Washington State Medicaid Transformation Project

Section 1115 Demonstration Extension Request

Washington State Health Care Authority
Washington State Department of Social and Health Services

December XX, 2020

Introduction

The Washington State Health Care Authority (HCA) is requesting a one-year extension of the Medicaid Transformation Project Demonstration section 1115 waiver, which is scheduled to expire on December 31, 2021. Since 2017, Washington has been successfully implementing waiver initiatives and standing up programs, and sustainability planning work started in 2019 to ensure successful programs and investments will remain. As of March 2020, all aspects of this work have been disrupted due to the impact of the COVID-19 pandemic. In addition to the programmatic impacts, COVID-19 has significantly impeded the state's ability to plan with providers and state agencies on a full renewal application. Due to the ongoing pandemic, the state has been forced to delay renewal and transition planning to respond to emerging issues and focus on implementation of programmatic flexibilities to address new challenges. In order to preserve the system we are transforming and ensure that essential services remain for clients who rely on them, it is critical to extend current waiver and expenditure authorities for one additional year.

Washington State's Medicaid program

In Washington State, Medicaid is called Apple Health. Washington's Medicaid program, including both managed care and fee-for-service, is managed by the Washington State Health Care Authority (HCA).

As of August 2020, there were a total of 1,924,079 Apple Health eligible clients in Washington State. Of these, about 85% of clients are enrolled in a managed care plan, with the remaining 15% in the fee-for-service program. Slightly less than half, (44.49 percent) of clients, were age 19 or under. While about 30% of Washingtonians identify as non-white, over 40% of Apple Health clients are people of color and therefore more likely to experience health inequities.

Apple Health program enrollment has increased considerably in the last several months due to economic implications of the COVID-19 pandemic. From March through August 2020, just under 100,000 new individual clients were enrolled in the program.

Medicaid Transformation 1115 Waiver history and background

Washington State has a rich history of projects and initiatives related to health system transformation. Notable movements include Medicaid expansion in 2014, and two State Innovation Model grants in 2012 and 2015. These laid the groundwork for the Medicaid transformation efforts we are currently working on today.

On January 9, 2017, the Centers for Medicare & Medicaid Services (CMS) approved Washington State's request for a Section 1115 Medicaid demonstration waiver No. 11-W-00304/0, titled "Medicaid Transformation Project (MTP)." The activities of MTP aim to improve the health care delivery system's capacity to address local health priorities; deliver high-quality, cost-effective, whole-person care; and create a sustainable link between clinical and community-based services.

Over the five-year MTP period, Washington State committed to:

- Integrate physical and behavioral health purchasing and services to provide whole-person care. Whole-person care means care for the mind, body, and substance use disorder.
- Convert 90 percent of Medicaid provider payments to reward outcomes instead of volume of service.
- Support providers as they adopt new payment and care models.
- Improve health equity by implementing population health strategies.
- Provide targeted services to support the state's aging populations and their family caregivers, and address social determinants of health.
- Help our most vulnerable population get and keep stable housing and employment.
- Improve substance use disorder (SUD) treatment access and outcomes.

The state pledged to accomplish these goals through the following programs:

- Transformation through Accountable Communities of Health (ACHs) and Delivery System Reform Incentive Payment (DSRIP) program.
- Long-Term Services and Supports (LTSS): Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA).
- Foundational Community Supports (FCS): Community Support Services (CSS) and Supported Employment – Individual Placement and Support (IPS).
- SUD Program – treatment services, including short-term services provided in residential and inpatient treatment settings that qualify as an institution of mental disease (IMD).
- Mental Health Program – treatment services, including short term services provided in residential and inpatient treatment settings that qualify as an IMD.

Description of existing waiver initiatives

Initiative 1: Health System Transformation through ACHs and IHCPs
Initiative 1 is also referred to as the Delivery System Reform Incentive Payment (DSRIP) program. DSRIP enables communities to improve the health system at the local level, and is implemented through Accountable Communities of Health (ACHs) and Indian Health Care Providers (IHCPs).

Each ACH is performing transformation projects specific to the needs of its region. These projects focus on:

- Health systems and community capacity building by adopting a value-based payment system, developing the health care workforce, and making improvements in population health management, including enhanced data collection and analytic capacity.
- Care delivery redesign by integrating physical and behavioral health care, improving care coordination, making better transitions between services and settings, and improving diversion interventions (helping people access the most appropriate service or facility for their needs).
- Prevention and health promotion by focusing on opioid use, maternal and child health, access to oral health services, and chronic disease prevention and management.

Separate from the ACH portion of Initiative 1 are the Indian Health Care Provider (IHCP)-specific projects. Unlike other funds under this initiative, these funds are administered directly from HCA to

IHCPs. The projects are designed to benefit and address the unique needs of the Indian health care system. Project focus areas include:

- Implementation of State Health Official Letter #16-002, including a new alternative payment model for IHCPs and processes related to maintaining a contracted provider network;
- Building IHCP capacity, such as by integrating physical and behavioral health care, both in the clinic and in electronic health records;
- Expanding workforce capacity through the Community Health Aide Program (CHAP);
- Elder care coordination;
- SUD response integrated into law enforcement; and
- Traditional Healing integration.

Initiative 2: Long-term Services and Supports

Initiative 2 focuses on expanding options for people receiving long-term services and supports so they can stay at home and delay or avoid the need for more intensive services. Initiative 2 also supports families in caring for loved ones while increasing the well-being of caregivers. This initiative has two components:

1. **Medicaid Alternative Care (MAC)** - Creation of a benefit package for individuals who are eligible for Medicaid but not currently accessing Medicaid-funded LTSS. This benefit package will provide services to unpaid caregivers designed to assist them in getting supports necessary to continue to provide high-quality care and to focus on their own health and well-being.

2. **Tailored Supports for Older Adults (TSOA)** - Establishment of a new eligibility category and benefit package for individuals "at risk" of future Medicaid LTSS use who currently do not meet Medicaid financial eligibility criteria. This is designed to help individuals avoid or delay impoverishment and the need for Medicaid-funded services. The TSOA benefit package provides services and supports to unpaid family caregivers as well as services and supports to individuals without unpaid caregivers.

MAC and TSOA include the following benefits:

- ***Caregiver Assistance Services:*** Services that take the place of those typically performed by unpaid caregiver.
- ***Training and Education:*** Assist caregivers with gaining skills and knowledge to care for recipient.
- ***Specialized Medical Equipment & Supplies:*** Goods and supplies needed by the care receiver.
- ***Health maintenance & therapies:*** Clinical or therapeutic services for caregivers to remain in role or care receiver to remain at home.
- ***Personal Assistance Services***: Supports involving the labor of another person to help the recipient (TSOA individuals only).

Initiative 3: Foundational Community Supports

Social determinants of health are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes (Centers for Disease Control and Prevention). The research is clear—unemployment and job insecurity, homelessness, and unstable housing contribute to poor health. Homelessness is traumatic and cyclical; it puts people at risk for physical and mental health conditions and substance use disorders. Similarly, evidence links unemployment to poor physical and mental health outcomes, even in the absence of pre-existing conditions.

Foundational Community Supports (FCS) provides a set of Home and Community Based Services (HCBS), including Community Support Services (also called Supportive Housing) and Supported Employment Services (also called Individual Placement and Support Services). These benefits are effectively serving people throughout the state, people who are often the most vulnerable and have complex care needs. FCS is a partnership between Health Care Authority (HCA) and DSHS' Aging and Long-Term Support Administration. Amerigroup is the contracted third-party administrator for FCS. They work with a variety of agencies that provide supportive housing and supported employment services based on evidence-based practices to help people find and keep housing and jobs.

Supportive housing and supported employment services work with employers and property owners to match individuals with the right environment while providing ongoing support. These services do not pay for housing or for wages or wage enhancements.

Initiative 4: Substance use disorder (SUD) IMD waiver amendment
In July 2018, Washington State received approval of its 1115 Waiver amendment to receive expanded federal financial participation (FFP) for SUD treatment services, including short-term residential services provided in residential and inpatient treatment settings that qualify as an IMD. An IMD is a facility with more than 16 beds where at least 51 percent of the patients receive mental health or substance use treatment.

Initiative 5: Mental Health IMD waiver amendment
In November 2020, Washington state received approval of the MH IMD amendment to receive expanded FFP for mental health treatment services, including short-term inpatient, residential and other services provided to otherwise-eligible Medicaid beneficiaries while residing in institutions for mental diseases (IMD) primarily to receive treatment for diagnoses of serious mental illness (SMI). This federal match allows the state to address other necessary programs and services for some of the state's most vulnerable populations.

Promising progress

As we conclude year four of the Medicaid Transformation Project, several promising practices and implementation results are emerging. These include:

An operational statewide system of Accountable Communities of Health, including over 600 contracted community-based organizations (CBO) and provider organizations.
ACHs were first established in Washington in 2014, and have been building capacity over time into what is now a robust statewide network of organizations with a focus on whole person care, community health, social determinants of health, and health equity. ACHs have two years of project implementation progress, coordinating across a diverse set of partnering providers and communities. In addition to the contracted CBO and provider organizations, many partners are collaborating on a voluntary basis and even more providers are participating in DSRIP as an extension of the organizations under contract. ACHs have had time to mature and are also now working together as a more intentional statewide system for the first time. Notably, the ACHs have been playing a critical role during the COVID-19

pandemic, and represent important community-based infrastructure that needs to be maintained as this public health crisis continues.

Positive preliminary results from Foundational Community Supports program

The Foundational Community Supports (FCS) program assists the state's most vulnerable Medicaid clients find and keep stable housing and employment. FCS consists of two services, supportive housing and supported employment. A preliminary evaluation was performed by the Washington state Department of Social and Health Services Research and Data Analysis division (DSHS-RDA) on the first nine months of FCS program implementation. Findings were positive and included:

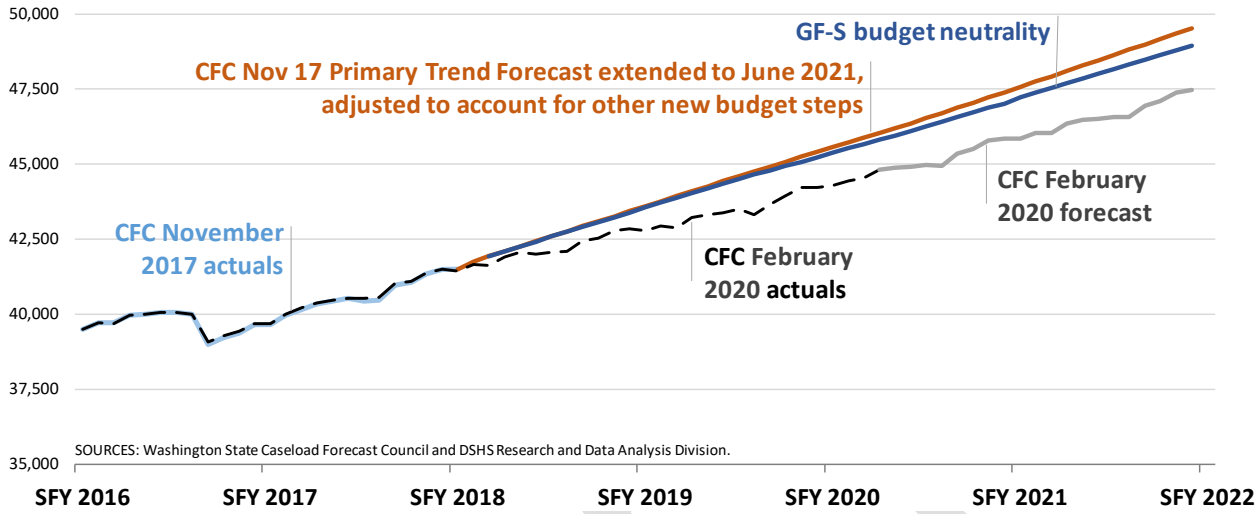
- People enrolled in supported employment services found employment at a higher rate, earned more money, and worked more hours.
- Supportive housing services helped people transition or begin to transition out of homelessness or housing instability.
- There were promising reductions in emergency room visits and hospitalizations for people enrolled in supportive housing services.

