State of Vermont
Agency of Human Services

GLOBAL COMMITMENT TO HEALTH

SECTION 1115 DEMONSTRATION
11-W-00194/1

Draft Demonstration Evaluation Design

Submitted to CMS: November 2014
Revised September 4, 2015

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I. INTRODUCTION

This evaluation plan updates Vermont's evaluation plan submitted in November 2014. This evaluation plan includes:

- Background information on the Demonstration and its principles, goals, and objectives;
- Detailed evaluation design; and
- Information on the evaluation reports to be provided to CMS during the lifetime of the Demonstration and at its conclusion.

Vermont will select an independent contractor to conduct the evaluation. The contractor's work will be overseen by the Quality Improvement team within the Agency of Human Services (AHS), Vermont's Single State Agency for Medicaid.

Background

The initial Global Commitment to Health (GC) and Choices for Care (CFC) demonstrations were approved in September of 2005, effective October 1, 2005. The GC demonstration was extended for three years, effective January 1, 2011, again for three years starting effective October 2, 2013. The CFC demonstration was extended for five years effective October 1, 2010. The following amendments have been made to the GC demonstration:

- 2007: the state added a component of the Catamount Health program, enabling the state to provide a premium subsidy to Vermonters who had been without health insurance coverage for a year or more, had income at or below 200 percent of the FPL, and did not have access to cost-effective, employer-sponsored insurance, as determined by the state.

- 2009: the state extended Catamount Health coverage to Vermonters with income at or below 300 percent of the FPL.

- 2011: the state added a palliative care program for children who are at or below 300 percent of the FPL and have been diagnosed with life-limiting illnesses that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training, and respite for caregivers.

- 2012: CMS provided authority for the state to eliminate the $75 inpatient admission co-pay and to implement nominal co-payments for the Vermont Health Access Plan (VHAP) as articulated in the Medicaid state plan.

- 2013: CMS approved the extension of the GC demonstration, which included sun-setting the authorities for most of the 1115 Expansion Populations since they would be eligible for Marketplace coverage beginning January 1, 2014. The renewal authorized Vermont to add the New Adult Group to the demonstration effective January 1, 2014; provide hospice services to adults concurrently with curative therapy; provide premium subsidies for individuals enrolled in a qualified health plan whose income is at or below 300 percent of the FPL; and made Designated State Health Program (DSHP) funding available to support individuals with a severe and persistent mental illness and income between 133 percent of the federal poverty level (FPL) and up to and including 185 percent FPL. Vermont received transitional coverage DSHP authority through April 30, 2014, to assist the state in transitioning individuals in the former Expansion Populations to the appropriate coverage vehicle.

- 2015: As of January 30, 2015, the GC demonstration was amended to include authority for the former Choices for Care demonstration. In addition, the state received section 1115 authority to provide full Medicaid state plan benefits to pregnant women who are determined presumptively eligible.

The Global Commitment to Health Section 1115(a) demonstration is designed to use a multi-disciplinary approach including the basic principles of public health, the fundamentals of effective administration of a Medicaid managed care delivery system, public-private partnership, and program flexibility. Specifically, Vermont expects to demonstrate its ability to achieve universal access to health care, cost containment, and improved quality of care.

Global Commitment Demonstration Goals

The state's goal in implementing the demonstration is to improve the health status of all Vermonters by:

- Increasing access to affordable and high-quality health care;
- Improving access to primary care;
- Improving the health care delivery for individuals with chronic care needs;
- Containing health care costs; and
- Allowing beneficiaries a choice in long-term services and supports and providing an array of home and community-based alternatives recognized to be more cost-effective than institutional-based supports.

The state employs five major elements in achieving the above goals:

1. *Program Flexibility:* Vermont has the flexibility to invest in alternative services and programs designed to achieve the demonstration's objectives (including the Marketplace subsidy program);
2. *Managed Care Delivery System:* Under the demonstration the AHS will enter into an agreement with the Department of Vermont Health Access (DVHA), which will

operate using a managed care model;

3. *Removal of Institutional Bias:* Under the demonstration, Vermont will provide a choice of settings for delivery of services and supports to older adults, people with serious and persistent mental illness, people with physical disabilities, people with developmental disabilities, and people with traumatic brain injuries who meet program eligibility and level-of-care requirements.
4. *Aggregate Budget Neutrality Cap:* Vermont will be at risk for the caseload and the per capita program expenditures, as well as certain administrative costs for all demonstration populations. Effective January 1, 2014, the new adult group will not be included in the total computable aggregate cap, but will be subject to a separate per member per month (PMPM) budget neutrality limit; and
5. *Marketplace Subsidy Program:* To the extent it is consistent with Vermont's aggregate budget neutrality cap, effective January 1, 2014, Federal Financial Participation (FFP) will be available for state funds for a Designated State Health Program (DSHP) to provide a premium Marketplace subsidy program to individuals up to and including 300 percent of the FPL who purchase health care coverage in the Marketplace.

Each of the Demonstration goals has specific, measurable, achievable, realistic, and timed (SMART) objectives that will assess and directly influence changes in access, cost, and quality during the life of the Demonstration. The objectives and related performance measures and targets are outlined in Section IV of this Evaluation Plan.

Evaluation Requirements and Scope

The Global Commitment Special Terms and Conditions (STC) contain specific requirements for evaluation of the Demonstration. STC 63 addresses submission of the draft evaluation design and is excerpted below:

> *The state must submit to CMS for approval a draft evaluation design for an overall evaluation of the demonstration no later than 120 days after CMS' approval of the demonstration amendment. At a minimum, the draft design must include a discussion of the goals and objectives set forth in section II "Program Description and Objectives," as well as the specific hypotheses that are being tested, including those indicators that focus specifically on the target populations and the public health outcomes generated from the use of demonstration funds. The evaluation must take into account lessons learned from the evaluation of demonstration periods prior to the current renewal period. The evaluation design must also discuss the state's plans to evaluate the Marketplace subsidy program. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include how the state will evaluate the*

impact that charging premiums has on children's coverage. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration must be isolated from other initiatives occurring in the state. The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

This Evaluation Plan, specifically Sections II through VI, addresses all of the required elements outlined in the Special Terms and Conditions. This Evaluation Plan is designed to answer four fundamental questions:

1. To what degree did the Demonstration achieve its goals and objectives?

2. What lessons were learned as a result of the Demonstration and what would Vermont recommend to other states that may be interested in implementing a similar Demonstration?

