

MEMORANDUM

TO: Karen Kimsey, Deputy Director, Complex Care and Services
Steve Ford, Deputy Director, Administration

THROUGH: Suzanne Gore, Director, Policy and Research
Tammy Whitlock, Director, Integrated Care and Behavioral Services

FROM: Gerald Craver, Ph.D., Senior Research Analyst, Policy and Research

DATE: October 1, 2013

SUBJECT: Proposal for Evaluating the Commonwealth Coordinated Care Program

I. PURPOSE:

The purpose of this memorandum is twofold. First, it is designed to provide management staff at the Department of Medical Assistance Services (DMAS) and individuals serving on the Evaluation Advisory Committee with a proposal for evaluating the Commonwealth Coordinated Care Program (i.e., Virginia's Medicare-Medicaid Financial Alignment Demonstration), and second, it is intended to elicit comments regarding the feasibility of the proposed study.¹ (Individuals serving on the Evaluation Advisory Committee are listed in Appendix A.)

II. BACKGROUND DISCUSSION:

In the United States, approximately 10.2 million seniors and non-elderly people with significant disabilities qualify for both Medicare and Medicaid benefits. Of these, roughly 7.4 million (or 73 percent) receive full Medicare and Medicaid benefits, while the remaining 2.8 million (or 27 percent) receive partial Medicaid benefits that only cover Medicare premiums and cost sharing expenses. Known as Medicare-Medicaid enrollees or "dual eligibles", these individuals represent some of the nation's most vulnerable citizens because they have a substantial mix of medical needs spanning the areas of acute, behavioral, chronic, primary, and long-term services and supports (LTSS).² While Medicare-Medicaid enrollees have access to a wide range of health and social services, the benefits are generally not well coordinated because they are provided mostly through traditional fee-for-service (FFS) programs. The lack of coordination is further complicated by the fact that the Medicare and Medicaid programs operate independently of one another, resulting in conflicting coverage and payment policies, inefficient service delivery

¹ An evaluation advisory committee is composed of a group of individuals with expertise who were selected to advise an evaluator on how to best conduct evaluation and use findings for policy and program improvement purposes. The committee has no governing authority and cannot impose its advice on the evaluator who manages it.

² Individuals who receive full Medicare and Medicaid benefits are known as full benefit dual eligibles, while individuals who receive partial Medicaid benefits are known as partial benefit dual eligibles. Full duals typically qualify for Medicare because of physical or mental disabilities rather than age. In addition, almost 20 percent of full duals have three or more chronic illnesses. Consequently, full duals (who comprise only 13 percent of the eligible Medicare and Medicaid populations) account for 34 percent of both programs' total spending on all dual eligibles.

systems, and incentives for provider cost shifting. By hindering efforts to improve access and care coordination, this environment promotes unnecessarily high costs and poor patient care for dual eligibles.

In response, the states and federal government are pursuing strategies to improve the quality and delivery of care for the dual eligible population. One such strategy is the financial alignment demonstration that will test two new payment and service delivery models for full benefit dual eligibles: capitation and managed FFS. Under the first model, the Centers for Medicare and Medicaid Services (CMS) and the states will contract with health plans to coordinate and improve patient care for dual eligibles, while under the second model, states will use their existing FFS infrastructures to provide dual eligibles with enhanced care management services. Of the 26 states that initially applied to participate in the financial alignment demonstration, 18 proposed testing capitated models, five opted for testing managed FFS models, and three proposed testing both models. Thus far, implementation has moved slower than anticipated and only six states (California, Illinois, Massachusetts, Ohio, Virginia, and Washington) have received approval from CMS to implement their demonstration projects, with start dates ranging from July 2013 to early 2014.³

On May 21, 2013, Virginia became the sixth state to receive approval to implement its demonstration project, known as the Commonwealth Coordinated Care (CCC) Program. Because the demonstration represents a new approach to providing care for full benefit dual eligibles, DMAS is interested in determining how the program will influence the behavior of providers and enrollees and its impact on various quality, utilization, and cost outcomes over time. To accomplish this, DMAS will partner with George Mason University (GMU) to conduct a rigorous evaluation of the CCC Program.⁴ The evaluation will be a critical component of the demonstration because it will provide agency management and other stakeholders with periodic feedback on the program's performance. As such, staff at both DMAS and GMU will be responsible for designing and conducting the evaluation.

The sections that follow provide additional information on the Commonwealth Coordinated Care Program; the conceptual framework of the evaluation and potential study questions; the research design for evaluating the program; and the study team, evaluation products, and timeline. The memorandum concludes with a summary of important points to consider about the proposed evaluation.

III. OVERVIEW OF THE COMMONWEALTH COORDINATED CARE PROGRAM

The Commonwealth Coordinated Care (CCC) Program is based on the capitated financial alignment model that involves the development of a three-way contract between CMS, the state, and selected health plans. Under the model, health plans will receive blended Medicare-

³ As of May 2013, seven states (Arizona, Hawaii, Minnesota, New Mexico, Oregon, Tennessee, and Wisconsin) had withdrawn from the financial alignment demonstration or were developing alternative care coordination projects for their full benefit dual eligibles.

⁴ CMS contracted with RTI International to conduct an overall evaluation of the financial alignment demonstrations as well as state-specific evaluations. The evaluations will include site visits, focus groups, key informant interviews, analysis of claims data, and cost savings calculations. The evaluation findings will be reported quarterly.

Medicaid payments in return for managing and coordinating all medical, behavioral health, prescription drug, substance use, LTSS, and social needs that full benefit dual eligible enrollees are qualified to receive.⁵ The overall goal of the program is to provide enrollees with high-quality, person-centered services that meet their medical and social needs through a coordinated and integrated managed care delivery system. It is anticipated that achieving this goal will generate savings over time by reducing or eliminating unnecessary or duplicative services for dual eligibles including emergency department visits, hospital admissions, and nursing facility stays.