Steady rise in LTSS program enrollment

As of Q2, 2020 Initiative 2 served a total of 4,300 clients in the MAC and TSOA programs. A year later, the total number of clients served was 7,595. Apart from COVID-19 impacts, the MAC and TSOA programs continue to see a steady rise in clients taking advantage of these new services that allow for the most appropriate care and family supports, while avoiding the need for more intensive services. When the MAC and TSOA programs were implemented in 2017, the Legislature assumed the programs would produce offsetting savings in HCBS services. Although MAC and TSOA program savings have since been rolled into the "primary trend" forecasts for HCBS services, the budget forecast framework can be used to assess whether the MAC and TSOA programs are generating the expected level of savings.

Table 1

MAC/TSOA Caseload Impact Model for In-Home Personal Care



The results so far are promising. Although in-home personal care service caseloads continue to grow at more than 3 percent per year, caseload growth has been slower than originally forecast when the MAC and TSOA programs were implemented in the fall of 2017. Although other factors may have affected caseload trends, in-home service caseload trends are consistent with the MAC and TSOA programs achieving the level of savings necessary to be budget neutral from a State General Fund perspective.

Survey results indicate that most MAC and TSOA program participants are satisfied with the services they have received:

- Overall, 83 percent of survey respondents indicated they were satisfied with their respective program. Only 5 percent indicated that they were not satisfied with their program.
- Overall, 78 percent of survey respondents indicated that their respective program would delay their moving to a nursing home or adult family home. Only 9 percent indicated that their program would not delay their moving.

System savings and new capacity under the SUD/MH IMD waivers

As a result of the SUD and MH IMD waivers and associated Federal Financial Participation (FFP), the state is able to address other vital services. It is critical to maintain these flexibilities to support FFP for services in IMD facilities, which in turn supports the state's expansion of capacity to address the needs of one of Washington's most vulnerable populations.

These promising results are bringing value to the health and wellness system in Washington while also maintaining budget neutrality compared to what would be spent on Medicaid services without the Medicaid Transformation initiatives. In addition, these results have been achieved in the face of monumental challenges brought on by the COVID-19 pandemic this year.

Impacts of COVID-19

On January 21, 2020, Washington State experienced the first CDC-confirmed case of the novel coronavirus disease (COVID-19) in the United States. COVID-19 was observed to be a very contagious respiratory illness where infected people required significant medical intervention and experienced a high rate of mortality. On February 29, 2020, Washington announced the first death from COVID-19 in the United States. Washington was also one of the first states to institute a far-reaching stay-at-home order, on March 23, 2020. Due to this early transmission, the state was hit particularly hard, and pandemic response, as well as response to economic impacts of the statewide stay-at-home order, became critical priorities.

The reality of this pandemic, and subsequent economic implications, were a significant disruptor to Medicaid Transformation implementation, administration, service provision, and sustainability planning. Some of these specific disruptions include:

Implementation disruptions:
Providers working across MTP's initiatives were suddenly tasked with developing pandemic response strategies, adapting to new service modalities to support isolation and quarantine, and addressing unanticipated needs across the state's most vulnerable populations. Washington State's MTP Independent Assessor reported the following:

> *Due to the pandemic, there was a need for large-scale, expedited adjustments by the entire health care system that posed a formidable challenge. Health care systems required personal protective equipment (PPE), telehealth capabilities, and significant hospital bed capacity. Communities required new and expanded approaches to address housing, food insecurity, and remote education. HCA, the ACHs, and partnering providers were required to focus their attention on responding to this unprecedented crisis. As a result, HCA requested and the Centers for Medicare and Medicaid Services (CMS) approved, modifications and flexibilities to the authorities that govern the Medicaid program and the Medicaid Transformation waiver.*

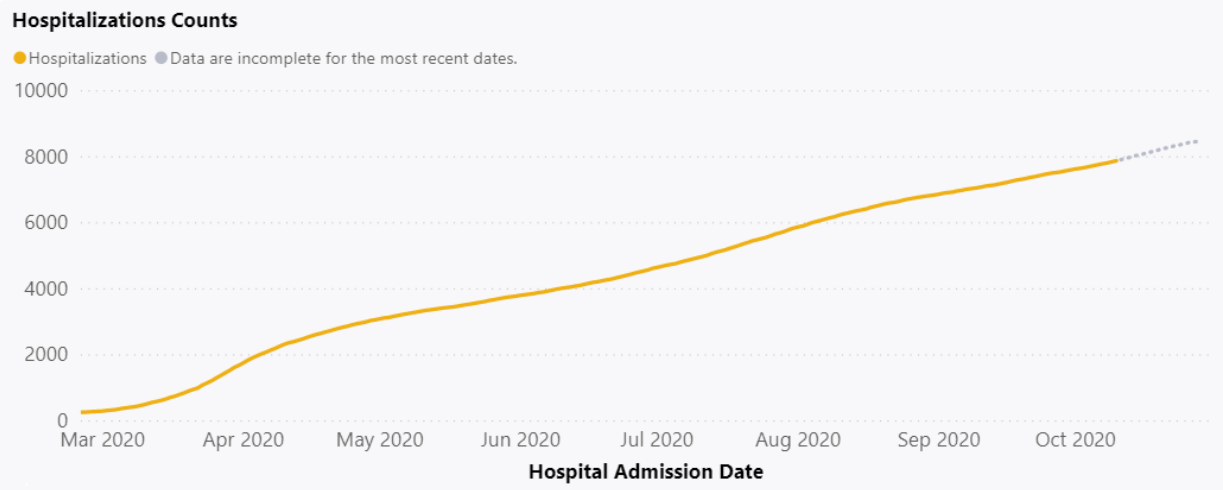
Sustainability planning disruptions:
As of early 2019, cross agency and cross-initiative work had begun to plan for the sustainability of waiver initiatives after the 5-year period was scheduled to end. This work involved facilitated discussion, policy research, and the analysis of promising practices and early evaluation results. Washington State had reached a phase early in 2020 where plans to pursue a full waiver renewal were in place, but more analysis and public input was needed to determine the best strategies and pathways to move forward. When the COVID-19 pandemic began, this work became untenable for several reasons. These included limited bandwidth of state leaders with roles in pandemic response, unknown future funding availability, disrupted implementation of waiver initiatives, and lack of capacity from partners to provide thoughtful input on the continuation of programs.

Health system disruptions
In addition to disruptions related to Medicaid transformation itself, COVID-19 also created large-scale disruptions to the state health system as a whole. Latest counts show over 105,000 confirmed COVID-19 cases in the state and approximately 8% of those have resulted in hospitalization. The graph below shows the steady rise in COVID-19 related hospitalizations impacting the health care system as reported by the Washington State Department of Health. [1]

[1] WA State DOH COVID-19 Dashboard: https://www.doh.wa.gov/Emergencies/COVID19/DataDashboard

Table 2

COVID-19 related hospitalizations impacting the health care system



207 hospitalizations do not have a hospital admission date reported. 31% of statewide confirmed cases have unknown hospitalization status. Hospitalizations from the last 18 days may not yet be reported.

By design, the Medicaid Transformation Project covers many different provider types and sectors, and with such large-scale disruptions affecting provider capacity, risk appetites, client needs, and state infrastructure, Medicaid Transformation and DSRIP performance was affected. Some examples include:

- **Sudden decrease in clients served:** In the spring and early summer, providers were determining how best to serve clients during the Governor's stay-at-home directive, and when they experienced fewer clients seeking services.

- **Delivery system fatigue impacting DSRIP:** Provider capacity constraints, revenue challenges, and reporting burden resulted in unavoidable impacts on DSRIP project implementation for a period of time due to competing priorities amidst the pandemic. These impacts were broad, as many providers were participating in many DSRIP projects. An example of this was provider reporting for progress on behavioral health integration and opioid treatment. COVID demanded provider capacity to transition to telehealth and implement new billing practices among other adjustments. Many providers were no longer able to keep up with these types of reporting requirements.

- **VBP advancement and contracting constraints:** Due to provider revenue shortfalls and other disruptions, providers and plans were more hesitant to enter into VBP arrangements that could add additional risk to an already uncertain outlook.

- **Amplified health disparities and increased need for social supports and clinical-community linkages:** COVID-19 made more visible the health disparities experienced by marginalized and vulnerable groups nationwide. In addition, economic consequences of pandemic response included widespread job-loss, shutting down of needed services such as public transportation, supply-chain disruptions, and other barriers to addressing basic social needs. To use an initiative 2 example, due to the disproportionate impacts of COVID on the older adult population there is

greater impact on care recipients, their caregivers and families. Issues of social isolation and caregiver stress and burden have been identified in national and state studies looking at the impacts of COVID. Workforce shortages which have been prevalent in long term care for years have been exacerbated during the pandemic.

- **Gaps in infrastructure and broadband among providers and communities, limiting telehealth and access to services:** It became clear that not all communities had the infrastructure to participate in health care services or receive supports remotely. Rural areas in Washington that lack reliable connectivity exacerbated the ability for people and their families to engage in needed services, even with new technologies and flexibilities being implemented.

The role of MTP initiatives in continued COVID-19 response

In spite of the real challenges and disruptions described above, the MTP initiatives provided the capacity to pivot and use existing infrastructure to respond to the pandemic in critical ways. These response efforts began in March 2020, and supported providers, communities, organizations, and health systems as they navigated unanticipated needs and issues. Each MTP initiative was well-positioned to respond to local and regional needs in a systematic way, through provider networks and robust community engagement mechanisms that were in place before the pandemic. CMS approved certain flexibilities early on, which allowed for additional relief to extend to providers and community organizations implementing projects. Flexible options for receiving and performing services were offered to clients and providers. This capacity across MTP resulted in targeted and effective COVID-19 response across a broad range of community needs. Below are additional examples of how initiatives contributed to COVID-19 response and recovery.