3. In what ways, and to what extent, were outcomes for enrollees, providers, and payers changed as a result of the Demonstration?

4. Did the reallocation of resources in the Demonstration generate greater value for the state's program expenditures?

The information learned from the evaluation will be used to guide and inform both current and future planning. The evaluation is separate from, but linked to, the state's other quality assessment and improvement activities. It goes beyond quality assurance, quality measurement, and performance improvement by evaluating areas of the Demonstration other than those specified in the Quality Strategy.

AHS is interested in using the evaluation to identify both successes and opportunities for improvement. In addition, the evaluation incorporates different types of measures (e.g., financial, clinical, and program) and different targets (e.g., population groups, payers, and providers).

The state plans to use the results of the evaluation to inform its future policy decisions with respect to the evolution of its health care system and policy planning efforts. In addition to the hypotheses being tested as part of this Evaluation Plan, the state will continue to monitor the program for its impact in relation to the Healthy Vermonters 2020 goals. While the above questions cannot be conclusively answered until the end of the Demonstration, this Evaluation Plan includes ongoing information collection on the incremental progress of the Demonstration; it is designed to measure changes before, during, and after the Demonstration.

External Quality Review Organization

AHS has contracted with an External Quality Review Organization (EQRO) to conduct the federally required review of the State's adherence to Medicaid Managed Care rules as defined in 42 CFR 438 Subpart E (i.e., the activities listed in Exhibit 1 below). Information from these activities is incorporated into this Evaluation Plan.

Exhibit 1: EQRO Activities

Activity	Requirement
Preparation of detailed technical report	Mandatory
Validation of Performance Improvement Projects	Mandatory
Validation of MCO performance measurements reported	Mandatory
Review to determine MCO compliance with standards	Mandatory

As noted, the Demonstration evaluation will be performed by an independent contractor, subject to ongoing oversight, analysis, and monitoring by AHS Quality Improvement staff. AHS also will be responsible for the quarterly and annual reporting requirements.

Evaluation Plan Components

Section II of this Evaluation Plan identifies the Evaluation Framework. The Framework lays out the state's proposed approach for assessing the impact of the Demonstration on certain aspects of care (i.e., structure, process, and outcomes) as they relate to access, quality, and cost of care.

Section III of this Evaluation Plan describes the evaluation strategy. This section outlines the Formative and Summative evaluation activities included in the plan and describes how evaluation findings will be incorporated into the state's continuous quality improvement activities. It also presents a timeline for completion of key evaluation activities.

Section IV identifies the goals, objectives, and hypotheses being tested, as well as the indicators (performance measures) being used to monitor progress toward achievement of the goals.

Section V provides additional information on evaluation methods, procedures, data sources, and sampling methodologies.

Section VI outlines the data analysis plan and discusses reporting of findings.

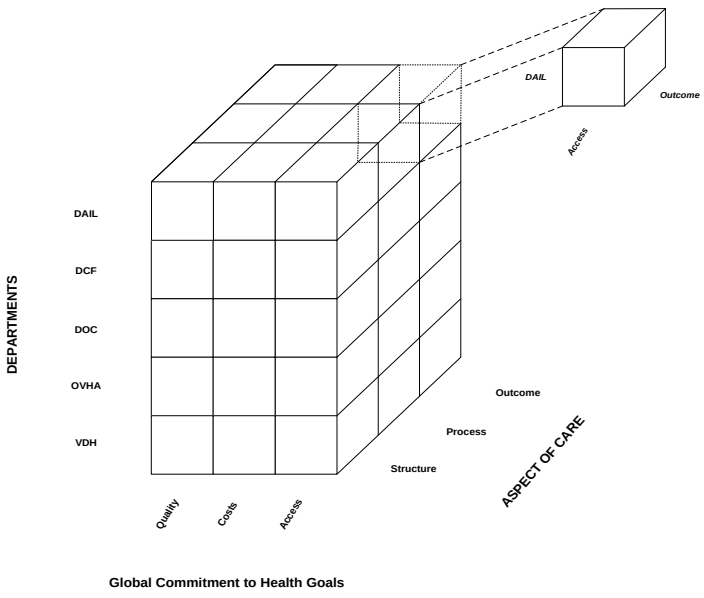
II. Evaluation Framework

According to the Global Commitment's Special Terms and Conditions (STCs), Vermont operates its Medicaid Program in accordance with federal managed care regulations, found at 42 CFR 438. The Agency of Human Services (AHS), as Vermont's Single State Medicaid Agency, is responsible for oversight of the managed care model. The Department of Vermont Health Access (DVHA) operates the Medicaid program as if it were a Managed Care Organization in accordance with federal regulations. Program requirements and responsibilities are delineated in an inter-governmental agreement (IGA) between AHS and DVHA. CMS reviews the IGA annually to ensure the State's compliance with the Demonstration STC's.

DVHA also has sub-agreements with the other state entities that provide specialty care for GC enrollees (e.g., mental health services, developmental disability services, and specialized child and family services). With the consolidation of the State's two Section 1115 Demonstrations in January of 2015, DVHA now has a sub-agreement with the Department of Disabilities, Aging, and Independent Living on the operations of the Choices for Care Managed Long-Term Services and Support (MLTSS) Program.

The Global Commitment Demonstration will use the Evaluation of Quality Rubric (EQR) evaluative framework depicted in Exhibit 2 below to guide its development, implementation, and evaluation. The EQR Model is a modification of Hammond's EPIC Evaluation Model (Hammond 1973; Fitzpatrick, Sanders, & Worthen 2004), addressing the specific contextual (department), conceptual (Institute of Medicine Quality Domains), and quality framework (Donabedian's Aspects of Care) inherent to the AHS mission and structure.