To implement the program, DMAS issued a request for proposals on April 10, 2013. Eight health plans responded and DMAS entered into negotiations with three of the plans. The CCC Program will operate in five regions (Central Virginia, Northern Virginia, Roanoke, Tidewater, and Western Virginia/Charlottesville) for approximately four years (beginning February 1, 2014 through December 31, 2017) and potentially impact up to 78,596 (or 77.3 percent) of the state’s 101,634 full benefit dual eligible enrollees (Table 1). Medicare enrollees aged 21 and older who receive full Medicaid benefits and reside in one of the 104 jurisdictions within the demonstration’s five regions are eligible to participate. Eligible subpopulations include individuals residing in nursing facilities and/or those enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver, as well as individuals with intellectual/developmental disabilities, persistent mental illnesses, or complex/multiple chronic conditions. Certain subpopulations are excluded from participating in the program. Examples include individuals

Table 1. Estimated Number of Dual Eligible Beneficiaries by Region and Service Category (CY 2011)

Region	Service Category			Total
	Nursing Facility	EDCD Waiver	Community Non-Waiver ^a	
Central VA	4,430	3,762	16,135	24,327
Northern VA	1,935	1,766	12,952	16,653
Tidewater	3,031	2,492	12,575	18,098
Western/Charlottesville	1,477	842	4,427	6,747
Roanoke	2,833	1,355	8,583	12,771
Total^b	13,706	10,217	54,672	78,596

^aNon-institutionalized full benefit dual eligible beneficiaries including individuals with intellectual/developmental disabilities, cognitive/memory problems, physical/sensory disabilities, serious/persistent mental illnesses, or complex/multiple chronic conditions.

^bThese numbers may increase by approximately one-third by January 2014.

Source: Request for Proposals 2013-05 (page 11).

⁵ The health plans will receive a payment from Medicaid and a payment from Medicare. Each payment will be determined based on historical costs and acuity adjustments. To generate savings for both programs, the payments will be reduced by 1%, 2%, and 4% in years 1, 2, and 3 of the demonstration.

with limited Medicaid benefits or who are receiving hospice services, residing in state mental health hospitals, or enrolled in the Program of All Inclusive Care for the Elderly.

Initial enrollment in the CCC Program will occur on a voluntary basis (beginning January 1, 2014 through July 31, 2014) for all qualified individuals, followed by passive enrollment of the remaining individuals who do not voluntarily enroll.⁶ While the program will utilize passive enrollment, all enrollees will have the option to switch health plans and/or withdraw (or opt-out) at any time. Once individuals are enrolled, the health plans will have up to 90 days to determine their medical and social needs through a health risk assessment process. After completing this step, the plans will provide enrollees with care management services that are tailored to their specific needs and preferences. Examples include medical advice on a 24/7 basis from a care manager; management of patient medication and compliance; close coordination during institutional/community care transitions; frequent communication among care managers and primary/specialty providers; and assistance with accessing available community resources. In addition to providing care management services, the plans will maintain provider networks capable of meeting the complex and diverse needs of full benefit dual eligible enrollees; honor all existing enrollee plans of care and prior authorizations established before the implementation of the CCC Program (until either the authorizations end or 180 days pass after enrollment); and maintain enrollee-friendly appeals and grievance processes.

IV. CONCEPTUAL FRAMEWORK FOR THE EVALUATION AND POTENTIAL STUDY QUESTIONS

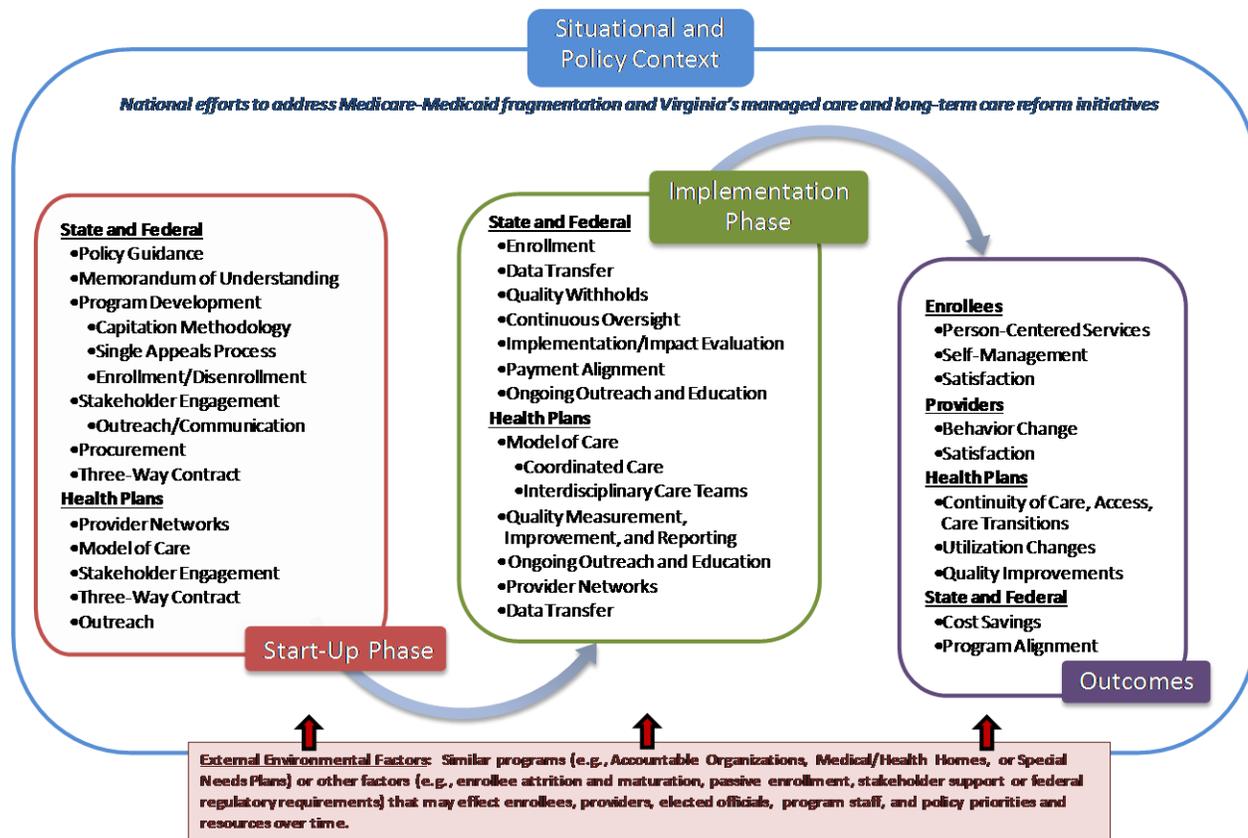
A logic model depicting the mechanisms and processes under which the Commonwealth Coordinated Care Program will operate to achieve its intended outcomes is presented in Figure 1. The model shows the situational/policy context under which the CCC Program was conceptualized as well as the program's main implementation activities that are intended to set in motion a sequence of outcomes. The logic model provides a structure for designing, planning, and implementing the proposed evaluation. Because the evaluation will provide DMAS management and other stakeholders with feedback on selected dimensions of the program's performance over time, the demonstration will be examined from both implementation (e.g., assessing various processes to identify best practices and/or areas for improvement) and impact (e.g., examining the program's effect on outcomes to judge overall success) perspectives. Based on this information, examples of study questions that may be addressed during the evaluation include⁷:

1. What are the key features of the health plans' care management programs? What subpopulations do they target? What implementation challenges have the health plans experienced? What suggestions do they have for improving the CCC Program?