Initiative 1

Through their community-based work, ACHs have developed a unique foundation to respond to and understand emerging community needs. Examples of ACH work under MTP include supporting and incentivizing the integration of physical and behavioral health care, preventing opiate misuse, and supporting community organizations that help people manage chronic illness. Because of this experience, ACHs are playing a key role in COVID-19 relief efforts by:

- Helping individuals receive food and health care.
- Assisting small providers and CBOs to shift to telehealth and/or improve access to services.
- Distributing personal protective equipment, including over 4.4 million masks.
- Partnering with local health jurisdictions and community organizations to alleviate uncertainty by informing community providers and families about the virus, testing, new state flexibilities, available resources, and federal relief.
- Addressing SDOH by supporting efforts to provide food, housing, language access, legal support, and other needs.

In addition, various grants and relief funding became available as the implications of COVID-19 became apparent. ACHs successfully identified and worked to mitigate two related challenges: 1) the need to coordinate recovery investments and efforts across communities and sectors, and 2) the need to support communities and organizations in accessing and navigating available supports at a time when

communities and organizations can't otherwise support themselves. This work began very early in the pandemic, and is ongoing.

Initiative 2

This initiative focuses on supporting older adults—a population deeply affected by COVID-19—and family caregivers. In response to the pandemic, Initiative 2 expanded care options for older people, while keeping them at home where risk of exposure is less than in congregate care facilities. Services, such as home-delivered meals, personal care, respite care, and errands to the grocery store and pharmacy, have been allowing at-risk populations to follow public health guidelines to stay home.

Initiative 3

Foundational Community Supports (FCS) promotes recovery and self-sufficiency for Medicaid beneficiaries with behavioral health needs and other health risks by finding and maintaining housing and competitive employment. During the COVID-19 pandemic, FCS has continued to provide critical services to clients seeking to obtain and maintain housing and employment. Covid had significant impacts to housing stability and increases in unemployment throughout the state, and the use of these two evidence-based practices provided foundational services during difficult economic times.

Initiatives 4 & 5

Initiative 4 provides additional federal MTP funding for expanded substance use disorder treatment in participating health care facilities. This financial support has continued throughout the COVID-19 pandemic. Initiative 5 supports the development of extended services in participating facilities for enrollees with serious mental health conditions.

The role of MTP in system-wide response efforts

It was clear early on that all of the waiver initiatives and programs had a responsibility to respond to the COVID-19 pandemic, even though this was a deviation from steady progress toward the goals and objectives of the Medicaid Transformation Project. After working with CMS to secure flexibilities on performance accountability and reporting requirements, initiatives were able to respond more fully to the critical needs of communities affected most from COVID-19 and related economic and health equity issues, as described above. In addition, MTP has been able to address more system-wide recovery issues. Below are several examples of emerging opportunities that are gaining momentum.

Telehealth and broadband to support access

HCA, in partnership with the Behavioral Health Institute at the University of Washington conducted a telehealth needs assessment to gather information about the telehealth needs of behavioral health clinicians and clients. This allowed HCA to better understand and respond to the needs of behavioral health agencies across the state, and inform state policy decisions around enabling telehealth access and technology. Early on in the pandemic, state guidelines on the ability to bill for telehealth or telephone visits changed to be more supportive of remote access options for providers and patients. ACHs provided training and technical assistance opportunities, including infrastructure grants, to support providers in offering more access to clients remotely and billing appropriately for these visit types.

HCA worked with the Governor's office to stablish a Broadband Subcommittee to help address gaps in broadband across the state. These gaps exist in rural and other underserved areas, and can have a marked impact on the ability of individuals to get needed care via telehealth. The Broadband Subcommittee launched an "internet speed test" for individuals and providers across the state to measure their connectivity, and in turn populate a statewide map to show the location of access gaps. This is another example of the important work to continue through the extension year to support access to services and supports.

In addition, HCA distributed thousands of donated phones to Washingtonians to support access to telehealth and community resources to better navigate services during COVID-19. FCS providers, homeless service providers, homeless outreach teams, and behavioral health outpatient facilities helped distribute the phones. This has been a unique opportunity to further test and better understand how these additional resources can help achieve the goals of permanent employment, stable housing, and related social supports.

Health Information Exchange to support clinical-community linkages:
Many HIE and Community Information Exchange efforts have emerged leading up to and in response to COVID-19 care coordination and contact tracing needs. Through the extension year, the state and ACHs will continue developing standards to support interoperability across programs and HIE solutions to better connect partners and enable closed-loop referrals.

Connecting community members to needed supports, such as housing, delivery of food or clothing, or other needs is critical to health and well-being. This helps individuals and communities remain healthy and safe through local care coordination and connection mechanisms (e.g., 211 and/or other regional community information exchange systems). Conversations about how to focus investments and connect information systems is ongoing, spurred forward by the voices and needs of individual communities.

Information dissemination and education:
State agencies partnered with ACHs, LTSS, and FCS providers to disseminate information on new guidelines, state and federal support opportunities, changes to billing requirements and codes, and best practices to support providers in adopting the latest treatment and care recommendations. With a broad network of health care providers and CBOs, ACHs continue to play an instrumental role in gathering and disseminating this information to their partners to reduce confusion and information gaps during this time of increased ambiguity. Similarly, LTSS and FCS providers are uniquely positioned to address this critical communication channel across the broader network of MTP partners, in order to better serve and provide information to clients.

COVID-19 capacity building and payment:
It became clear that infrastructure and payment to health care providers and social service entities needed to transition to a pandemic environment with fewer in-person visits and increased social needs. These challenges were exacerbated among smaller providers and Community-Based Organizations with thin margins. MTP initiatives responded to the opportunity to sustain these providers by assisting with navigating reimbursement and payment issues, including temporary supports and COVID-19 capacity

building investments provided through DSRIP to address business impacts experienced by many providers.

FCS, MAC and TSOA clients continued to be served during the COVID -19 pandemic as the programs shifted to remote assessments, telephonic service delivery, allowed remote personal care or respite when feasible, and providers were provided enhanced provider rates in response to the pandemic.

Addressing health equity and the social determinants of health:
It has been critical to not only provide support to heath systems, but also to programs that maintain community health and resiliency. This includes food banks, meal delivery services, community action agencies, local coalitions, and other programs that support at-risk community members as they navigate pandemic impacts that fall outside of what the traditional health system can deliver. This support also centers on health equity, targeting more vulnerable people and their families and connecting them with basic supports to help mitigate their risk of adverse health outcomes.

Maximizing and aligning resources and investments:
Ensuring maximization of investments via local, state, and federal resources has been a priority, as it takes significant resources to shift to new ways of delivering care, connect and align information systems, and respond to growing community needs. ACHs and IHCPs are well positioned to act as intermediaries based on their understanding of the needs of vulnerable community members and existing relationships with providers and social service agencies.

COVID Extension Year

Washington State is seeking a one-year Extension of authorities from CMS that would create a "year 6" for current MTP waiver activities, with no programmatic changes or additional program funding. While continuing to address COVID-19 recovery, we expect a return to making continued progress on the goals and objectives of MTP, with continued coordination and planning for renewal, sustainability, and transition strategies. Minimal changes are expected and the additional time will allow for a complete final evaluation.

This extension request which adds DY6 (2022), includes all MTP initiatives and seeks to extend spending authority within current program limits. Initiatives 1, 2, and 3 will continue, utilizing the existing, unused program spending authority from the first five years. This unused program spending authority will allow for an extension into one additional year without requiring any new funding from CMS. The extension will also continue to support the substance use disorder IMD and (anticipated) mental health IMD waivers, and their projected savings.

Extension Year Funding Mechanics and Accountability

With the extension of current program spending limits, HCA is not requesting additional Delivery System Reform Incentive Payment (DSRIP) program funding authority. HCA requests a temporary continuation of Designated State Health Program (DSHP) funding for Initiatives 2 and 3, and administrative costs for

the extension year. STCs will need to be amended to include a year 6 and reduce program limits across DY1-5.

It is important to allow DSRIP funding to support urgent COVID-19 response and related advancements in 2022, without payment delays. To this end, the state requests a Pay-for-Reporting (P4R) incentive payment construct for DY6 while maintaining prior Pay-for-Performance (P4P) accountability for DY3-5. The Extension will continue to support community partners' capacity to participate in the development and implementation of future innovative payment models and multi-payer collaborations. Similarly, IHCP projects are currently on a P4R construct and would continue as such.

The state is not seeking programmatic changes but will utilize the extension as an opportunity to reinforce alignment and standardization to promote greater scalability. In addition, Washington state remains committed to advancing its "Paying for Health" strategies and proposes allocating 5% of available DSRIP funds to directly incentivize VBP progress. Specifically, the state will develop a construct to incentivize ACH support of VBP advancement among rural and behavioral health provider communities.

What an extension year could accomplish

Across all initiatives, one of the most critical goals of the extension year is the additional time for implementation, evaluation, renewal and transition planning to ensure these essential programs and services are maintained in the years to come. This extension year is essential to allow for the continuation of promising practices and preliminary evaluation results. For this reason, we are not requesting programmatic changes or content changes to the Project Toolkit. Due to the disruption of COVID, we see a clear need for MTP to continue through 2022.

Initiative 1

ACHs will use this extension year to continue project implementation and support the delivery system in COVID-19 response and recovery activities, while also working with providers to sustain the promising practices gleaned from implementing Toolkit projects in their regions. The extension year provides a unique opportunity to continue addressing issues emerging from the pandemic and provides additional time for the state and ACHs to finalize renewal, sustainability, and transition strategies for priority projects, such as Community-Based Care Coordination and Bi-Directional Integration.

The impact of the pandemic on the health system and local economies is inextricably linked, and response and recovery efforts are dependent on links within the system. Because of this, ACHs acting as a bridge between clinical efforts and community response and resources will continue to be vital through the extension year. ACHs are uniquely positioned to advocate for vulnerable populations, consult with and convene disparate community supports as a neutral convener, and make sure there is high-quality community care coordination through local and statewide planning efforts.

With additional time, IHCPs will have the opportunity to more fully implement their specific projects, especially those which require non-tribal participation, both locally and at the federal level. Much of that participation and capacity has been over-shadowed by the pandemic and slowed the implementation of projects. An extension year would include crucial infrastructure development and a

continuation of the partnerships built under Medicaid Transformation, which would greatly benefit the IHCPs.

Initiative 2

We will continue administering this important program, offering services to older adults and their caregivers, helping to delay transitions to institutional care settings.

This extension year will be used to:

- Continue outreach activities to populations at risk of entry to more intensive Medicaid funded services as well as to caregivers work with home care agencies on system adjustments and workforce development activities
- Continue essential supports to families and providers delivering care during the pandemic
- Implement strategies to reduce social isolation caused by pandemic

Initiative 3

During this extension year, FCS will continue to provide critical services to clients seeking to obtain and maintain housing and employment. FCS will also continue to implement and evaluate the use of these two evidence-based practices during difficult economic times. A learning collaborative approach to implementing fidelity to the evidence-based practices will continue through the extension period.

Initiatives 4 & 5

Extending MTP for one additional year will allow for continued support and funding for expanded substance use disorder and mental health treatment in participating health care facilities.