Exhibit 2 – EQR Model



The EQR Model facilitates making the model's goals and performance objectives operational, while providing a unified mechanism for assessing factors that influence the success or failure of specific activities at the department level and across the larger AHS. A brief definition of each dimension and respective cell components follows.

Departments

The following lists the characteristics of the individual departments comprising AHS.

- *Department of Disabilities, Aging, and Independent Living (DAIL)*: DAIL assists older Vermonters and people with disabilities to live as independently as possible. It provides support to families of children with disabilities to help maintain them in their home. It helps adults with disabilities find and maintain meaningful employment, and it ensures quality of care and life for individuals receiving health care and/or long-term care services from licensed or certified health care providers. DAIL also protects vulnerable adults from abuse, neglect, and exploitation and provides public guardianship to elders and people with developmental disabilities. DAIL operates the Choices for Care MLTSS program and also oversees programs for two of Vermont Special Health Needs populations defined under the Global Commitment demonstration, including persons with: Traumatic Brain Injury; and Developmental Disabilities.

- *Department for Children and Families (DCF)*: DCF promotes the social, emotional, physical, and economic well-being of Vermont's children and families. It achieves this mission by providing Vermonters with protective, developmental, therapeutic, probation, economic, and other support services. To this end, DCF works in statewide partnership with families, schools, businesses, community leaders, and service providers.
- *Department of Corrections (DOC)*: In partnership with the community, DOC supports safe communities by providing leadership in crime prevention, repairing the harm done, addressing the needs of crime victims, ensuring accountability for criminal acts, and managing the risk posed by offenders. This is accomplished through commitment to quality services and continuous improvement while respecting diversity, legal rights, human dignity, and productivity. DOC manages offender risk in partnership with communities, operates correctional facilities for the disciplined preparation of offenders to become productive citizens, supervises offenders serving sentences in the community, and reintegrates offenders after release. DOC helps communities with Reparative Boards and Community Restorative Justice Centers to address victims' needs and provides opportunities for offenders to make amends for the harm done to the community.
- *Department of Mental Health (DMH)*: The mission of DMH is to promote and improve the mental health of Vermonters and to provide Vermonters with access to effective prevention, early intervention, and mental health treatment and supports as needed to live, work, learn, and participate fully in their communities. DMH consists of two programmatic divisions: the Adult Mental Health Services Division and the Child, Adolescent, and Family Mental Health Services Division. DMH has primary responsibility for overseeing the quality of psychiatric and mental health care provided for two of Vermont’s Special Health Needs populations defined under the Global Commitment

demonstration, including persons with a severe and persistent mental illness and children who are experiencing a severe emotional disturbance.

- *Department of Vermont Health Access (DVHA)*: DVHA, which operates the Medicaid program as if it were a public MCO under Global Commitment Demonstration, has a three-fold mission:
  - To assist beneficiaries in accessing clinically appropriate health services;
  - To administer Vermont's public health insurance system efficiently and effectively; and
  - To collaborate with other health care system entities in bringing evidence-based practices to Vermont Medicaid beneficiaries.

- *Vermont Department of Health (VDH)*: VDH's goal is to have the nation's premier system of public health, enabling Vermonters to lead healthy lives in healthy communities. VDH leads the state and communities in the development of systematic approaches to health promotion, safety, and disease prevention. VDH continuously assesses, vigorously pursues, and documents measurable improvements to the health and safety of Vermont's population. VDH will succeed through excellence in individual achievement, organizational competence, and teamwork within and outside of VDH.

Demonstration Goals

Quality of Care

"Quality" is defined as the degree to which programs/services and activities increase the likelihood of desired outcomes. The EQR Framework uses the Institute of Medicine health care quality domains as a guide.

The six domains necessary for assuring quality health care identified by the Institute of Medicine (IOM, 2001) are:

- *Effectiveness*: Effective health care provides evidence-based services to all who can benefit, refraining from providing services that are not of benefit.
- *Efficiency*: Efficient health care focuses on avoiding waste, including waste of equipment, supplies, ideas, and energy.
- *Equity*: Equal health care provides care without variation in quality due to gender, ethnicity, geographic location, or socioeconomic status.
- *Patient Centeredness*: Patient-centered care emphasizes a partnership between provider and consumer.
- *Safety*: Safe health care avoids injuries to consumers from care that is intended to help.

- *Timeliness*: Timely health care involves obtaining needed care and minimizing unnecessary delays in receiving care.

Access to Care

All Global Commitment (GC) enrollees must have access to comprehensive care, including financial, geographic, physical, and communicative access. This means having health insurance, appropriate providers, timely access to services, culturally sensitive services, and the opportunity for second opinions as needed. Access to Care Standards were developed for the Global Commitment Demonstration based on requirements outlined in 42 CFR 438.206 - 210.

Cost of Care

Cost effectiveness takes into consideration all costs associated with providing programs, services, and interventions to the GC population. It is measurable at the category-of-service, individual enrollee, aid category, and aggregate program levels.

Aspects of Care

The Evaluation Framework also uses Donabedian's aspects of care (i.e., structure-process-outcomes) (Donabedian, 1980).

- *Structure*: Structure refers to components (e.g., organizational units and individuals) and their relationships to each other. Evaluating "structure" means determining the degree to which the necessary components and relationships are in place, operational, and of sufficient quality to produce the outcomes desired.
- *Process*: Process refers to what the components do. Evaluating "process" means measuring the level of performance of the components individually and of the system, program, or waiver as a whole.
- *Outcomes*: Outcomes refer to the results for, and impacts on, different parties (e.g., enrollees, providers, payers, and employers). Evaluating "outcomes" means measuring the results and impacts for each type of party. Outcomes can be classified as financial, clinical, or humanistic:
    - Financial Outcomes - Utilization and cost patterns;
    - Clinical Outcomes - General and disease-specific functional measures (e.g., health status), events (e.g., myocardial infarction, hospital acquired infection, and hospitalization), and surrogate markers (e.g., clinical depression - Hamilton Depression Inventory score $\geq$ 19.0); and

- Humanistic Outcomes - Beneficiary perspective measures of day-to-day well-being and functioning (e.g., quality of life) and experience in receiving care (ambulatory/inpatient care surveys).