⁶ Enrollment will initially be performed in two phases by region. In Phase I, (starting February 1, 2013), enrollment will cover the Central Virginia and Tidewater regions, while in Phase II (starting May 1, 2013), enrollment will cover the Western Virginia/Charlottesville, Northern Virginia, and Roanoke regions.

⁷ Because the evaluation will cover approximately four years, the study questions are presented for discussion purposes only and are subject to change.

Figure 1. Schematic Overview of the Commonwealth Coordinated Care Program Evaluation Logic Model^a



^aThe logic model is a draft and subject to change.

Source: DMAS and GMU staff analysis of program-related documents.

2. What perceptions do providers have about the CCC Program? How do these perceptions change over time? To what extent do providers view the program as influencing the quality of care they deliver to dual eligible beneficiaries? What suggestions do they have for improving the program?
3. How do agency program staff view the CCC Program? To what extent do they believe that the CCC Program is achieving its goal of providing enrollees with appropriate services through an integrated managed care delivery system? What suggestions do they have for improving the program at the health plan, state, and federal levels?
4. What are the demographic, utilization, and cost characteristics of the dual eligibles who enroll and disenroll (or opt-out) from the CCC Program? What factors are associated with both enrollment and disenrollment?⁸

⁸ The analysis needed to address this question may be limited to Medicaid data if the agency unable to obtain Medicare data.

5. What is the relative impact of the CCC Program on service utilization and cost by service type (e.g., emergency department visits, hospital admissions, and nursing facility stays) for program participants, after adjusting for other factors? To what extent does the impact differ by health plan and dual eligible subpopulation?
6. For enrollees who remain in the CCC Program, what perceptions do they have about the quality of care received after program enrollment? For individuals who opt-out, what perceptions do they have about the quality of care (including access to care and continuity of care) provided through the program compared to their usual sources of care?
7. What dimensions of quality, including quality of care and quality of life, are most salient to dual eligibles enrolled in the CCC Program? To what extent are enrollees receiving health and social services that are aligned with their views on quality of care and life? Do enrollees view the CCC Program as improving their overall quality of care and life and, if so, how?

V. RESEARCH DESIGN FOR EVALUATING THE COMMONWEALTH COORDINATED CARE PROGRAM

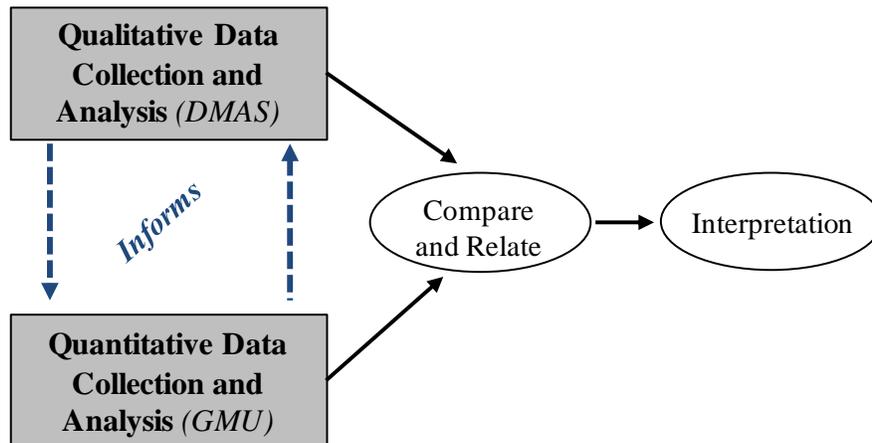
To gain a broad understanding of the Commonwealth Coordinated Care Program, the evaluation will employ a concurrent (or parallel) mixed methods research design that simultaneously incorporates both qualitative and quantitative data collection and analysis procedures to facilitate comparison and interpretation of study findings (Figure 2). The rationale for the design is that one data collection component will inform and offset the weaknesses of the other, thus allowing for a more complete understanding of the program to emerge. Using this approach, DMAS staff will be responsible for the qualitative component of the evaluation, while GMU staff will be responsible for the quantitative component. Details on the research design are provided below.

Qualitative Component of the Mixed Methods Research Design

For the qualitative component, DMAS staff will use a case study approach coupled with several anthropological methods (e.g., interviews, observations, and document reviews) to gain insights into how the CCC Program is actually working by studying it in person, over time, and from the diverse perspectives of several groups of stakeholders. The goal of this process will be to construct a holistic view of the program by collecting contextual data that are useful on their own as well as complementary to numerical data collected through the quantitative component. Because implementation of the CCC Program is contingent upon the development of a three-way contract, data collection will formally begin upon the contract's execution. Additional information on the sampling strategy, data collection methods, and analysis procedures that will be used during the qualitative component are provided below and summarized in Table 2.⁹

⁹ Qualitative evaluation plans are much looser than quantitative plans because they are basically educated speculations about the form and direction the study will take. The information presented in this section is therefore subject to change.

Figure 2. Diagram of the Concurrent Mixed Methods Research Design Selected to Evaluate the Commonwealth Coordinated Care Program



Source: DMAS staff adaptation of information presented in *Educational Research: Planning, Conducting, and Evaluating Quantitative and Qualitative Research* (4th ed.) by John W. Creswell (2012).