In addition, Extending MTP will allow for greater statewide support of value-based payment, which includes uptake beyond the 2021 target of 85%.

How the extension year will further the goals of Medicaid Transformation:

- **Integrate physical and behavioral health purchasing and services to provide whole-person care.** The last 3 remaining regions integrated physical and behavioral health purchasing January 2020. The extension year allows the state to continue partnering with MCOs and ACHs to standardize bi-directional integration models and a common assessment approach to support ongoing advancement of whole-person care.

- **Convert 90 percent of Medicaid provider payments to reward outcomes instead of volume of service, and support providers as they adopt new payment and care models.** The extension year provides an additional year of incentives tied to VBP advancements. The continuation of related care coordination and social supports enable providers to take on a higher degree of population health management and associated risk.

- **Improve health equity by implementing population health strategies.** COVID-19 has further highlighted the need to address systemic inequities. As an example, ACHs have reaffirmed their commitment in recent months to work together across the state and with their local partners to further education and action to promote equity and respond to systemic racism.[2]

- **Provide targeted services to support the state's aging populations and their family caregivers.** The flexibilities provided under MAC and TSOA will benefit from an additional year of implementation and data analysis to establish a clear sustainability path for these essential services.

- **Help our most vulnerable population get and keep stable housing and employment.** Similarly, preliminary results are very promising but the FCS program will greatly benefit from additional implementation and evaluation in light of the time it took to implement the program and the more recent COVID-19 disruptions. These services are more critical now than ever.

- **Improve substance use disorder (SUD) and Mental Health (MH) treatment access and outcomes.** The state is seeing the early results from the SUD IMD waiver and anticipates further success under the MH IMD waiver in the coming months. The extension year allows for further evaluation of the improvements tied to access, treatment, and related capacity and service enhancements afforded by the FFP under these waivers.

Expenditure and Waiver Authorities

Washington State is not requesting any changes to federal expenditure and waiver authorities already approved in the Medicaid Transformation Project Demonstration.

Previously approved expenditure authorities:
ƒ § 1903. Authority to receive federal matching dollars for designated state health programs.
ƒ § 1903. Authority to receive federal matching dollars for payments related to transformation projects made under the Demonstration.
ƒ § 1903. Authority to receive federal matching dollars for services provided to the "At Risk" for Medicaid group.
ƒ § 1903. Authority to allow the reinvestment of state-designated shared savings towards applicable Demonstration expenditures. The amount of savings available for use under this authority will be based on the difference between the actual expenditures under the Demonstration and pre-established agreed to per capita amounts.
ƒ § 1903(m) and 42 CFR §438.60. Authority to allow direct payments to managed care providers or

[2] Washington's ACHs: Promoting Equity and Investing in Social Needs. https://img1.wsimg.com/blobby/go/cc171531-b5b4-4c94-a39e-4fb0570ac588/downloads/WA%20ACHs%20SDoH%20and%20Equity.10.2020.pdf?ver=1604077094814

supportive housing and supported employment services.
ƒ § 1903. Authority to allow for reimbursement for specific managed care plan, provider, behavioral health organization and system payments that support performance, quality, system alignment and whole-person care coordination to the extent not otherwise allowed. This may include fee-for-service and managed care-based incentive payments, and expenditures that support value-based payment evolution.

Previously approved waiver authorities:
ƒ § 1902(a)(1). Authority to operate the Demonstration on a less-than-statewide basis.
ƒ § 1902(a)(10)(B). Authority to vary the amount, duration, and scope of benefits provided to the TSOA population.
ƒ §1902(a)(10)(B). Authority to vary the amount, duration, and scope of benefits for individuals who meet current eligibility criteria for Medicaid funded long term care services, but who wish to receive MAC benefits in lieu of more intensive services.
ƒ §1902(a)(10)(B). Authority to vary the amount, duration, and scope of benefits for individuals who wish to receive supportive housing and supported employment services.
ƒ §1902(a)(10)(B). Authority to limit housing-based case management to certain targeted groups of Medicaid beneficiaries.
ƒ § 1902(a)(17). Authority to allow ACHs to target transformation projects to different sub-populations.
ƒ § 1902(a)(17). Authority to target certain state-administered benefits to subpopulations.
ƒ § 1902(a)(17). Authority to apply a more liberal income and resource standard for individuals determined to be “At Risk” for future Medicaid enrollment.
ƒ § 1902(a)(17). Authority to provide the TSOA benefit package to the “At Risk” for Medicaid group.
ƒ § 1902(a)(17). Authority to provide the MAC benefit package to individuals meeting current eligibility criteria for LTSS, but who are not currently receiving and do not choose more intensive Medicaid-funded nursing facility “most intensive” services.

Eligibility and Enrollment

Washington state is not requesting any changes to eligibility and enrollment requirements and criteria already approved in the Medicaid Transformation Project Demonstration. Aside from Initiative 1, which impacts all Medicaid beneficiaries through ACH and IHCP project implementation, MTP initiatives have specific eligibility requirements specific to the populations they serve. We are not requesting any changes in this extension request; thus we do not anticipate any impacts in this area.

Because MTP does not include any limits on general Medicaid eligibility, this extension request will not cause any reductions or other impacts to eligibility. We expect Medicaid enrollment to remain the same, in alignment with current enrollment trends.

Below is the estimated annual enrollment projections for Initiative 2 and 3 in DY06. MAC and TSOA enrollment assumes an average annual growth rate of 3%. This trend is based on historical growth from July 2019 through June 2020. FCS 1 enrollment is projected to increase by 5% and FCS 2 is projected to increase by 3%. FCS trends are based on the program’s average caseload increase from May 2019 through April 2020.

Estimated Annual Enrollment Projections for CY2022 (DY06)				
	MAC	TSOA	FCS 1	FCS 2
January-22	172	4,951	13,084	7,516
February-22	172	4,963	13,801	7,764
March-22	173	4,976	14,557	8,020
April-22	173	4,988	15,355	8,285
May-22	174	5,001	16,197	8,558
June-22	174	5,013	17,084	8,840
July-22	174	5,026	18,021	9,132
August-22	175	5,038	19,008	9,433
September-22	175	5,051	20,050	9,745
October-22	176	5,063	21,149	10,066
November-22	176	5,076	22,308	10,398
December-22	177	5,089	23,530	10,742

Medicaid Transformation Eligibility:

Initiative	Eligibility criteria
Initiative 1: Delivery system transformation	Benefits all Medicaid clients through large scale delivery system and payment reform projects implemented by ACHs and IHCPs.
Initiative 2: Long term services and supports	Medicaid Alternative Care (MAC): • Age 55 or older; • Income at or below 150% of the Federal Poverty Level; • Eligible for Categorically Needy (CN) services • Meet functional eligibility criteria for HCBS as determined through an eligibility assessment (these individuals would not need to meet the higher functional eligibility criteria that will be established under the Demonstration for nursing facility care); • Have not chosen to receive the LTSS Medicaid benefit currently available under optional state plan or HCBS authorities. Tailored Supports for Older Adults (TSOA) • Be age 55 or older; • Not be currently eligible for Medicaid; • Meet functional eligibility criteria for HCBS as determined through an eligibility assessment (these individuals would not need to meet the higher functional eligibility criteria that will be established under the Demonstration for nursing facility care); • Have income up to 300% of the Federal Benefit Rate.
Initiative 3: Foundational Community Supports	Individuals must be 18 years or older for Supportive Housing services and 16 years or older for Supported Employment services and be Medicaid eligible. Individuals must meet at least one assessed heath needs-based criteria and is expected to benefit from community support services: • Mental health need where there is need for improvement, stabilization or

	prevention of deterioration of functioning resulting from the presence of a mental illness (receiving services through a behavioral health organization [BHO] or integrated managed care [IMC]) • Need for outpatient substance use disorder (SUD) treatment (receiving services through BHO or IMC) • Need for assistance with three or more activities of daily living (ADL) (receiving long-term care [LTC] services) • Need for hands-on assistance with one or more ADL (receiving LTC services) • Complex physical health need, which is a long continuing or indefinite physical condition requiring improvement, stabilization or prevention of deterioration of functioning Individuals must also meet at least one of the following risk factors: • Supportive housing services serves clients who experience: o Chronic homelessness (as defined by the U.S. Department of Housing and Urban Development) o Frequent or lengthy institutional contacts o Frequent or lengthy stays in adult residential care o Frequent turnover of in-home caregivers o Predictive Risk Information System (PRISM) Risk score of 1.5 or above • Supported employment services serves clients who: o Are enrolled in the Aged, Blind or Disabled Program or the Housing and Essential Needs Program o People diagnosed with severe and persistent mental illness (SPMI), substance use disorder (SUD), or co-occurring mental illness and SUD o Vulnerable youth and young adults with behavioral health needs o People who receive long-term services and supports
Initiative 4: Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD)	Individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).
Initiative 5: Residential and Inpatient Treatment for Individuals with Serious Mental Illness (SMI)	Individuals who are primarily receiving treatment for serious mental illness who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

Benefits and Cost Sharing

Washington State is not requesting any changes to benefits as approved in the original waiver application. MTP does not have any cost sharing requirements, and we are not requesting any changes in this area via this extension request MTP benefits, by initiative, are as follows:

Initiative 1:
Benefits all Medicaid clients through large scale delivery system and payment reform projects implemented by ACHs and IHCPs. In addition, care transition, care coordination, chronic-disease self-management and other prevention activities target some of the state's most vulnerable populations, including those facing the greatest health disparities and co-morbidities.

Initiative 2:
1. Medicaid Alternative Care (MAC) - Creation of a benefit package for individuals who are eligible for Medicaid but not currently accessing Medicaid-funded LTSS. This benefit package will provide services to unpaid caregivers designed to assist them in getting supports necessary to continue to provide high-quality care and to focus on their own health and well-being.
2. Tailored Supports for Older Adults (TSOA) – A separate eligibility category and benefit package for individuals "at risk" of future Medicaid LTSS use who currently do not meet Medicaid financial eligibility criteria. This is designed to help individuals avoid or delay impoverishment and the need for Medicaid-funded services. The TSOA benefit package provides services and supports to unpaid family caregivers as well as services and supports to individuals without unpaid caregivers.

MAC and TSOA include the following benefits:

- Caregiver Assistance Services: Services that take the place of those typically performed by unpaid caregiver.
- Training and Education: Assist caregivers with gaining skills and knowledge to care for recipient.
- Specialized Medical Equipment & Supplies: Goods and supplies needed by the care receiver.
- Health maintenance & therapies: Clinical or therapeutic services for caregivers to remain in role or care receiver to remain at home.
- Personal Assistance Services: Supports involving the labor of another person to help the recipient (TSOA individuals only).

Initiative 3:
Foundational Community Supports (FCS) provides a set of Home and Community Based Services (HCBS), including Community Support Services (also called Supportive Housing) and Supported Employment Services (also called Individual Placement and Support Services). Supportive housing and supported employment services work with employers and property owners to match individuals with the right environment while providing ongoing support. These services do not pay for housing or for wages or wage enhancements.