Rarely are all 45 cells within the rubric of the EQR Model used in any evaluation study. Frequently many cells prove irrelevant to a specific evaluation yet help in defining those cells that are most important. Thus, the EQR Model is serving as a guide for identifying appropriate assessment activities for formative and summative evaluation.

References

Donabedian, (1980). Definitions of quality and approaches to its assessment. Foundation of the American College. New York, NY.

Hammond, R.L. (1973). Evaluation at the local level. In B.R. Worthen & J.R. Sanders, *Educational evaluation: Theory and practice.* Belmont, CA: Wadsworth.

Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century.*Washington, DC: National
Academy Press, 2001

Institute of Medicine. (2001). Envisioning the national health care quality report. Washington, DC: National Academy Press.

Fitzpatrick, J.L., Sanders, J.R., Worthen, B.R.. (2004). *Program evaluation: Alternative approaches and practical guidelines* (3rd Ed.). New York: Allyn & Bacon.

III. EVALUATION STRATEGY

The evaluation strategy for the Global Commitment Demonstration is designed to measure the degree to which its purposes, aims, goals, and objectives have been achieved. The evaluation is designed to not only address the long-term impact, but also to provide intermediate and short-term data on its performance.

In addition to assessing its overall impact, the evaluation examines the specific effects of the innovative changes made possible as a result of the Demonstration. As a result, the plan utilizes both performance measurement results (providing more real-time data focused on whether a program is achieving measurable objectives) and more rigorous program evaluation findings that typically examine a broader range of performance information.

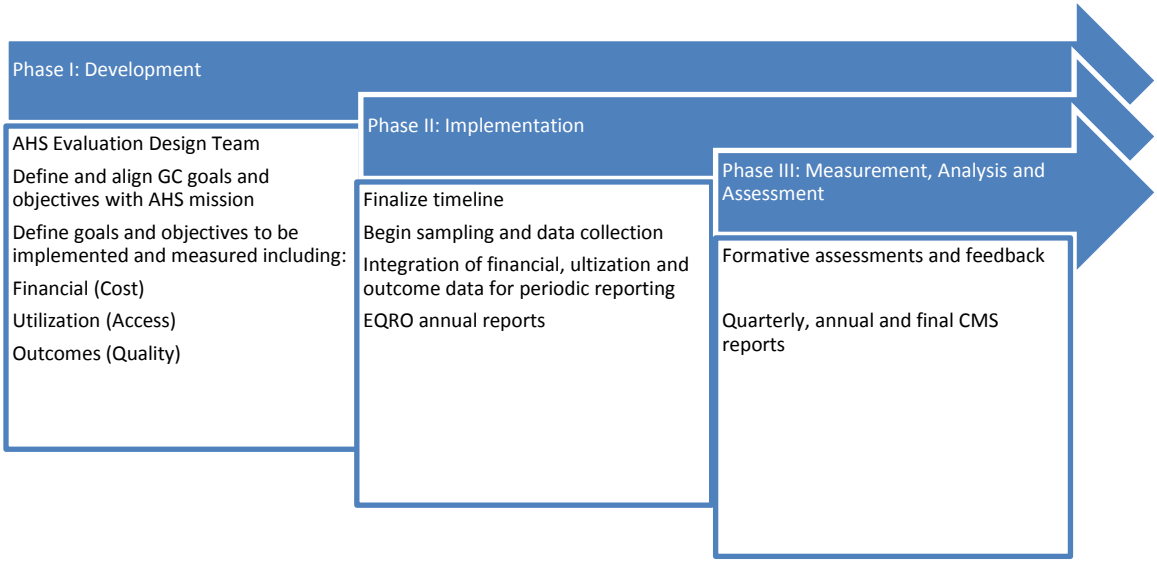
Broader evaluation provides an assessment of whether the Demonstration achieved its overall goals, as well as helps to identify adjustments that may improve its results. As a result, the data collection methodology is applied during all three phases of implementation (i.e., pre-implementation, implementation, and post-implementation). The methodology is illustrated in Exhibit 3 on the next page.

To ensure that the Demonstration is implemented as intended and achieves the related goals/objectives and desired outcomes, this Evaluation Plan comprises both **Formative** and **Summative** designs and employs both qualitative and quantitative methods to collect and analyze data. This Evaluation Plan will not focus on outcomes exclusively, but is also interested in capturing any evidence that the Demonstration is building momentum toward: (A) increased access (including choice of LTSS settings); (B) enhanced quality; and (C) decreased cost. In addition, both designs allow for feedback that is used to modify implementation and the programs/services/interventions or changes that happen as a result.

Formative Evaluation

Formative evaluation addresses whether the Demonstration was implemented as planned and is meeting its intended goals, objectives, and outcomes. Results from the Formative evaluation activities will act as an "early warning system," alerting AHS to any deviations from the proposed plan. This information will directly influence decision-making by giving AHS early and frequent insights into any potential shortcomings, oversights, or problems. Documenting the Demonstration's development and operation provides an understanding of the reasons for successful or unsuccessful performance, provides direction in shaping program modifications and improvement, and provides information about whether evaluation findings can be generalized.

Exhibit 3 – Evaluation Strategy Phases



The Formative evaluation incorporates both *qualitative* and *quantitative methods* designed to answer the following questions: (1) Is the Demonstration being implemented in the manner in which it was intended? (2) What types of deviations occurred? (3) What impact did the deviations have on the objectives? and (4) What programs/services/interventions are being provided to whom and at what cost?

In order to answer the above questions, data will be collected and analyzed to determine the relationship between actual and proposed accomplishments. Analysis will be conducted from a number of different perspectives.

First, an Implementation Analysis will be conducted to determine if the Demonstration is being executed as planned. This analysis will be based on semi-structured, in-person interviews with key informants from the AHS Departments/Divisions, as well as community leaders, administrators, physician leaders, and others directly responsible for or knowledgeable about MCOs and health care in Vermont. Data collection will follow generally accepted principles for qualitative research. Common, structured interview protocols will be used to guide the in-person interviews, with separate protocols constructed for respondents in different organizations.