Sampling Strategy. In qualitative evaluation, the intent is not to generalize findings to a population, but to conduct an in-depth exploration of a program. Thus, evaluators purposefully select a small number of information-rich individuals and sites to study in order to thoroughly understand a program. To develop such an understanding of the CCC Program, DMAS staff will collect data from four key groups of stakeholders: agency program staff, health plan staff, health care providers, and dual eligible enrollees (including the caregivers of enrollees who have difficulty verbalizing their thoughts). Because the experiences of dual eligibles may depend in part on their specific conditions and needs, enrollees may be sampled based on selected enrollee subpopulations (e.g., individuals enrolled in the EDCD Waiver or residing in nursing facilities) and the availability of proxy respondents.

As with many qualitative evaluations, the actual sample size that will be needed for the CCC evaluation cannot be stated at this time because it will depend on several factors (e.g., the length of time of the evaluation, the quality of previously collected data, costs, and “saturation” or the point at which no new insights are identified through additional data collection); however, for planning purposes, approximately three agency program staff, six health plan staff, 60 providers and enrollees, and five data collection sites (e.g., one provider site in each region) may be sampled.¹⁰ While there are several qualitative sampling strategies available, DMAS staff will initially work with agency management, members of the Evaluation Advisory Committee, health plan staff, and GMU staff to identify participants and data collection sites to sample (i.e., a process known as snowball sampling). (Appendix B contains descriptions of the sampling

¹⁰ These numbers are presented for discussion purposes only and are subject to change. No hard rules govern sample size in qualitative inquiry. As a result, sample sizes can range up to 40 or more participants/sites because the sampling logic is based on the study purpose, research problem, major data collection strategy, and the availability of information-rich cases. It should also be noted that as the evaluation develops, DMAS staff anticipate studying some participants and sites in more detail than others.

Table 2. Key Characteristics of the Qualitative Component of the Mixed Research Methods Design

Research Methods	Sampling Process	Data Collection	Data Analysis
1. In-depth Semi-Structured Interviews	Purposeful sampling initially using snowball and convenience, and then maximum variation and opportunistic strategies	In-person, telephone, or email interviews with health plan staff, agency program staff, health care providers, and dual eligible enrollees	Constant comparative analysis of interview transcripts, field notes, and emails
2. Focus Groups Interviews	Purposeful sampling using snowball, convenience, and homogenous strategies	In-person/telephone focus groups	Constant comparative analysis of interview transcripts and field notes
3. Participant Observations	Purposeful sampling using snowball and maximum variation strategies	In-person observations of providers/ enrollees	Constant comparative analysis of field notes
4. Document Reviews	Purposeful sampling of all relevant public/private documents	Identify and collect relevant documents and review for appropriateness	Content/textual analysis of documents and document review notes

strategies that may be used in the evaluation.) To recruit enrollees, staff may offer a small financial incentive (approximately \$50 per person); however, no financial incentives will be offered to agency program staff, health plan staff, or providers.¹¹ Instead, DMAS staff will simply ask these individuals to participate in the evaluation.¹²

Data Collection. To collect data, DMAS staff will primarily conduct in-depth semi-structured interviews with individuals from the stakeholder groups. The interviews will allow participants to tell their stories in a detailed and uninterrupted manner. To ensure that reliable and comparable data are obtained from participants, the interviews will be conducted using protocols (or guides) containing standard lists of open-ended questions. The interviews will be performed periodically in-person or via telephone or email depending upon the stakeholder group and program implementation phase. For example, in-person, telephone, and email interviews may be performed quarterly with agency and health plan staff during the early stages of the program and then less frequently as the program matures, while in-person, telephone, and email interviews may be performed either biannually or annually with providers and enrollees throughout the program’s duration.¹³ All interviews will last approximately 30 minutes and will be audio recorded as appropriate.¹⁴ To protect the privacy and confidentiality of participants, DMAS staff

¹¹ The financial incentive depends on the ability of DMAS staff to obtain additional funding to support the evaluation. Staff estimate that it may cost approximately \$2,000 to recruit up to 40 beneficiaries for the evaluation.

¹² The health plans are required to participate in the evaluation as part of the three-way contract.

¹³ Ultimately, data collection will depend on the frequency with which agency management and other stakeholders require information about the program.

¹⁴ While DMAS staff will transcribe the initial interviews, staff will need assistance with transcribing the remaining interviews from one of the agency’s court reporting vendors. During the evaluation of the *Virginia Gold Quality*

will obtain informed consent (either written or verbal) prior to data collection and will not disclose identifiable information in any documents generated as part of the evaluation.¹⁵ To the extent possible, DMAS staff will interview the same individuals during each stage of data collection; however, participant recruitment will be ongoing throughout the evaluation.

To elicit information about the development and delivery of program services that might not be easily obtained through individual interviews, DMAS staff will conduct up to four separate enrollee and provider focus groups.^{16,17} While the in-depth interviews will be conducted throughout the course of the CCC Program, the focus groups will be performed primarily during the initial and latter stages of the program to explore participant expectations and experiences in group settings. The focus groups will consist of four to six participants, last roughly 60 minutes, and will be conducted either in-person or via telephone. The focus groups will also be performed using protocols containing standard lists of open-ended questions and audio recorded. In addition, informed consent (either written or verbal) will be obtained from all focus group participants.

In addition to interviews and focus groups, DMAS staff will use participant observation (e.g., observations of provider-enrollee interactions) to collect data on the CCC Program as it occurs in real time.¹⁸ The observations will allow DMAS staff to identify issues that need to be explored using other data collection methods, to triangulate earlier findings, and to directly observe phenomena that participants discuss during the interviews. The observations will be performed throughout the evaluation using standard note taking protocols and may last up to approximately eight hours per session.¹⁹ Informed consent will not be obtained from individuals observed during the observations unless they agree to be interviewed.

Finally, data from the interviews, focus groups, and observations will be supplemented with information from program-related artifacts, documents, and records (e.g., policies, procedures, regulations, marketing brochures, websites, reports, memorandums, opinion pieces, and various research studies and/or evaluations). Collecting and systematically reviewing a wide range of relevant documentation will provide DMAS staff with insights into how the CCC Program and similar programs are intended to work and how stakeholders view these initiatives.²⁰

Improvement Program, DMAS staff conducted 20 focus groups with certified nursing assistants and nursing facility residents. The focus groups generated 784 transcript pages that cost approximately \$2,500 to transcribe.

¹⁵ Written informed consent will be obtained for face-to-face interviews and verbal informed consent will be obtained for telephone interviews.