Initiative 4 provides extended treatment services in participating facilities for clients with serious mental health conditions.

Initiative 5 provides extended treatment services in participating facilities for clients with serious mental health conditions.

Delivery System

Washington State is not requesting changes to our original delivery system transformation plan approved under the current 1115 waiver. Washington intends to continue transforming Medicaid over the extension year to improve its delivery and payment system and sustain the program in the face of a growing and aging Medicaid population. All facets of Washington's transformation strategy share a common theme—the need to grow competency in health improvement and recovery strategies. This will allow Washington to deliver higher value care that meets each beneficiary's range of needs, thereby decreasing the use of avoidable intensive and costly services.

Demonstration Financing and Budget/Allotment Neutrality

Washington State is not requesting new expenditure authority as the State expects to have sufficient unspent expenditure authority funding from prior years to cover the extension year. Washington State also expects to have sufficient room within the budget neutrality limits to cover the extension year and is not requesting changes to the budget neutrality methodology.

Below is a summary table showing the without-waiver expenditure limits compared to our with-waiver projections for the main budget neutrality test. The state is projecting savings of $1.6B (total computable) for DY01-DY05 plus the extension year projections.

Budget Neutrality Summary

The with-waiver financial summary below reflects actuals + projections through DY5 plus projected costs for the extension period (DY06).

Without-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY) 1	2	3	4	5	Extension projections 6	Total
Medicaid Per Capita								
Non-Expansion Adults Only	**Total**	$4,528,920,848	$4,603,028,088	$3,002,026,247	$3,202,687,164	$3,365,920,701	$3,500,548,566	
	PMPM	$1,012.82	$1,046.24	$694.38	$722.16	$751.05	$781.09	
	Mem-Mon	4471595	4399591	4323319	4434872	4481620	4481620	
TOTAL		**$ 4,528,920,848**	**$ 4,603,028,088**	**$ 3,002,026,247**	**$ 3,202,687,164**	**$ 3,365,920,701**	**$ 3,500,548,566**	**$ 22,203,131,613**

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY) 1	2	3	4	5	Extension projections 6	Total
Medicaid Per Capita							
Non-Expansion Adults Only	$4,127,090,476	$4,588,372,995	$2,650,967,700	$2,516,458,778	$2,467,964,560	$2,509,551,597	
Medicaid Aggregate - WW only							
DSHP	$192,631,562	$181,206,690	$117,008,060	$76,543,710	$98,879,556	$82,161,748	
DSRIP	$242,100,000	$231,700,000	$187,180,434	$151,510,022	$71,250,000	$101,679,588	
TOTAL	**$4,561,822,038**	**$5,001,279,685**	**$2,955,156,194**	**$2,744,512,510**	**$2,638,094,116**	**$2,693,392,933**	**$ 20,594,257,477**
VARIANCE	**($32,901,190)**	**($398,251,597)**	**$46,870,053**	**$458,174,654**	**$727,826,585**	**$807,155,633**	**$1,608,874,137**

Below are the summary tables for the supplemental – hypothetical programs.

Supplemental - Hypothetical Expenditures

Without-Waiver Total Expenditures

Hypothetical 1 Aggregate		DEMONSTRATION YEARS (DY) 1	2	3	4	5		Total
MAC & TSOA		$5,979,600	$19,327,770	$0	$0	$0		
Tailored Supports for Older Adults (TSOA)		$0	$0	$22,432,000	$34,517,000	$48,052,000		
Medicaid Alternative Care (MAC)		$0	$0	$607,000	$976,000	$1,399,000		
TOTAL		$5,979,600	$19,327,770	$23,039,000	$35,493,000	$49,451,000	$0	$133,290,370

With-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY) 1	2	3	4	5	Extension projections 6	Total
Hypothetical 1 Aggregate								
Tailored Supports for Older Adults (TSOA)		$145,387	$3,711,733	$10,977,875	$18,840,142	$48,052,000		
Medicaid Alternative Care (MAC)		$4,021	$63,052	$229,622	$477,458	$1,399,000		
MAC & TSOA							$47,453,000	
TOTAL		$149,408	$3,774,785	$11,207,497	$19,317,600	$49,451,000	$47,453,000	$131,353,290
HYPOTHETICALS VARIANCE 1		$5,830,192	$15,552,985	$11,831,503	$16,175,400	$0	($47,453,000)	$1,937,080

HYPOTHETICALS TEST 2

Without-Waiver Total Expenditures

Hypothetical 2 Aggregate		DEMONSTRATION YEARS (DY) 1	2	3	4	5		Total
HepC Rx		$131,821,200	$136,171,300	$140,664,952	$145,306,896	$150,102,023		
TOTAL		$131,821,200	$136,171,300	$140,664,952	$145,306,896	$150,102,023	$0	$704,066,371

With-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY) 1	2	3	4	5	Extension projections 6	Total
Hypothetical 2 Aggregate								
HepC Rx		$84,720,557	$31,141,120	$24,304,599	$16,940,157	$21,557,949	$17,309,970	
TOTAL		$84,720,557	$31,141,120	$24,304,599	$16,940,157	$21,557,949	$17,309,970	$195,974,352
HYPOTHETICALS VARIANCE 2		$47,100,643	$105,030,180	$116,360,353	$128,366,739	$128,544,074	($17,309,970)	$508,092,019

HYPOTHETICALS TEST 3

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY) 1	2	3	4	5		Total
Hypothetical 3 Aggregate							
Foundational Community Supports 1	$9,425,000	$22,182,000	$19,322,095	$23,846,960	$25,581,527		
Foundational Community Supports 2	$5,567,000	$11,044,000	$8,024,095	$15,308,960	$16,912,527		
TOTAL	$14,992,000	$33,226,000	$27,346,190	$39,155,919	$42,494,053	$0	$157,214,162

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY) 1	2	3	4	5	Extension projections 6	Total
Hypothetical 3 Aggregate							
Foundational Community Supports 1		$385,245	$4,851,945	$14,461,845	$24,904,416	$47,968,347	
Foundational Community Supports 2		$726,425	$4,368,959	$9,582,649	$17,589,637	$17,576,886	
TOTAL		$1,111,670	$9,220,904	$24,044,494	$42,494,053	$65,545,233	$142,416,354
HYPOTHETICALS VARIANCE 3	$14,992,000	$32,114,330	$18,125,286	$15,111,425	$0	($65,545,233)	$14,797,808

HYPOTHETICALS TEST 4

Without-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY) 1	2	3	4	5	Extension projections 6	Total
Hypothetical 4 Per Capita								
Medicaid Disabled IMD	Total	$0	$14,092	$93,644	$1,738,437	$1,823,926	$1,949,274	
	PMPM	$0	$1,084	$1,142	$1,149	$1,189	$1,229	
	Mem-Mon	$0	13	82	1513	1534	1586	
Medicaid Non-Disabled IMD	Total	$0	$4,380	$116,400	$805,179	$844,928	$906,717	
	PMPM	$0	$292	$300	$311	$322	$334	
	Mem-Mon	$0	15	388	2589	2624	2718	
Newly Eligible IMD	Total	$0	$35,574	$607,538	$5,124,000	$5,515,100	$6,044,202	
	PMPM	$0	$462	$478	$500	$524	$548	
	Mem-Mon	$0	77	1271	10248	10525	11020	
American Indian/Alaska Native IMD	Total	$0	$312,936	$1,274,706	$6,786,012	$7,158,051	$7,608,357	
	PMPM	$0	$3,009	$3,079	$3,174	$3,273	$3,374	
	Mem-Mon	$0	104	414	2138	2187	2255	
TOTAL		$0	$366,982	$2,092,288	$14,453,628	$15,342,005	$16,508,550	$48,763,453

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY) 1	2	3	4	5	Extension projections 6	Total
Hypothetical 4 Per Capita							
Medicaid Disabled IMD	$0	$987	$15,093	$1,304,673	$1,823,190	$1,949,274	
Medicaid Non-Disabled IMD	$0	$685	$17,261	$604,522	$844,797	$906,717	
Newly Eligible IMD	$0	$13,514	$86,311	$3,848,705	$5,513,732	$6,044,202	
American Indian/Alaska Native IMD	$0	$194,951	$870,454	$5,097,346	$7,157,701	$7,608,357	
TOTAL	$0	$210,137	$989,119	$10,855,246	$15,339,420	$16,508,550	$43,902,472
HYPOTHETICALS VARIANCE 4	$0	$156,845	$1,103,169	$3,598,382	$2,585	$0	$4,860,981

The State will continue to phase-out DSHP, but proposes use of DSHP to fund the non-federal share of MAC/TSOA, FCS and administrative costs in the extension year. The State is not requesting additional DSHP authority, but rather use of DSHP savings from prior years underspent.

Preliminary Evaluation Results and Evaluation Design for the Extension

Washington State has contracted with Oregon Health Sciences University's Center for Health System Effectiveness, CSHE, as the MTP Independent External Evaluator (IEE), as required in the MTP Special Terms and Conditions.

Evaluation Activities to Date

Evaluation activities completed to date include:

- Receipt of Washington State Institutional Review Board approvals for evaluation design, collection and use of quantitative and quantitative data.
- Extensive and on-going analysis of relevant reports and documents.
- Conducted and analyzed first round of Key Informant Interviews.
- Development and administration of first round of provider and health facility surveys.
- Receipt of an quantitative data; development of data infrastructure
- Development of attribution model.
- Development of data models for statewide performance and ACH health improvement projects.
- Development and delivery of quarterly Rapid Cycle Reports and a Baseline Report (final report received in May 2020)

Preliminary Evaluation Results and Assessment of MTP Progress to date:

The state has prepared a Preliminary Findings Summary Report: Independent External Evaluation for the Medicaid Transformation Project, which can be found in Appendix B of this draft application.

The Baseline Report and quarterly Rapid Cycle Reports (September 30, 2020 report), together, serve as preliminary reports in advance of the Interim Report due in December 2020, and are the basis for the summary report referenced above. Based on these reports, all indications are that MTP is on target and on a trajectory to meet its goals and objectives. This conclusion is based on the Baseline and Rapid Cycle Reports, as well as activates reported for each Initiative earlier in this application. Of particular note is the most recent quarterly report (Quarterly Progress Repot September 2020) includes an analysis of statewide performance metrics. The report presents a preview of how findings will be organized where 45 performance measures will be organized into 10 domains.

All evaluation reports can be found here.

COVID-19 Impacts on Evaluation:
The state is not proposing any adjustment to the CMS-approved evaluation design in light of the challenges raised by COVID 19. However, the challenges of COVID-19 have resulted in impacts of data for both quantitative and qualitative evaluation. As outlined below, the state is requesting an additional evaluation year to coincide with the extension and will change the IEE's activities and reporting to accommodate for COVID-19 challenges in order to mitigate these challenges and get the most robust evaluation over the course of the extension year.