Next, a Managed Care Analysis will be conducted to provide a profile of the MCO at different points in time throughout the evaluation. Information will be gathered through interviews with key informants in the MCO, a sample of their providers, and state officials. Information will also be collected regarding: number of enrollees by type and age, number and types of providers, enrollment and disenrollment numbers, and grievance/appeal numbers.

Finally, a fiscal analysis will be conducted to monitor the Demonstration's impact on expenditures; information will be gathered from financial reports indicating the costs of service utilization by Medicaid enrollees by PCP, Specialist, ED visits, and inpatient stays. As outlined above, data collection will follow generally accepted principles for qualitative research.

The results of the Formative evaluation will be used to provide program staff with specific goals for the month, quarter, or year, and/or provide direction in shaping modifications that may be required to implement a more effective Demonstration.

Summative Evaluation

In addition to the Formative evaluation described above, Summative evaluation is used to measure how the Demonstration has changed or improved the health and well-being of the GC population. The Summative evaluation will answer the following questions: (1) Has the Demonstration increased access (including choice of LTSS settings) among enrollees? (2) Has the Demonstration reduced Medicaid costs? and (3) Has the Demonstration enhanced the quality of care for enrollees? In order to answer these questions, pre/post implementation data that identifies the impact of the Demonstration on access, cost, and quality will be collected.

To be a success at both the macro and micro levels, the Demonstration must show that there were positive changes to access, cost, and quality that came about as a result of the Demonstration and/or its sponsored programs/services/interventions or changes. As a result, effectiveness of the Demonstration depends on its ability to address the factors in communities that limit access, increase costs, and compromise quality.

In an attempt to capture this data, the MCO is required to submit annual Performance Measurement data to AHS. Measures, Metrics, and Indicators will be used to help define and measure progress towards the Demonstration's ability to enhance quality of the care (including outcomes and consumer satisfaction), increase access to care, and contain the cost of care.

The required performance measures are either HEDIS or HEDIS-like measures (see next section for complete list of Performance Measures used). The MCO will also be required to report enrollee experience based on the CAHPS or CAHPS-like model, with findings to be supplemented by targeted surveys for special needs populations. Annual data will be tracked and trended over time (when available).

In addition, inpatient and outpatient utilization, cost, and quality indicators for GC enrollees before and after their enrollment in the Demonstration will be analyzed and compared to benchmarks and/or targets to assess the attainment of these goals. This analysis will determine whether statistically significant differences exist year to year in access, cost, and quality.

Continuous Quality Improvement

The full value of any evaluation is only realized when it can provide ongoing feedback to the program and the affected population at large. As a result, flexibility and adaptability are institutionalized in this Evaluation Plan's careful commitment and ongoing adherence to Continuous Quality Improvement, which assigns paramount priority to continuing improvement (not merely initial), needs assessment, and ongoing monitoring and evaluation.

AHS will regularly monitor the Demonstration on the key outcome measures and performance targets and make changes as appropriate (obtaining CMS or legislative approval where needed). The information may include statistics related to program outcomes (quantitative data) or stories about a success with a beneficiary or organizing effort (qualitative data).

If, in the course of the implementation of the Demonstration, AHS finds it is not performing as expected on some of the measures, the AHS can make adjustments (obtaining CMS or legislative approval where needed) to improve the performance in meeting its purposes, aims, objectives, and goals. When a problem or opportunity for improvement is identified, Department/Division leaders will objectively define the issue, share valuable feedback, and provide recommendations for agreed upon changes in direction or improvement.

Using the expertise of Departments/Divisions and community partners, AHS will answer the following questions: What is causing the identified anomaly? What is the proposed solution or modification to promote improvement? What is the justification for the modification? What are the modifications (including the goals, objectives, responsibilities, and timelines)? By answering these questions, AHS will be able to examine why expected results are not materializing and decide on a new approach to achieve the intended results.

Subsequent to the analysis described above, AHS will identify possible solutions, implement changes as authorized, and collect additional data and information to see if the change has resulted in an improvement. Modifications to the plan will be made to include the necessary changes. New versions of the plan will be disseminated to CMS, while old copies will be filed for future reference.

In real practice, this commitment will yield a virtuous feedback cycle among and across evaluation activities. AHS evaluators consistently focus equally on *Formative* and *Summative* evaluation as a means of continually enhancing programs and helping course-correct activities with maximum flexibility and adaptability. This process of regularly measuring, monitoring, and making changes should result in continuous performance improvement in terms of achieving its performance targets and intended outcomes.

Timeline

This Evaluation Plan will be implemented in a highly integrated manner through completion of eight milestones:

1. Establishing the evaluation design;
2. Determining the research methods;
3. Identifying valid/reliable data;
4. Identifying and engaging stakeholders;
5. Collecting data on performance with respect to access, quality, and cost;
6. Analyzing and interpreting data;
7. Drafting evaluation report;, and
8. Disseminating findings.

These activities, which are explained in greater detail in the remaining sections, will be integrated under the direct supervision and oversight of the AHS Performance Accountability Committee (PAC), with day-to-day operational leadership from the AHS Quality Improvement Manager.

Exhibit 4 contains sample target dates for completion of the milestones. Final timelines will depend on dates of renewal approvals and CMS approved Demonstration design.

Exhibit 4 – Sample Evaluation Timelines

Year 9: (10/1/14-9/30/15)

		Waiver Year 9											
		Month:											
Activity/Milestone		**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
Establish Evaluation Design Based on final renewal design approved by CMS													X

Years 10: (10/1/15-9/30/16)

		Waiver Year 10											
		Month:											
Activity/Milestone		**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
Determine Research Methods		X											
Identify Valid/Reliable Data		X											
Collect Data		X	X	X	X	X	X						
Analyze and Interpret Data				X				X	X	X	X		
Create Report				X								X	
Disseminate Interim Findings				X									X

Years 11 and Beyond: (10/1/16-9/30/17)

		Waiver Year 11											
		Month:											
Activity/Milestone		**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
Revise design as needed		x	x	x	x	x	x						
Collect Analyze and Interpret Data						x	x	x	x				
Create Report								x	x	x			
Disseminate Interim Findings										x	x	x	x

IV. GOALS, HYPOTHESES, OBJECTIVES, & PERFORMANCE MEASURES

Goals

As identified in Section I, the interventions/changes implemented as a result of the Global Commitment Demonstration have the following overarching goals:

- To increase access;
- To enhance quality;
- To contain costs; and
- To allow choice of settings for long-term services and supports.