¹⁶ Based on a recommendation contained in *Focus Groups: A Practical Guide for Applied Research* (4th ed.) by Richard A. Krueger and Mary Anne Casey (2009).

¹⁷ The participant interviews and focus groups may not be mutually exclusive. For example, individuals who participate in the interviews may also participate in the focus groups and vice versa.

¹⁸ For example, DMAS staff may conduct participant observations during interdisciplinary care team meetings or at community service boards or nursing facilities to collect detailed descriptions of behavior and to examine how people make sense of their particular situations.

¹⁹ Participant observation is a long-standing method in qualitative inquiry (see *Doing Qualitative Research*, 2nd ed., by Benjamin F. Crabtree and William L. Miller). For the CCC evaluation, observations will initially last up to an hour, but may increase in length over time to about eight hours.

²⁰ At the request of DMAS management, staff will also collect data on the number of enrollees living in institutions and in institutional settings in order to determine if changes occur in these areas due to the CCC Program.

Data Analysis. Data collected for the qualitative component will consist of large amounts of interview and focus group recordings and transcripts, field notes from participant observations, textual documents, and notes prepared about the data collection process. Because the data are non-numeric, DMAS staff will analyze this information using a process known as the constant-comparative method, which involves the continuous collection and analysis of data throughout the duration of the study in order to generate findings and insights useful for informing stakeholders about the program’s progress and activities. As part of the analysis, staff will individually review data and then periodically meet as a group to discuss and compare findings and to arrive at agreed-upon interpretations. A strength of this approach is that by continuously collecting and analyzing data throughout the evaluation, staff will be able to easily reconsider and/or reconstruct study findings. To facilitate this process, DMAS staff will use NVivo10, which is a computer-assisted qualitative data analysis software package.

Advantages and Limitations. The qualitative methods discussed in this section have certain advantages that make them especially useful for evaluating the CCC Program. For example, using the methods will allow DMAS staff to create a more in-depth picture of the program by collecting data from multiple stakeholders. Using the methods will also allow DMAS staff to collect data on the “whys” and “hows” of the program that should support the quantitative component through comparison and triangulation of findings. In addition, using the methods will allow staff to gain insights about the CCC Program through repeated data collection and analysis cycles that may be useful for shaping the future direction of the program as well as other Virginia Medicaid quality improvement initiatives.

However, the methods also have limitations that may make them difficult to use in the evaluation. In particular, the collection and analysis of qualitative data is time consuming and requires a specific set of skills. As a result, DMAS staff assigned to this project should be allocated sufficient time to assist with data collection and analysis and have prior training in qualitative research methods or be capable of receiving such training (the lead DMAS staff evaluator will provide this training as needed). Finally, the smaller sample size used for the qualitative component will not allow for generalizations beyond the group of individuals who participate in the evaluation. While the use of mixed methods can enhance generalizability of the study findings, this limitation will not be entirely overcome in the CCC evaluation.

Quantitative Component of the Mixed Methods Research Design

To perform the quantitative component, GMU staff will initially conduct a statistical analysis of individual-level demographic/enrollment and program satisfaction/experience data. The demographic/enrollment data will be collected through the Virginia Medicaid Management Information System and analyzed to identify important characteristics of dual eligibles who enroll/disenroll from the program during its first year of operation and the factors that are associated with (or predict) enrollment status.²¹ The satisfaction/experience data will be collected through a survey of a subsample of dual eligibles and analyzed to describe important trends in patient care attitudes, opinions, and behaviors. The subgroups that will be interviewed include enrollees with high average costs and/or complex care needs as well as the elderly and

²¹ The contract between DMAS and GMU covers a 12 month time period and costs approximately \$126,000. The longitudinal analysis and follow-up surveys are contingent upon additional funding.

younger disabled individuals who use waiver services. As with the qualitative component, the statistical analyses will be stratified by enrollee subpopulation (e.g., aged vs. non-aged). Depending upon the availability of additional funding, GMU staff will follow these analyses with a more detailed longitudinal study examining the program's impact on utilization and cost outcomes over time as well as additional enrollee and/or provider surveys. (See Appendix C for information on the quantitative component.)

V. EVALUATION TEAM, EVALUTION PRODUCTS, AND TIMELINE

The qualitative component of the evaluation will be led by Dr. Gerald Craver (DMAS Policy and Research Division), while the quantitative component will be led by Drs. Alison Cuellar and Gilbert Gimm (GMU Department of Health Administration and Policy). Currently, DMAS has only assigned one staff person to the CCC evaluation on a full-time basis; however, agency management may wish to consider assigning two or more staff on a part-time basis due to the labor intensive nature of this project.²² Meredith Lee (DMAS Policy and Research Division) has expressed interest in the evaluation and would be an ideal candidate due to her current involvement with the CCC Program and previous work experience at Mathematica Policy Research. Elizabeth Smith (DMAS Integrated Care and Behavioral Services Division) has also expressed interest in the evaluation and would be a good candidate due to her current involvement with the CCC Program and previous work experience in the agency's Long-Term Care Division. Finally, Jodi Manz (an intern at DMAS) has expressed interest in the evaluation and would be a good candidate due to her experience as a graduate student in the School of Social Work at Virginia Commonwealth University.

Because the CCC Program is intended to test an innovative payment and service delivery model for full-benefit dual eligible enrollees, the evaluation will be performed to provide DMAS management and other stakeholders (e.g., members of the Evaluation Advisory Committee and the agency's CCC Program Advisory Committee) with real-time information on the program to promote and support continuous quality improvement and to gauge its impact on various outcomes over time. To accomplish this, the evaluators will provide periodic written reports that detail their findings throughout the program's duration. To ensure that the findings are both timely and useful, the evaluators will work with agency management to establish a schedule for delivering such information.