- **Quantitative Data Impacts**: COVID-19 has been acknowledged by CMS as resulting in significant impacts on health system delivery. The impacts affect Washington State's health care payment landscape, including temporary changes made in many providers' Medicaid payment arrangements. In turn, those impacts will be reflected in administrative data that is the basis for quantitative analysis and performance evaluation. Recognizing those impacts, CMS guidance is to remove accountability for calendar year 2020. For evaluation purposes, this means 2020 is no longer a suitable post-implementation period from which to draw conclusions about the impact of MTP and statewide accountability and the 5 MTP Initiatives. Under the current MTP five year time frame, this means post-implementation results would be limited to calendar years 2019 and 2021.

- **Qualitative Data Impacts:** COVID-19 disruptions across Washington's health care system also had impacts on the collection of qualitative data. This was reflected in the availability of key informants for interviews as well as response rates from provider and facility surveys fielded during 2020. With some timeline adjustments, the evaluator would still be able to complete the initially planned qualitative data collection and analysis. While these quantitative results are likely to confirm significant CCOVID-19 health care delivery impacts, they would miss quantitative data regarding health the MTP ends after DY 5.

What an extension year would add to the MTP Evaluation:
As noted above, the state is not proposing any changes to the CMS approved evaluation design due to COVID-19 impacts. However, the state is proposing changes to the CHSE''s evaluation **activities** and **reporting.**

- **Quantitative Data Production and Analysis:**

The extension would allow for the extension of the quantitative measurement period of the MTP evaluation by one year to extend analysis of performance for statewide Medicaid system for as well as all five Initiatives to include data all or partway through Q4 2022.

The rationale for this approach is that the evaluation design, which relies on the comparison of performance measures and/or derived from health care claims from a baseline period (typically 2017 and 2018) to a "post implementation" period late in the MTP demonstration (2020 and 2021) for the Final Evaluation Report. As noted above, the impact of COVID-19 on Washington's health care system means 2020 is no longer a suitable post-implementation period from which to draw conclusions about the impact of MTP. Extending the measurement period by one year will allow for a post-implementation measurement period of 2021 and 2022, and reduce the likelihood that changes observed in Washington's Medicaid system performance are due to COVID-19 rather than MTP.

Under this approach, Washington State will be required to provide four additional quarter of administrative data to CHSE. The state will be able to leverage data infrastructure and operationalized administrative data exchanges already in place to support the extension year quantitative evaluations. The state would extend the deadline for the final MTP evaluations for all initiatives one calendar year forward from their current deadlines.

- **Quantitative Data Collection and Analysis:**

The extension would allow extending data collection and qualitative data analysis for the final rounds of key informant and provider organization interviews and provider organization surveys through December 2022. This would include extending the fourth round of interviews with ACH and State key informants by six months to conduct participant recruitment and data collection through December 2021. The third round of provider organization interviews would be extended by twelve months and conducted through June 2022. The second round of surveys to provider organizations would be extended by twelve months to conduct participant recruitment and data collection through June 2022.

The rationale for this approach includes adjustments to maximize the opportunities for qualitative data collection and subsequent analysis to capture quantitative data points that otherwise may be missed. For example, there were several qualitative research activities intended to occur late in the demonstration period when ACHs were engaged in efforts to "scale and sustain" their work with partners. In addition,

COVID-19 related health facility operations closures and shifts to telework have also had dramatic but potentially temporary effects on provider organizations' workforce and use of technology.

- **Reporting Requirements:**

Under an extension year approval, the state propose extending the MTP evaluation reporting period by one year. This shift retains the intended reporting schedule of the original MTP evaluation design but updates remaining deliverable due dates to reflect the inclusion of an additional measurement year through December 2022. This would also add Quarterly Progress Reports (e.g. "rapid cycle reports") in months March, June, September and December 2023. This would include shifting the delivery of the Final (summative) Evaluation Report for Medicaid Statewide Accountability and Initiatives 1, 2, and 3 January 28, 2023. The delivery of the Initiative 4 and 5 reports on the SUD and IMD waivers, respectively, would shift to June 30, 2024.

Quality and Access to Care Review and Monitoring

Federal requirements mandate that every state Medicaid agency that contracts with managed care organizations provide for an external quality review (EQR) of healthcare services provided to enrollees, to assess the accessibility, timeliness, and quality of care they provide. As Washington's Medicaid external quality review organization (EQRO), Comagine Health conducted 2019 reviews for the state.

Refer to Appendix D for a summary of the 2019 technical report and comparative and regional analysis report. The full reports are available on HCA's website.

Washington State CMS Form 416 EPSDT/CHIP Report
The 2018 Form 416 EPSDT/CHIP report (File name: 2018EPSDT_StateRprt20191113.pdf; Pages 145-147) is available at https://www.medicaid.gov/sites/default/files/2019-12/fy-2018-data.zip.

Appendices

Appendix A: Budget Neutrality Workbook

Appendix B: Independent External Evaluation Preliminary Findings Summary Report

Appendix C: Approved Medicaid Transformation Evaluation Design

Appendix D: Summary of 2019 EQRO Reports

Budget Neutrality Summary

The with-waiver financial summary below reflects actuals + projections through DY5 plus projected costs for the extension period (DY06).

Without-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY) 1	2	3	4	5	Extension projections 6	Total
Medicaid Per Capita								
Non-Expansion Adults Only	**Total**	$4,528,920,848	$4,603,028,088	$3,002,026,247	$3,202,687,164	$3,365,920,701	$3,500,548,566	
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	Mem-Mon	4471595	4399591	4323319	4434872	4481620	4481620	
TOTAL		**$ 4,528,920,848**	**$ 4,603,028,088**	**$ 3,002,026,247**	**$ 3,202,687,164**	**$ 3,365,920,701**	**$ 3,500,548,566**	**$ 22,203,131,613**

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Non-Expansion Adults Only		$4,127,090,476	$4,588,372,995	$2,650,967,700	$2,516,458,778	$2,467,964,560	$2,509,551,597	
Medicaid Aggregate - WW only								
DSHP		$192,631,562	$181,206,690	$117,008,060	$76,543,710	$98,879,556	$82,161,748	
DSRIP		$242,100,000	$231,700,000	$187,180,434	$151,510,022	$71,250,000	$101,679,588	
TOTAL		**$4,561,822,038**	**$5,001,279,685**	**$2,955,156,194**	**$2,744,512,510**	**$2,638,094,116**	**$2,693,392,933**	**$ 20,594,257,477**
VARIANCE		**($32,901,190)**	**($398,251,597)**	**$46,870,053**	**$458,174,654**	**$727,826,585**	**$807,155,633**	**$1,608,874,137**

Supplemental - Hypothetical Expenditures

Without-Waiver Total Expenditures

Hypothetical 1 Aggregate		DEMONSTRATION YEARS (DY) 1	2	3	4	5		Total
MAC & TSOA		$5,979,600	$19,327,770	$0	$0	$0		
Tailored Supports for Older Adults (TSOA)		$0	$0	$22,432,000	$34,517,000	$48,052,000		
Medicaid Alternative Care (MAC)		$0	$0	$607,000	$976,000	$1,399,000		
TOTAL		**$5,979,600**	**$19,327,770**	**$23,039,000**	**$35,493,000**	**$49,451,000**	**$0**	**$133,290,370**

With-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY) 1	2	3	4	5	Extension projections 6	Total
Hypothetical 1 Aggregate								
Tailored Supports for Older Adults (TSOA)		$145,387	$3,711,733	$10,977,875	$18,840,142	$48,052,000		
Medicaid Alternative Care (MAC)		$4,021	$63,052	$229,622	$477,458	$1,399,000		
MAC & TSOA							$47,453,000	
TOTAL		**$149,408**	**$3,774,785**	**$11,207,497**	**$19,317,600**	**$49,451,000**	**$47,453,000**	**$131,353,290**
HYPOTHETICALS VARIANCE 1		**$5,830,192**	**$15,552,985**	**$11,831,503**	**$16,175,400**	**$0**	**($47,453,000)**	**$1,937,080**

HYPOTHETICALS TEST 2

Without-Waiver Total Expenditures

Hypothetical 2 Aggregate		DEMONSTRATION YEARS (DY) 1	2	3	4	5		Total
HepC Rx		$131,821,200	$136,171,300	$140,664,952	$145,306,896	$150,102,023		
TOTAL		**$131,821,200**	**$136,171,300**	**$140,664,952**	**$145,306,896**	**$150,102,023**	**$0**	**$704,066,371**

With-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY) 1	2	3	4	5	Extension projections 6	Total
Hypothetical 2 Aggregate								
HepC Rx		$84,720,557	$31,141,120	$24,304,599	$16,940,157	$21,557,949	$17,309,970	
TOTAL		**$84,720,557**	**$31,141,120**	**$24,304,599**	**$16,940,157**	**$21,557,949**	**$17,309,970**	**$195,974,352**
HYPOTHETICALS VARIANCE 2		**$47,100,643**	**$105,030,180**	**$116,360,353**	**$128,366,739**	**$128,544,074**	**($17,309,970)**	**$508,092,019**

HYPOTHETICALS TEST 3

Without-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY)						Total
		1	2	3	4	5		
Hypothetical 3 Aggregate								
Foundational Community Supports 1		$9,425,000	$22,182,000	$19,322,095	$23,846,960	$25,581,527		
Foundational Community Supports 2		$5,567,000	$11,044,000	$8,024,095	$15,308,960	$16,912,527		
TOTAL		**$14,992,000**	**$33,226,000**	**$27,346,190**	**$39,155,919**	**$42,494,053**	**$0**	**$157,214,162**

With-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY)					Extension projections	Total
		1	2	3	4	5	6	
Hypothetical 3 Aggregate								
Foundational Community Supports 1			$385,245	$4,851,945	$14,461,845	$24,904,416	$47,968,347	
Foundational Community Supports 2			$726,425	$4,368,959	$9,582,649	$17,589,637	$17,576,886	
TOTAL			**$1,111,670**	**$9,220,904**	**$24,044,494**	**$42,494,053**	**$65,545,233**	**$142,416,354**
HYPOTHETICALS VARIANCE 3		**$14,992,000**	**$32,114,330**	**$18,125,286**	**$15,111,425**	**$0**	**($65,545,233)**	**$14,797,808**

HYPOTHETICALS TEST 4

Without-Waiver Total Expenditures		DEMONSTRATION YEARS (DY)					Extension projections	Total
		1	2	3	4	5	6	
Hypothetical 4 Per Capita								
Medicaid Disabled IMD	**Total**	$0	$14,092	$93,644	$1,738,437	$1,823,926	$1,949,274	
	PMPM	$0	$1,084	$1,142	$1,149	$1,189	$1,229	
	Mem-Mon	$0	13	82	1513	1534	1586	
Medicaid Non-Disabled IMD	**Total**	$0	$4,380	$116,400	$805,179	$844,928	$906,717	
	PMPM	$0	$292	$300	$311	$322	$334	
	Mem-Mon	$0	15	388	2589	2624	2718	
Newly Eligible IMD	**Total**	$0	$35,574	$607,538	$5,124,000	$5,515,100	$6,044,202	
	PMPM	$0	$462	$478	$500	$524	$548	
	Mem-Mon	$0	77	1271	10248	10525	11020	
American Indian/Alaska Native IMD	**Total**	$0	$312,936	$1,274,706	$6,786,012	$7,158,051	$7,608,357	
	PMPM	$0	$3,009	$3,079	$3,174	$3,273	$3,374	
	Mem-Mon	$0	104	414	2138	2187	2255	
TOTAL		**$0**	**$366,982**	**$2,092,288**	**$14,453,628**	**$15,342,005**	**$16,508,550**	**$48,763,453**