These goals encompass the Institute for Healthcare Improvement's (IHI) "Triple AIM." The Triple AIM's three dimensions include improving the beneficiaries' experience of care, improving the health of beneficiaries, and reducing the cost of health care.

Access to Care

The first goal of the Demonstration is to increase GC beneficiary access to primary care. In addition to directly measuring eligibility and enrollment and access to primary care providers, the evaluation will capture indirect measures such as emergency department visits and inpatient days.

Quality of Care

The second goal of the Demonstration is to enhance the quality of care, especially for individuals with chronic care needs. Methods used to determine quality include the review of the health care received by beneficiaries who were treated for a particular condition (e.g., childhood asthma, adult depression), the review of the standard of care provided to a particular group (e.g., young children), and examining beneficiaries' experience of care through surveys.

Cost of Care

The third goal of the Demonstration is to contain (i.e., maintain or reduce) spending in comparison to what would have been spent absent the Demonstration. While the Demonstration does not seek to make any fiscal changes (e.g., to increase copayment requirements) or programmatic changes (e.g., to reduce the scope of covered benefits), it does assume that the impact will be "cost neutral." In addition to measuring the average expenditures per beneficiary, looking at the amount of money spent on acute care, home health care, and prescription drugs, as well as the amount of money spent on those with chronic conditions, will help determine the impact of the Demonstration on the cost of care.

Choice of LTSS Settings

The fourth goal of the Demonstration is to allow beneficiaries a choice of where they receive their long-term services and supports. The State equalizes access to home- and community-based alternatives and institutional-based supports. Methods used to monitor institutional bias will include monitoring the number of beneficiaries receiving home care rather than institutional care. Measurement of participant choices will be through the use of beneficiaries' experience of care surveys.

Hypotheses

AHS has developed a series of hypotheses about the impact of the Demonstration on the applicable populations. These hypotheses articulate the outcomes AHS expects as a result of the Demonstration.

The specific hypotheses to be tested to measure the changes/intervention success in meeting these objectives are presented in Exhibit 5 below.

Exhibit 5 - Demonstration Hypotheses by Goal

Goal	Hypothesis
Access	The Demonstration will result in positive outcomes as measured by individual access to the care.
Quality	The Demonstration will result in positive outcomes as measured by quality of care.
Cost	The Demonstration will result in positive impacts as measured by cost of care.
Choice	The Demonstration will result in positive outcomes as measured by beneficiary choice of LTSS settings.

In addition to testing the hypotheses described in this Evaluation Plan, Vermont will continue its many activities directed at improving the quality of the program and the achievement of the Healthy Vermonters 2020 goals. The state has a long-term commitment to examining program results in an objective and unbiased manner. Where indicators show that the desired result is not being achieved, the state will be prepared to modify the program to ensure a positive result over the life of the Demonstration.

Objectives and Performance Measures/Targets

Objectives

AHS has established distinct Specific, Measurable, Achievable, Realistic, and Time (SMART) objectives that are linked to the goals of the Demonstration. These objectives will be used to

evaluate the performance of the Demonstration against the stated goals and related hypotheses, as well as drive AHS-wide performance improvement efforts.

Performance Measures

This Evaluation Plan incorporates the use of performance measures for the objectives based on the following criteria: 1) evidenced based; 2) potential for improvement; 3) prevalence or incidence; 4) substantial impact on health status and/or health outcomes; and 5) to the extent possible, adaptable measures across various practice settings. These measures will translate the goals of the Demonstration into concepts that can be measured and understood.

The Demonstration uses HEDIS as a guideline for its methodology to develop, collect, and report data for most of the targeted performance measures. Measures will be constructed from databases and analyzed using quasi-experimental, pre-post designs. Using these constructed measures, AHS will determine whether efforts to improve access (e.g., eligibility, enrollment, primary care visits, ED visits, and providers accepting Medicaid), enhance quality (e.g., immunization rates, appropriate medications for those with asthma, and LDL screening), and decrease costs (e.g., pharmacy, inpatient, and ED) were achieved. Performance measures specific to HCBS will also be included, such as ability of participants to live longer in their communities and experience an improved quality of life.

The performance measures give trend information, which provides guidance in designing focused interventions for quality improvement. Reported HEDIS rates also can be benchmarked to NCQA Medicaid HEDIS means and percentiles, and compared to results from other states.

One other important source of information to initiate and guide improvement efforts is the beneficiary. The most widely used instrument for collecting reports and ratings of health care services from the beneficiary's perspective is the CAHPS Health Plan Survey. CAHPS survey data allows entities to: 1) analyze performance compared to benchmarks; 2) identify changes or trends in performance; and/or 3) consider other indicators of performance. Vermont will combine CAHPS data with information collected through periodic surveys of targeted groups of Demonstration enrollees.

Demonstration objectives and performance measures are presented in Exhibit 6a through 6d and Exhibit 7 starting on the following page. Exhibit 6 provides measures for overall GC populations and Exhibit 7 provides measures associated with the Choices for Care Managed Long-Term Services and Support Program. All exhibits also address data collection methods for each measure, including sampling methodology, source of data, and measurement period.