VI. SUMMARY AND CONCLUSIONS

The Commonwealth Coordinated Care Program represents a significant reform opportunity for Virginia's most vulnerable citizens. As a result, it is critical to evaluate the implementation and outcomes of the CCC Program to inform DMAS management and other stakeholders on whether it represents a good investment of limited public resources. The evaluation outlined in this document is intended to address that need. However, three key points should be considered before proceeding with this project. First, while the evaluation will use credible research methods to examine the CCC Program, the study cannot definitely answer cause and effect questions about the program. Demonstrating causation with observational (or non-experimental) data can be challenging because investigators do not have deliberate control of the system under

²² As the lead evaluator, Dr. Craver will perform the majority of work related to the evaluation.

study (e.g., they cannot randomly assign participants to treatment and control conditions).²³ Second, the evaluation should examine the CCC Program over time from multiple perspectives; however, accomplishing this will require allocating additional staff to the study. For example, two additional DMAS staff should be assigned to the evaluation on a part-time basis and time should be allotted for all members of the evaluation team to adequately study the program. Third, the evaluation will require funding if it is to be performed as thoroughly as possible. In particular, staff may need funding to cover travel and lodging expenses during periods of intensive data collection, to recruit beneficiaries to participate in the evaluation, and to pay for transcription services. In addition, GMU staff will need additional funding to extend their contract with DMAS to conduct follow-up analyses on the program.²⁴

²³ While certain statistical “adjustment” methods (e.g., instrumental variables regression and propensity scores) can be used to estimate causal relationships in observational studies, their usefulness is still largely dependent on issues that investigators have no control over such as the quality of available data and the identification of all relevant causal factors (or proxies for causal factors) for use in the statistical models. Additional information on this topic in Medicaid program evaluation is available in Using Instrumental Variables Regression to Evaluate Medicaid Disease Management Program Effectiveness: An Exploratory Analysis by Gerald Craver and Daniel Longo (*Journal of Health Care Finance*, 2009).

²⁴ DMAS and GMU staff are exploring the possibility of obtaining additional funding to support the evaluation from external organizations; however, no organizations have agreed to provide funding thus far.

Appendix A. Commonwealth Coordinated Care Program Evaluation Advisory Committee
Members

Member	Organization
Jack Brandt	Partnership for People with Disabilities
Debbie Burcham	Chesterfield Community Services Board
Emily Osl Carr	Department of Medical Assistance Services
Parthy Dinora	Partnership for People with Disabilities
Sheryl Garland	Virginia Commonwealth University
Maureen Hollowell	Endependence Center, Inc.
Betty Long	Virginia Hospital and Healthcare Association
Linda Redmond	Virginia Board for People with Disabilities

Appendix B. Potential Qualitative Sampling Strategies for the CCC Evaluation

Stage	Definition
1. Maximum Variation	Documents diverse variations among participants and identifies important common patterns
2. Homogenous	Reduces, simplifies, and facilitates focus group interviews
3. Snowball or chain	Identifies participants and cases of interest from people who know which individuals are information rich
4. Stratified Purposeful	Illustrates participants subgroups; facilitates comparisons among subgroups
5. Opportunistic	Follow new leads; taking advantage of unexpected encounters and/or findings
6. Convenience	Saves time, money, and effort but at expense of information and credibility

Source: *Doing Qualitative Research* (2nd ed.) by Benjamin F. Crabtree and William L. Miller

Note: Because the evaluation will run for four years, several sampling strategies (but not necessarily all) will be used to collect data from participants.

Appendix C

A Dual Demonstration Evaluation Tailored for Virginia

Alison Cuellar, PhD

Gilbert Gimm, PhD

Department of Health Administration and Policy

George Mason University

October 24, 2012

Background

The Virginia Dual Demonstration waiver program represents a unique opportunity to improve care for Medicaid-Medicare eligible beneficiaries who are elderly or disabled. Many of these beneficiaries have high medical needs due to chronic conditions, but a subset also require personal care and other long-term services and supports. By combining general medical and long-term care under one capitated plan, the state seeks to better address care coordination and disease management and leverage opportunities to address highly prevalent chronic conditions, psychiatric care, and long-term care. With joint Medicare and Medicaid financing and a shared savings program, incentives are created to better monitor care and overcome service fragmentation. Implicitly, when plans are capitated for a full-range of services, they must balance resources for general medical services, behavioral health, and long-term care needs.

In light of the unique structure of the demonstration and its strong incentives, DMAS expects that the demonstration will improve quality of care, improve the health and functional status of participants, and reduce costs by avoiding preventable hospital stays and nursing home admissions, reducing emergency department utilization, and improving care transitions across settings. These are important outcomes for the state, stakeholders, and beneficiaries. Therefore, we propose to evaluate the demonstration along a subset of important dimensions in order to provide early feedback on consumers' experience.

The federal government has retained a contractor to track progress in the approximately 25 state dual demonstration sites. The federal project will provide dashboard-like indicators of health indicators for the dual eligible population across states and, ultimately, some risk-adjusted state measures. This work also will focus on cost savings determinations. By necessity, cross-state comparisons will blur many of the unique features of each state's demonstration in order to make general statements about the average effect of dual-eligible demonstration programs across all participating states. In contrast, our proposal seeks to focus on understanding the particular characteristics of the Virginia demonstration and, more importantly, to evaluating how the Virginia demonstration program, specifically, affects dual-eligibles in the state.

Study Questions and Overview of Approach

The estimated eligible population for the Virginia DMAS demonstration is about 57,000 dual-eligible beneficiaries. These beneficiaries are not required to enroll in the demonstration; rather, enrollment is passive with an opt-out provision. The DMAS demonstration population is heterogeneous with a wide range of health and LTSS needs. Many dual-eligibles are low-income

elderly individuals who receive Supplemental Security Income (SSI), but do not receive long-term care services funded by state Medicaid. Of the 57,000 dual-eligible beneficiaries, roughly 6,000 are receiving long-term care in institutions and another 7,000 beneficiaries receive long-term care services through the Elderly or Disabled with Consumer Direction Waiver. Among those receiving waiver services one group is receiving direct services and another is receiving consumer directed services.

The evaluation seeks to answer the following policy questions:

1. What are the participant characteristics of dual eligible beneficiaries who enrolled and/or disenrolled during the first year of the Virginia demonstration?
2. Do participants report greater satisfaction and access to medical, behavioral health, and long-term care services within six months of the demonstration?

Separately, we will seek funding to address these additional questions:

3. Did the demonstration lead to more appropriate service utilization, better coordination and improved quality?
4. Did the demonstration reduce the Medicaid expenditures?

We propose to pursue a careful analysis of quantitative data, initially through enrollment data and enrollee surveys. Separately, DMAS staff will undertake qualitative interviews with long-term care and medical care providers and MCO administrators. If we are successful in raising additional funds, we would analyze Medicaid and Medicare administrative data to the extent DMAS can provide these data files to the research team. The combination of quantitative and qualitative data will provide DMAS a richer understanding of implementation and outcomes under the expansion of managed care.