With-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY)					Extension projections	Total
		1	2	3	4	5	6	
Hypothetical 4 Per Capita								
Medicaid Disabled IMD		$0	$987	$15,093	$1,304,673	$1,823,190	$1,949,274	
Medicaid Non-Disabled IMD		$0	$685	$17,261	$604,522	$844,797	$906,717	
Newly Eligible IMD		$0	$13,514	$86,311	$3,848,705	$5,513,732	$6,044,202	
American Indian/Alaska Native IMD		$0	$194,951	$870,454	$5,097,346	$7,157,701	$7,608,357	
TOTAL		**$0**	**$210,137**	**$989,119**	**$10,855,246**	**$15,339,420**	**$16,508,550**	**$43,902,472**
HYPOTHETICALS VARIANCE 4		**$0**	**$156,845**	**$1,103,169**	**$3,598,382**	**$2,585**	**$0**	**$4,860,981**

Appendix B: Preliminary Findings Summary Report: Independent External Evaluation for the Medicaid Transformation Project

Washington state has contracted with Oregon Health Sciences University's Center for Health System Effectiveness, CSHE, as the MTP Independent External Evaluator (IEE), as required in the MTP Special Terms and Conditions. This summary report highlights preliminary findings from the MTP IEE as of September 30, 2020. More detailed information can be found in these reports: https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-resources.

Evaluation Activities to Date

Evaluation activities completed to date include:

- Analysis of Washington state administrative data to analyze performance metrics reflecting health care access, health care quality and health related social outcomes.
- Provider organization surveys, including a sample of primary care clinics and hospitals across Washington state. The surveys captured data on value based payment arrangements, workforce shortages, and health information technology use.
- Key Information interviews, including representatives of state agencies involved in designing and implementing the MTP, as well as representatives of each ACH.
- Analysis of secondary data on Initiatives 2 and 3, which included aggregated enrollment information as some Department of Social and Health Services survey data.

Preliminary Reports and Assessment of MTP Progress to date:

The Baseline Report and quarterly Rapid Cycle Reports, together, serve as preliminary reports in advance of the Interim Report due in December 2020. Based on these reports, all indications are that MTP is on target and on a trajectory to meet its goals and objectives as supported by the following KEY FINDINGS.

Key Findings:

Statewide Medicaid System Performance Analysis.

Source: *September 30, 2020 Quarterly Rapid Cycle Report*

This Rapid Cycle Report included 45 performance measures across the following ten domains:

- Social determinants of health
- Access to primary and preventive care
- Reproductive and maternal health care
- Prevention and wellness
- Behavioral health care
- Oral health care
- Care for people with chronic conditions
- Emergency department hospital and institutional care

- Substance use disorder care
- Opioid use, mortality, and treatment

Analysis of changes in statewide performance metrics revealed that Washington State's Medicaid system saw a mixed or unchanged performance across most domains of care from 2018 to 2019. These results should be considered within the context of Washington State's goals for the Medicaid Transformation Project. 2019 represents the first "implementation" year of the demonstration, with many activities related to infrastructure development or change occurring during this period.

- *Performance generally improved in the areas of Substance Use Disorder Care and Opioid Use, Mortality and Treatment.*
- *Performance was mixed, with some metrics improving while others remained unchanged or worsened, in the following areas: Social Determinants of Health; Reproductive and Maternal Health Care; Prevention and Wellness; Behavioral Health Care; and Emergency Department, Hospital and Institutional Care Use.*
- *Performance was similar or unchanged from 2018 in Primary and Preventive Care, Oral Health Care, and Care for People with Chronic Conditions.*

These trends, as well as analyses for specific groups such as rural residents and people of color, will be examined in detail in the forthcoming Interim Evaluation Report. Future reports will also examine changes in performance metrics during later periods of the demonstration.

Progress toward Value-Based Payment Adoption Targets

Source: *May 29, 2020 Baseline Report, pages 68-71*

Health provider and facility surveys results indicated of widespread participation in value-based payment (VBP) arrangements among primary care practices, a finding consistent with reports and MCOs that MCOs have met their VBP targets for MTP.

MTP's Impact on Health Care Workforce Capacity

Source: *May 29, 202 Baseline Report, pages 72 – 76*

Staff shortages were widespread among primary care practices in 2018, the Initiative 1, Domain 1 (Health Systems and Capacity Building) as incorporating health care workforce activities prescribed in the MTP's Project Toolkit.

MTP Impacts on Health Information Technology (HIT) Use

Source: *May 29, 2020 Baseline Report, pages 77 – 83*

Among primary care providers, electronic health record systems (EHRs) are widely used to accomplish important patient care tasks and exchange information with outpatient clinics and hospitals. Financial investments were prevalent among practices in 2018. AHCs focused their HIT investments on filling gaps among behavioral health care provider ability to store and share social determinant of health information.

Implementation and Impacts of Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)

Source: *May 29, 2020 Baseline Report, pages 91 – 95*

Washington state has a long history of emphasizing home and community-based services in its Medicaid program. MAC and TSOA fit with the state's emphasis on long-term care choice by introducing a lower-intensity, lower cost option for long term care. Area agencies on aging play key roles in MAC and TSOA administration, as locations for program applications. Eighty percent of TSOA survey respondents who received services said TSOA benefits would keep them from moving into a nursing home or adult family home. Overall, survey respondents reported high satisfaction with the TSOA application process and benefits.

Implementation and Impacts of Foundational Community Supports

Source: *May 29, 2020 Baseline Report, pages 96 – 100; MTP Extension Request p. 6.*

Eligibility in supportive housing and supportive employment increased steadily from January 2018 to January 2019. Positive findings were also found in a preliminary report produced by the Washington State Department of Social and Health services:

- People enrolled in supported employment services found employment at a higher rate, earned more money, and worked more hours.
- Supportive housing services helped people transition or begin transitioning out of homelessness or housing instability.
- There were promising reductions in emergency room visit and hospitalizations for people enrolled in supportive housing services.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

OCT 2 6 2017

MaryAnne Lindeblad
Medicaid Director
Washington State Health Care Authority
626 8th Avenue SE
P.O. Box 45502
Olympia, Washington 98504-5502

Dear Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the evaluation design for Washington State's section 1115(a) demonstration (Project No. 11-W-00304/0), entitled "Medicaid Transformation Project" (MTP). We have determined that the submission dated October 10, 2017 meets the requirements set forth in the Special Terms and Conditions and hereby approve the MTP evaluation design.

If you have any questions, please do not hesitate to contact your project officer, Mr. Adam Goldman. Mr. Goldman can be reached at (410) 786-2242, or at Adam.Goldman@cms.hhs.gov. We look forward to continuing to partner with you and your staff on the Washington State MTP demonstration.

Sincerely,

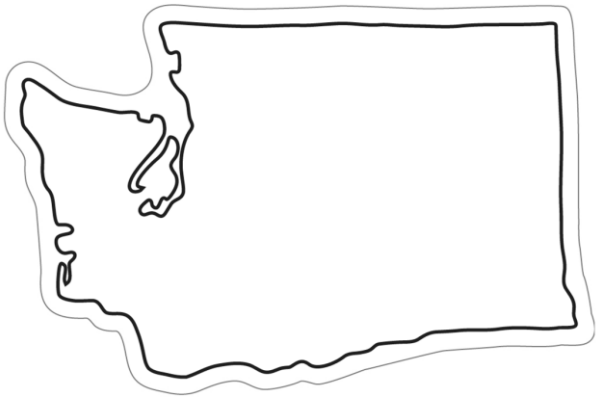
Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc: David Meacham, Associate Regional Administrator, Seattle Regional Office

Medicaid Transformation Project Demonstration Evaluation Design

Washington State Medicaid Transformation Project
Section 1115(a) Medicaid Demonstration



OCTOBER 9, 2017

Approved January 9, 2017

Last Updated 5/9/2017

Contents

Medicaid Transformation Project Demonstration Evaluation Design

Washington State Medicaid Transformation Project Section 1115(a) Medicaid Demonstration

APPROVED JANUARY 9, 2017

Section 1: Overview of the Medicaid Transformation Project Demonstration

On January 9, 2017, the Centers for Medicare and Medicaid Services (CMS) approved Washington State's request for a Section 1115 Medicaid demonstration entitled Medicaid Transformation Project. The activities under the Demonstration are targeted to transform the health care delivery system to address local health priorities, deliver high-quality, cost-effective care that treats the whole person, and create sustainable linkages between clinical and community-based services. The Demonstration will test changes to payment, care delivery models and targeted services. The Demonstration is approved through December 21, 2021.

Over the next five years, Washington will:

- Integrate physical and behavioral health purchasing and service delivery to better meet whole person needs;
- Convert 90 percent of Medicaid provider payments to reward outcomes instead of volume;
- Support provider capacity to adopt new payment and care models;
- Implement population health strategies that improve health equity; and
- Provide new targeted services that address the needs of the state's aging populations and address key determinants of health.

The state will address the aims of the Demonstration through three programs:

- Delivery System Reform Incentive Payment (DSRIP) Program: Transformation through Accountable Communities of Health
- Long Term Services and Supports (LTSS) - Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)
- Foundational Community Supports (FCS) -Targeted Home and Community-Based Services (HCBS) for eligible individuals.

DSRIP Program: Transformation through Accountable Communities of Health

This initiative aims to transform the health care delivery system through regional, collaborative efforts led by ACHs. ACHs are self-governing organizations comprised of multiple community representatives, and focused on improving health and transforming care delivery for the populations that live within the region. Providers within ACH regions will partner to implement evidence-based programs and promising practices, as defined in the DSRIP Planning Protocol (Attachment C), that address the needs of Medicaid beneficiaries.

Each ACH, through its partnering providers, is required to implement at least four transformation projects from the Transformation Project Toolkit and participate in statewide capacity building efforts to address the needs of Medicaid beneficiaries. Project performance will be measured based on state-defined milestones and metrics that track project planning, implementation, and sustainability. Transformation projects are spread across three domains:

- ***Domain 1: Health Systems and Community Capacity Building:*** This domain addresses the core health system capacities to be developed or enhanced to support delivery system transformation. Domain 1

outlines three required focus areas to be implemented and expanded across the delivery system, inclusive of all provider types, to benefit the entire Medicaid population.

- ***Domain 2: Care Delivery Redesign:*** Transformation projects within this domain focus on innovative models of care that will improve the quality, efficiency, and effectiveness of care processes. Person-centered approaches and integrated models are emphasized. Domain 2 includes one required and three optional projects. ACHs are required to select at least one of the optional projects for a minimum of two Domain 2 projects in total.
- ***Domain 3: Prevention and Health Promotion:*** Transformation projects within this domain focus on prevention and health promotion to reduce disparities and achieve health equity across regions and populations. Domain 3 includes one required and three optional projects. ACHs are required to select at least one of the optional projects for a minimum of two Domain 3 projects in total.