Exhibit 6a. Demonstration Performance Measures (Access to Care)

Access to Care Measures				
Performance Measure	**Metric**	**Sampling Methodology**	**Source of Data**	**When Measured**
Ambulatory Care	Percent of adult enrollees who had an ambulatory or preventive care visit	Total population	MMIS	Annually
Well-Child Visits	Percent of children under age 12 who received well-child care from a PCP in accordance with the EPSDT periodicity schedule	Total population	MMIS	Annually
Adolescent Well-Care Visits	Percent of adolescents ages 12 to 21 who receive one or more well-care visits with a PCP during the measurement year	Total population	MMIS	Annually
Emergency Department Visits	Rate of ED visits per 1,000 member months	Total population	MMIS	Annually
Inpatient Admissions	Rate of inpatient admissions per 1,000 member months	Total population	MMIS	Annually
Mental Health Utilization	Percent of enrollees receiving mental health services	Total population	MMIS	Annually
Problems Getting Care	Percent of survey respondents indicating problems obtaining needed preventive care, tests or treatments	Random sampling	CAHPS survey, supplemented by targeted surveys for the special needs populations	Annually (CAHPS)
Getting Care Needed	Percent of survey respondents indicating they received necessary care	Random sampling	CAHPS survey, supplemented by targeted surveys for the special needs populations	Annually (CAHPS)

Physician Participation in Medicaid	Percent of active physicians participating in Medicaid – primary care and specialists	Total Population	Vermont Medical Association and MMIS	Pre- and Post-Demonstration
Health Coverage	Percent of uninsured Vermonters	Total Population	Vermont Household Insurance Survey	Every 3 years
Effect of Children's Premiums	Percent of families that activate enrollment by paying the first month's premium	Premium Population	Eligibility Records	Annually
Impact of Vermont Premium Assistance Program (VPA)	Percent of enrollees receiving VPA subsidy who maintain QHPs with no breaks in coverage	VPA Population	VPA Data	Annually

Exhibit 6b. Demonstration Performance Measures (Quality of Care)

Quality of Care Measures				
Performance Measure	**Metric**	**Sampling Methodology**	**Source of Data**	**When Measured**
Timeliness of Prenatal Care	Percent of pregnant women receiving prenatal care in first trimester	Random sampling	MMIS	Annually
Oral Health	Percent of enrollees ages 2 – 21 receiving at least one dental visit in measurement year	Random sampling	MMIS	Annually
Comprehensive Diabetes Care	Percent of enrollees ages 18 – 75 with diabetes who had HbA1c test, retinal exam, LDL-C screening, and medical attention for nephropathy	Random sampling	MMIS	Annually
Use of Appropriate Medications for People with Asthma	Percent of enrollees ages 5 – 56 with persistent Asthma who were appropriately prescribed medication	Random sampling	MMIS	Annually
Antidepressant Medication Management	Percent of enrollees receiving appropriate antidepressant medication management	Random sampling		Annually
Breast Cancer Screening	Percent of female enrollees age 50 to 74 who receive screening at appropriate intervals	Random sampling	MMIS	Annually
Chlamydia Screening	Percent of female enrollees screened	Random sampling	MMIS	Annually

Quality of Care Measures				
Performance Measure	**Metric**	**Sampling Methodology**	**Source of Data**	**When Measured**
Controlling High Blood Pressure	Percent of enrollees with high blood pressure who were appropriately prescribed medicine	Random sampling	MMIS	Annually
Follow up after Hospitalization for Mental Illness	Percent of enrollees discharged who had follow-up at 7 & 30 days	Random sampling	MMIS	Annually
Substance Use Treatment	Percent of enrollees using substances who engage in treatment	Random sampling	MMIS	Annually

Exhibit 6c. Demonstration Performance Measures (Experience of Care)

Experience of Care Measures				
Performance Measure	**Metric**	**Sampling Methodology**	**Source of Data**	**When Measured**
Health Plan	Enrollee rating of satisfaction with health plan	Random sampling	CAHPS survey, supplemented by targeted surveys for the special needs populations	Annually
Quick Care	Enrollee rating of ability to get care quickly	Random sampling	CAHPS survey, supplemented by targeted surveys for the special needs populations	Annually (CAHPS);
Overall Rating of Care	Enrollee rating of care received	Random sampling	CAHPS survey, supplemented by targeted surveys for the special needs populations	Annually (CAHPS);
Customer Service	Enrollee rating of customer service	Random sampling	CAHPS survey, supplemented by targeted surveys for the special needs populations	Annually (CAHPS);
Chronic Care Management	Percent of enrollees with targeted chronic conditions enrolled in chronic care management program	Total Population	VCCI Ad hoc reports	Annually

Exhibit 6d. Demonstration Performance Measures (Cost of Care)

Cost of Care Measures				
Performance Measure	**Metric**	**Sampling Methodology**	**Source of Data**	**When Measured**
Emergency Department Cost	Average annual per enrollee cost of ED visits	Total Population	MMIS	Annually
Inpatient Hospital Cost	Average annual per enrollee cost of inpatient hospital	Total Population	MMIS	Annually
Pharmacy Cost	Average annual per enrollee cost of prescription drugs	Total Population	MMIS	Annually
Total Cost per Enrollee	Average annual total cost per enrollee	Total Population	MMIS	Annually
Total Cost per Major Aid Category	Average annual total cost per major aid category group	Total Population	MMIS	Annually
Chronic Care Management Costs	Average annual per enrollee costs for chronic care management program participants	Total Population	MMIS	Annually
Budget Neutrality	Actual aggregate expenditures versus budget neutrality limit	Total Population	MMIS	Annually

Exhibit 7: Global Commitment Managed Long Term Services and Supports (Choices for Care)

Choices for Care MLTSS Measures							
Access	**Cost**	**Quality**	**Elimination of Institutional Bias**	**Metric**	**Sampling Methodology**	**Source of Data**	**When Measured**
✓				Total # of people served in CFC	CFC Population	MMIS	Annually
✓			✓	Total # of people served by setting: • Home and Community Based • Enhanced Residential Care • Nursing Facility	CFC Population	MMIS	Annually
✓			✓	Percent of people on CFC waiting by aid category	CFC Population	Care Management System (SAMS)	Annually
	✓		✓	Annual variance in expenditures to state CFC appropriation	CFC Population	MMIS; VISION Financial System	Annually
		✓		Percent of participants who report that the degree to which needs are met is excellent or good	Random Sampling CFC Population	CFC Participant survey	Annually
		✓	✓	Percent of participants who report that choice and control in planning services is excellent or good	Random Sampling CFC Population	CFC Participant survey	Annually
		✓		Percent of participants who report that they are satisfied with their social lives	Random Sampling CFC Population	CFC Participant survey	Annually
		✓		Percent of participants who agree or strongly agree that services help to maintain or improve their health	Random Sampling CFC Population	CFC Participant survey	Annually
✓		✓	✓	Percent of participants who agree or strongly agree that their current setting is the setting they choose	Random Sampling CFC Population	CFC Participant survey	Annually