Key Subpopulation

Because the experiences of dual-eligibles in managed care may differ for individuals depending on their specific health conditions, health care needs, and location, we will stratify our analyses for different subgroups of dual-eligibles. Thus, there are many possible subgroups to examine among the 57,000 eligible beneficiaries. Subject to feedback from DMAS, our initial proposal is to examine the following five sub-groups:

1. Dual eligibles who do not use long-term care services and supports (LTSS) and who do not have serious behavioral health disorders (N=38,000)
2. Dual eligibles who have serious behavioral health disorders (N=7,400)
3. Nonelderly duals who receive community-based LTSS (N=1,900)
4. Elderly duals who receive community-based LTSS (N=5,000) and
5. Duals receiving long-term care in institutional settings (N=6,000).

Enrollment Analysis

The enrollment analysis will examine patterns of enrollment and disenrollment among beneficiaries. Dual eligible beneficiaries in the demonstration are permitted to disenroll -- at least for their Medicare benefits -- on a month-to-month basis. At the plan level, disenrollment rates are an important outcome and will be examined separately across the 5 subgroups described above. In addition, we will examine enrollment and disenrollment rates by plan as well as subpopulation.

Analysis of Early Beneficiary Experience

Many dimensions of care, such as medical expenditures or NCQA quality measures, can be captured in claims data. However, there are several limitations of using claims data. First, the lag time for these data creates a significant challenge as it impedes the state's ability to monitor the performance of the demonstration in its critical early phases and hampers the state's attempts to consider future conditions or contracts in a timely manner. Second, claims data may not fully capture the patient's own experience, such as barriers to care, satisfaction with care, or provider communication. Third, the service utilization of particular groups, such as users of community-based LTSS cannot be fully captured in claims data.

For individuals with a diverse set of needs, due to multiple chronic conditions, behavioral conditions, or functional limitations, each health plan must decide how to spread resources across different service sectors. These diverse delivery systems -- general medical, behavioral health, and long-term care services -- will seek to coordinate care through systems that have hardly existed in the past. With the flexibility that the capitated financing offers, such new care coordination systems, the demonstration could greatly improve care for dual beneficiaries who use general medical, behavioral, and LTSS.

For three important groups -- the elderly who use waiver services, beneficiaries with behavioral health conditions, and the younger disabled who use waiver services -- we propose to conduct an early round of telephone surveys of beneficiaries within six months of the start of the demonstration. Telephone surveys were successfully implemented for a related population as part of the national Cash and Counseling demonstration. In that evaluation, 29% of the interviews in the disabled sample were conducted using a proxy, as were 71% of the interviews in the elderly sample. Subject to input and feedback from DMAS we propose that this survey would include questions to address the following domains:

- Access to medical and specialty care
- Access to behavioral health care
- Care coordination and care management
- Functional or cognitive impairment and unmet need for personal care services
- Medical equipment use and access to equipment
- Beneficiary decision-making and experience

In each case participants will be asked about their current experience with the demonstration. Second, participants will be asked to recall their own experience with access and quality of

services prior to the demonstration and any change in experience using a timeline follow-back method. Most of the relevant domains can be adequately captured through questions that are part of the **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** instrument set or the CAHPS supplemental item set. However, questions that address a need for assistance with activities of daily living or instrumental activities of daily living or unmet need with respect to these services must be taken from national surveys such as the National Health and Aging Trends **Study** (<http://www.nhats.org/scripts/instruments/SC.pdf>) **or the Medicare Current Beneficiary Survey or from the Participant Experience Survey instrument** (<http://www.hcbs.org/moreInfo.php/doc/652>). **Our proposed telephone survey would be limited to roughly 30 minutes.**

Using the survey data our analytic strategy would be to compare participant outcomes before and early into the demonstration, controlling for beneficiary health and functional status and local characteristics. The analysis would include data that asks beneficiaries to compare outcomes pre and post, e.g., over the last period of months is your care getting better, worse, or about the same. We estimate that we would need completed responses from 500 younger disabled, 500 elderly disabled individuals, and 200 individuals with behavioral health disorders.

To successfully recruit the sample, we assume that DMAS will provide a waiver participant list with full contact information for the survey, as well as administrative data eligibility type (elderly or young disabled). To enhance response rates we propose a pre-mailing to inform beneficiaries about the upcoming survey and include a cover letter explaining the value of their participation.

The analyses of beneficiary survey data will complement and enhance the qualitative work from focus groups with providers and health plan administrators and medical directors. Focus groups can capture information on the general response to the managed care policy shift, as well as anticipated benefits and concerns with the policy shift. They can identify implementation facilitators and barriers and achievements related to continuity of care and complex care coordination. By comparison, the survey will reflect the beneficiary experience where improvements in care coordination and a systematic care coordination approach can be felt and measured on the consumer side. A survey approach will allow us to reach a representative group of beneficiaries and to obtain information from individuals who may not otherwise participate in focus groups due to disabling conditions. Beneficiary focus groups would be suggestive of patient experience, but are not representative. Changes that are noted in surveys can be compared to key efforts, facilitators, and promising strategies for service delivery that are identified in focus groups by providers and health plans. The survey also has the advantage that it can suggest areas for further exploration in beneficiary focus groups.

Appendix: Future Work with an Analysis of Administrative Data

Pending additional support, we propose to examine a set of outcomes that rely on administrative data from hospital discharge data, enrollment, claims, and functional assessments. We are also exploring the use of data gathered by billing entities that would capture ancillary services provided by physicians. These analyses must await the accrual of administrative data and a claims lag period. This allows us to pursue funding from other sources. If we are successful in raising additional funds, using administrative Medicaid and Medicare claims,

enrollment and MDS data provided by DMAS, we would estimate the impact of the duals demonstration on total medical expenditures and medical expenditures by service type (inpatient, outpatient, home health, NH, HCBS, and prescription drug), utilization of services by type, and a series of quality measures (derived from HEDIS and MDS) for each of these groups. We can use the claims data, augmented by functional assessment information and variables describing local area environments, to estimate enrollee-level equations of the following basic form:

$$\text{Outcome} = \text{After Demonstration} + \text{Patient Characteristics} + \text{Local Area Characteristics} + \text{Year}$$

We would use interrupted time series methods to identify changes in outcomes. One important challenge in estimating expenditures is that the demonstration will lead to a shift in the structure of the administrative data, particularly the shift from fee-for-service to encounter data. The change we observe could be an artifact of differences in how completely the data, particularly the encounter data, are captured. Analyses of claims and encounter data that lack appropriate care and rigor will not provide meaningful results. We would work in partnership with the entities that have collected the claims and encounter data to fully understand the variables included in the administrative files and the ways in which utilization and claims are recorded.

