure Report for Year 7 (SFY 2012-13) (December 1)

#### **January – June 2014**

- Receive and analyze claims, eligibility, and encounter data through June 30, 2013 (February)
- Submit preliminary LIP Milestone Statistics and Findings Report for Year 7 to the Agency (February 28)
- Submit final annual reports of analyses related to domains 1-4 (March)
- Submit final LIP Milestone Statistics and Findings Report for Year 7 to the Agency (March 31)
- Submit preliminary annual report of analyses related to domains v-ix to the Agency (April)
- Receive and analyze CAHPS survey data through Year 6 (June)
- Receive and analyze PMAPs and PIPs for 2013 (June)
- Submit final annual report of analyses related to domains v-ix to the Agency (June)

#### **July – December 2014**

- Review Agency quarterly and annual reports (July)
- Receive and analyze EBIS data through June 30, 2013 (July)
- Review health plan policies, procedures, and manuals related to compliance and fraud and abuse for Year 8 (State Fiscal Year 2013-14) (July)
- Submit draft of overall evaluation report to the Agency (August)
- Receive and analyze HEDIS and Agency-defined performance measure data submitted in 2014 (if possible for Agency to send to the evaluation team by the end of August 2014)
- Submit preliminary annual reports of analyses related to domains 1-4 (September)
- Receive and analyze data for the Primary Care and Alternative Delivery Systems Expenditure Report for Year 8 (SFY 2013-14) (September and October)
- Submit Draft Evaluation Report to CMS (no later than October 28)
- Submit preliminary Primary Care and Alternative Delivery Systems Expenditure Report for Year 8 to the Agency (November 1)
- Submit final annual reports of analyses related to domains 1-4 (December)
- Submit final Primary Care and Alternative Delivery Systems Expenditure Report for Year 8 to the Agency (December 1)