V. DESIGN, METHOD, PROCEDURES & DATA SOURCES

Design

Both qualitative and quantitative designs will be used to address the research questions. Qualitative designs will be used to better understand the process of Demonstration implementation, and will include the use of purposeful sampling, interviews, and inductive analysis to discover patterns, themes, and interrelationships.

Quantitative designs will be used to better understand the impact of Demonstration implementation (i.e., the relationship that Demonstration participation has on access (including LTSS choice of settings), cost, and quality), and will include the use of probability sampling, descriptive/inferential statistics, and deductive analysis to generate relationships between variables that can be generalized to the broader Medicaid population. Quantitative designs can be descriptive or longitudinal and either cross-sectional or longitudinal.

Method

The analyses will utilize a mixed method approach to evaluating the impact of the Demonstration.

Qualitative research and methods involve hypothesis generation and the use of non-representative samples, unstructured or semi-structured data collection instruments, and non-statistical data analysis, resulting in findings that cannot be generalized. Common types of methods used include observations and in-depth interviews. The state, through the independent evaluators, will conduct interviews with AHS and health plan personnel responsible for the Demonstration to obtain their perspective on its successes, shortcomings, and lessons learned.

Quantitative research and methods involve hypothesis testing, use of random sampling, use of structured data collection instruments, statistical data analysis, and findings that can be generalized. This type of research involves the use of tools, such as questionnaires or equipment to collect numerical data. The state will use a variety of data collection techniques, as illustrated in Exhibit 6.

Procedure

Data will be collected using a structured and systematic process to ensure that information given to or requested from subjects does not vary by staff member or program participant. Evaluators will take into consideration variables such as demographic attributes and health status. In general, external factors are not expected to significantly affect the assessment of the hypotheses presented in this Evaluation Plan. However, where market conditions and other factors could have an impact, AHS and its evaluators will develop approaches to quantify and/or isolate the impact of such factors.

Instruments

Monitoring and evaluation rely on data collection instruments to elicit and record information. Existing data collection instruments will be used, when available. When appropriate, new data collection instruments will be developed. Various types of standard and/or developed data collection instruments (e.g., questionnaires, surveys, and interview guides) will be used throughout all phases of Demonstration implementation.

Frequency

This Evaluation Plan will incorporate the use of both cross-sectional and longitudinal data. Information on selected measures has been collected prior to Demonstration implementation. Data on the same measures will be collected post Demonstration. This data will show the change as a result of the Demonstration. In addition, data will be collected on a monthly, quarterly, and annual basis during the course of the Demonstration. This data will show how well the Demonstration is progressing toward meeting its goals.

Data Source

AHS will use a variety of sources and methods to test the above hypotheses, including beneficiary surveys and provider claims data. AHS staff and independent evaluators will also analyze data from third-party sources, such as the U.S. Census Bureau, for the purpose of measuring changes in the number of uninsured Vermonters over the life of the Demonstration, stratified by income and employment status.

Vermont data sources used to evaluate performance against Demonstration goals will include:

- DVHA (encounter and utilization data from MMIS Claims)
- State Medicaid information system files that include eligibility and enrollment data (ACCESS and Vermont Health Connect/Premium Assistance)
- Consumer Assessment of Health Plan Surveys (CAHPS)
- DAIL (Choices for Care) Consumer Experience Surveys
- DAIL Care Management System (Social Assistance Management System – SAMS)
- Vermont Health Care Quality Reports prepared by the state's External Quality Review Organization
- Targeted enrollee and provider surveys conducted specifically for the evaluation
- Quarterly Ombudsman Reports
- Vermont Department of Financial Regulation (formerly, Banking, Insurance, Securities and Health Care Administration (BISHCA)) 2005, 2008, 2009, 2012 and future Vermont Household Health Insurance Surveys.

VI. DATA ANALYSIS & REPORTING

Data Analysis

The evaluation data analysis will consist of both exploratory and descriptive strategies and incorporate univariate, bi-variate, and multi-variate techniques. SAS software will be used to systematically apply statistical and/or logical techniques to describe, summarize, and compare data within the state and across time, and to prepare data in a manner that permits comparison to results from other states applying the same methodology (e.g., HEDIS reports).

Descriptive statistics will be used to describe the basic features of the data and what they depict, and to provide simple summaries about the sample and the measures. Together with simple graphics analysis, the descriptive statistics form the basis of quantitative analysis of data. They are also used to provide simple summaries about the participants and their outcomes. An exploratory data analysis is used to compare many variables in the search for organized patterns. Data will be analyzed as rates, proportions, frequencies, measures of central tendency (e.g., mean, median, mode), and/or qualitatively analyzed for themes.

Inferential statistics will be used to try to reach conclusions that extend beyond the immediate data alone. Fundamentals statistics will be used to describe inferences about the populations from which they were drawn.

Reporting

In quarterly and annual reports, AHS will describe results of the formative and summative evaluation methods outlined earlier. In addition, a final report will include the aforementioned information, and an analysis of pre/post-test access, cost, and quality data. This reporting format will allow interested parties to differentiate the incremental and overall impacts of the Demonstration.

Numerous strategies will be used to communicate evaluation findings (e.g., annual reports, website, and community meetings). Reports will be presented at meetings as well as distributed to AHS Departments/Divisions and more broadly to AHS community partners. Broad dissemination will occur via email distribution, as well as through AHS's website. Reports will be written so as to be readily understood by a variety of audiences and populations, including the special needs populations.