As an alternative we propose examining changes in utilization of hospital inpatient services, ER, and nursing home admissions, using a data source that likely will not change: the Virginia uniform hospital discharge and ER data. The evaluation team would need permission to access to these data and it would need to have patient identifiers. Another possibility is analysis of Medicare Beneficiary Summary Files, if DMAS has access to these data. These data would allow us to estimate changes in the use of nursing home care because the summary data rely on Minimum Data Set and OASIS for all payers.

Once we have solid estimates of changes in utilization for different services we can apply standardized dollar values for each service, using standard Medicaid and Medicare payment rules, and obtain changes in estimated expenditures. These can be compared to actual payments made to plans. This analysis would complement, not replace, the independent actuarial estimates required of shared savings under the demonstration.

Research Team

Alison Evans Cuellar (Ph.D., Health Economics, University of California at Berkeley; MBA, University of Texas at Austin) is Associate Professor of Health Administration and Policy at George Mason University. Dr. Cuellar has spent much of the past year on detail to the Office of the Assistant Secretary for Planning and Evaluation (ASPE), Disability and Long-term Care Policy, in the federal Department of Health and Human Services. In this position she has conducted targeted analyses of behavioral health and health care reform and has overseen projects on comparative effectiveness related to populations with disabilities, in addition to special policy and research projects for the Assistant Secretary. She was a member of a national collaborative network supported by the MacArthur Foundation that conducted research on mental health policy issues. Dr. Cuellar has rigorous training in health economics and health care systems, and has expertise in Medicaid, disability, and mental health care. Her other work

has evaluated organizational forms, such as hospital and physician integration, and their effects on quality, efficiency, costs, prices, and technology adoption. She currently is working on a project related to a national health plan's wellness program and incentives for its members who meet health targets. Dr. Cuellar has extensive research experience working with Medicaid data. Two examples of her work are attached. One example relates to the implementation of a Medicaid behavioral health carve-out and another to care patterns for youth with behavioral health problems who are involved in the justice system.

Gilbert W. Gimm (Ph.D., Health Economics and Policy; MBA, Health Care Management, University of Pennsylvania), is Associate Professor of Health Administration and Policy at George Mason University. Dr. Gimm brings more than 5 years of experience with designing, conducting, and managing program evaluations for the Centers for Medicare and Medicaid Services (CMS) and other federal agencies. He has worked as a task leader, researcher, deputy director, and director of several multi-year program evaluations at Mathematica Policy Research, which involved partnering with subcontractors. He also has rigorous training and experience in quantitative methods and secondary data analysis.

Dr. Gimm is an expert in Medicaid program evaluations, care coordination models for adults with disabilities and chronic conditions, aging research, and health care financing. In 2012, Dr. Gimm was the principal investigator (PI) and recipient of a grant award from the Borchard Foundation on Law and Aging to study the effect of paid leave policies on the health and employment of family caregivers for the elderly. Previously, Dr. Gimm was a senior researcher at Mathematica Policy Research in Washington, DC, where he directed a CMS national evaluation (i.e., the Demonstration to Maintain Independence and Employment or DMIE) that used a randomized study design to analyze interventions that included person-centered case managers, wraparound health services, and employment supports for working adults with chronic conditions. A more detailed description of the DMIE evaluation project is included in the attached project examples. Using Medicare cost report data, he conducted a differences-in-differences analysis to examine the financial performance of small rural hospitals in response to enhanced Medicare inpatient payments. He played a lead role in determining the selection criteria to identify and analyze a comparison group of rural hospitals.

Carole Roan Gresenz (Ph.D., Economics, Brown University) is the Bette Jacobs Endowed Professor in the Department of Health Systems Administration at Georgetown University and an Adjunct Senior Economist at the RAND Corporation. Dr. Gresenz will act as a consultant on the project. She is the former Director of the Health Economics, Finance and Organization program within RAND Health. Her research interests and expertise span a diverse set of issues. Dr. Gresenz has led research evaluating state health care reform efforts, explored the role of health care market characteristics on access to health care among vulnerable populations such as the uninsured and Hispanic immigrants, and analyzed potential spillover effects of community uninsurance rates on access to and quality of health care among insured community residents. She has published articles on mental health disorders and labor market outcomes, income inequality and mental health disorders, health insurance coverage outcomes among welfare recipients in the wake of welfare reform, and enrollment and utilization behavior among individuals in managed behavioral health care. Over the last decade, she has worked closely with policymakers in the District of Columbia and Maryland on local health care issues.

Center for Social Science Research, George Mason University. Our team will be able to use the excellent services of the George Mason University Center for Social Science Research (CSSR). Dr. James Witte leads the center which has conducted numerous surveys in the state and elsewhere. Studies conducted by the center employ a range of quantitative and qualitative research methods including survey research, focus groups, interviews, analysis based on leading social indicators, and the exploration of virtual world environments.

The CSSR is located on the George Mason University Fairfax Campus and has a phone lab, including fifteen Computer Assisted Telephone Interviewing (CATI) stations. Digital assets include qualitative and quantitative analysis software, the proprietary OnQ survey software for phone and web surveys, an island in Secondlife and access to other virtual world environments. The center is a member of the National Consortium of Social Science Research Centers and Institutes, the Association of Academic Survey Research Organizations and the Virtual Worlds Consortium.

Deliverables

Within 3 months we propose to provide an evaluation design report including the survey plan and a draft of the survey instrument. Within 6 months of the start of the Virginia dual demonstration we will field the beneficiary survey. Within 12 months we will provide a report on enrollment and disenrollment patterns as well as results from the beneficiary survey. In addition, we plan to submit at least one draft manuscript to a peer-reviewed journal summarizing our methods and findings. We would send a draft copy to DMAS to provide comments before it is submitted to a journal.