The domains, and the strategies defined within each domain, are interdependent. Domain 1 is focused on system wide planning and capacity building to reinforce transformation projects. Domain 1 strategies are to be tailored to support efforts in Domain 2 and Domain 3; projects in Domain 2 and Domain 3 integrate and apply Domain 1 strategies to the specified topics and approaches. In addition to the foundational activities in Domain 1, the Transformation Project Toolkit includes eight projects areas.

TABLE 1.
Menu of Transformation Projects

Domain 1	Health and Community Systems Capacity Building	
		Financial Sustainability through Value-based Payment
		Workforce
		Systems for Population Health Management
Domain 2	Care Delivery Redesign	
Project	2A	Bi-directional Integration of Physical and Behavioral Health through Care Transformation *(Required)*
Project	2B	Community-Based Care Coordination
Project	2C	Transitional Care
Project	2D	Diversion Interventions
Domain 3	Prevention and Health Promotion	
Project	3A	Addressing the Opioid Use Public Health Crisis *(Required)*
Project	3B	Reproductive and Maternal/Child Health
Project	3C	Access to Oral Health Services
Project	3D	Chronic Disease Prevention and Control

In support of delivery system reform and alignment with the aims of the overall demonstration, this initiative seeks to achieve the following objectives:

- ***Health Systems and Community Capacity.*** Create appropriate health systems capacity in order to expand effective community based-treatment models; reduce unnecessary use of intensive services and settings; and support prevention.
- ***Financial Sustainability through Participation in Value-based Payment.*** Accelerate the transition to paying for value across the continuum of Medicaid services to assure the sustainability of the transformation activities under DSRIP, and support the success of Alternative Payment Models required by the state for Medicaid managed care plans (see: STC 41, Table 1).
- ***Bi-directional Integration of physical and behavioral health.*** Achieve comprehensive integration of physical and behavioral health services through new care models.

- ***Community-based Whole-person Care.*** Use or enhance existing services in the community to promote care coordination across the continuum of health for beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.
- ***Improve Health Equity and Reduce Health Disparities.*** Implement prevention and health promotion strategies for targeted populations to address health disparities and achieve health equity.

Long Term Services and Supports (LTSS) - Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)

Washington is a national leader in providing long-term services and supports (LTSS) to help people remain in their homes and communities, saving billions of dollars over the past two decades. Our LTSS system has sustained AARP's ranking of second in the nation for its high performance, while at the same time ranking among the lowest (34th) in cost. However, our population is aging, increasing the number of individuals who will be in need of these services. By 2040, the number of people 65 and older will more than double. As we age, we often need assistance with daily tasks such as bathing and medication reminders in order to stay in our own homes and communities rather than in expensive institutional care. While we will continue to provide more intensive services to those who need them, the Demonstration will help Washington State prepare for the "age wave." It will test new services and expand existing services traditionally provided outside of Medicaid that support unpaid family caregivers.

This "next generation" system of care will help protect people's savings and provide more support for family members and other unpaid caregivers who provide approximately 80 percent of care to people in need of long-term services and support. The majority of Washingtonians are uninsured for LTSS, with no affordable options for coverage. Individuals and their families often have no practical way to prepare financially for future LTSS needs, except by impoverishing themselves so they are eligible for full-scope Medicaid benefits. To highlight the importance of supporting unpaid caregivers, if just one-fifth of these caregivers stopped providing care, it would double the cost of LTSS in Washington State. Providing care for a family member can be among the most rewarding things a person can do, but it also has challenges. A high proportion of caregivers show increases in stress and effects on their own physical and mental health.

The Demonstration will offer additional choices that are intended to:

- Preserve and promote choice in how individuals and families receive services
- Support families in caring for loved ones while increasing the well-being of caregivers
- Delay or avoid the need for more intensive Medicaid-funded LTSS when possible

Medicaid Alternative Care (MAC) will provide support for unpaid family caregivers who support individuals who are eligible for Medicaid but choose to wrap services around their unpaid caregiver as an alternative to other forms of traditional paid services. This benefit package will provide supports enabling unpaid caregivers to continue to provide high-quality care while also focusing on their own health and well-being. It will include needed services such as training, support groups, respite services, and help with housework, errands, supplies, and home-delivered meals.

Tailored Supports for Older Adults (TSOA) will establish a new eligibility category and benefit package for individuals at risk of future Medicaid LTSS use, who currently do not meet Medicaid financial eligibility criteria, but do meet functional criteria for care. It is designed to help individuals and their families avoid or delay impoverishment and the future need for Medicaid LTSS services, while providing support to individuals and unpaid family caregivers. As with MAC, TSOA will include supports such as training, support groups, respite services, and help with housework, errands, supplies, and home-delivered meals. Individuals who do not have unpaid caregivers will receive services such as personal care, adult day services and home delivered meals.

Foundational Community Supports (FCS) -Targeted Home and Community-Based Services (HCBS) for Eligible Individuals

Demonstration HCBS, Community Transition Services (CTS) and Community Support Services (CSS), will help Medicaid beneficiaries reside in stable community settings.[1] The goal is to enhance the availability of services for those who are the most vulnerable and have complex care needs. The CTS and CSS benefits will provide services that link qualifying Medicaid enrollees to appropriate services, and one-time supports necessary for individuals to avoid more intensive care placements and move into stable community settings. The Demonstration -funded CTS and CSS benefits will not supplant existing services currently available to eligible populations. It will be targeted to serve specific high-risk populations and achieve the following outcomes:

- Support those who are unable to reside in stable community settings
- Decrease dependence on costly or restrictive institutional or residential care
- Provide continuity of care by reducing incidents of eviction and provider turnover
- Support those at highest risk for adverse outcomes

Demonstration-funded supported employment services will help Medicaid enrollees with physical, behavioral, or LTSS service needs gain and maintain stable employment. These services will include individualized job coaching and training, employer relations, and assistance with job placement. Informed by stakeholder engagement and population analysis, four outcomes have been identified and corresponding target populations are proposed. Targeted outcomes include:

- Helping individuals stay engaged in the labor market,
- Preventing the escalation of behavioral health service needs,
- Supporting those with significant long-term services and supports needs, and
- Supporting vulnerable youth and young adults.

In order to be eligible for these services, individuals must receive a needs assessment and meet well-defined housing or employment support need criteria, along with additional risk criteria.

Section 2: Evaluation Goals and Objectives

This section describes the overarching framework for evaluation of Demonstration impacts on delivery systems, clinical care, health outcomes, and costs in Washington State. Evaluation activities will be led by an independent external evaluator and supported by state agency teams with complementary data management and analytic subject matter expertise. Detailed design elements related to qualitative evaluation and quasi-experimental evaluation of ACH projects will be determined in conjunction with the independent external evaluator, and after detailed project design information becomes available from ACH project plans. The evaluation will encompass both an assessment of the impact of the Demonstration on the entire delivery system and evaluation of specific projects implemented under all three initiatives. Evaluation goals will include:

- **Assessment of overall Medicaid system performance under the DSRIP program** in developing community capacity to support health system transformation. This will be based on an assessment of post-demonstration changes in statewide performance levels, relative to pre-demonstration baseline performance levels, across the following measurement domains:[2]

[1] Potential changes to the FCS protocol are currently being reviewed with CMS. This document references FCS program descriptions reflected in the originally approved STCs, for purposes of illustrating the proposed evaluation approach. The final evaluation approach will reflect the actual design of the implemented FCS program.

[2] At this time we cannot commit to a comparison-group approach to measuring statewide Demonstration impacts, primarily due to uncertainty about the availability of the national T-MSIS data necessary for identifying comparison groups and

- Access to primary care, behavioral health care, and other preventive health care services;
- Quality of care;
- Reduction in use of costly ED, inpatient, or institutional care, including through the reduction of utilization for ambulatory care sensitive conditions and reduction of utilization disparities for persons with behavioral health risk factors;
- Social outcomes including housing stability and employment measured using beneficiary-level administrative data drawn from the State's rich integrated data environment (described further below); and
- Overall Medicaid expenditures on a per beneficiary per month basis.

- **Assessment of progress toward meeting VBP penetration targets.** This assessment is expected to be both qualitative and quantitative in nature, based on data sources such as provider surveys, focus groups, key informant interviews, and document review.[3] The independent external evaluator will assess the extent of use of VBP in contracting, the effectiveness of readiness support provided to providers, and the impact of use of VBP approaches on provider/plan behavior, patient health outcomes, and patient experience. This activity will leverage the assessments of the role of VBP approaches at the project scale, as outlined in the project-level evaluation design detail in Section 5.
- **Assessment of the impact of the Demonstration on the development of the workforce capacity needed to support health system transformation.** This assessment is also expected to be both qualitative and quantitative in nature, based on data sources such as:
  - Provider network adequacy information supplied by MCOs;
  - Performance metrics related to access to services, quality of care, and reduction in use of costly inpatient or institutional care; and
  - Provider surveys, focus groups, and key informant interviews, leveraging assessment of workforce capacity at the project scale as outlined in the project-level evaluation design detail in Section 5.
- **Assessment of the impact of the Demonstration on provider adoption and use of health information technology.** The methodology for assessing impacts in this area will be determined by the independent external evaluator and is expected to leverage provider surveys, focus groups, and/or key informant interviews to assess whether the Demonstration has affected the use of electronic and interoperable health information exchange to promote care coordination, targeted services, and positive outcomes of clinical care. As required by STC 109(b), this assessment will examine the extent to which the Demonstration has enhanced the state's health IT ecosystem to support delivery system and payment reform and the impact on ACH and provider partners' governance, financing, policy/legal issues and business operations. This evaluation activity would include providers who are and are not eligible for the Medicaid EHR Incentive Program, with a focus on use of HIT to improve health outcomes for high-risk populations including persons with co-occurring physical and behavioral health conditions. This activity will leverage the assessments of the role of HIT at the project scale, as outlined in the project-level evaluation design detail in Section 5.
- **Measurement of project-level impacts at the state and ACH level.** Outcomes will be assessed for project-specific target populations at the state and ACH level. Outcome measures will be produced centrally leveraging the state's rich integrated data environment and capacity for performance measure

measuring outcomes for beneficiaries drawn from Medicaid populations in other states. At the time of this writing, we note that the evaluation of the impact of Washington State's Health Home program on Medicaid program costs conducted for CMS by RTI, which takes a comparison-state approach using T-MSIS data, is two years overdue as a result of T-MSIS data limitations. We also note that a within-state contemporaneous comparison group cannot be used to measure overall Demonstration impacts, given the statewide scope of the Demonstration.

[3] More detail concerning the types of documents expected to be reviewed is contained in Section 3.

production. Evaluation will not rely on aggregation of performance measures produced separately by ACHs. This allows great flexibility in the creation of valid comparison groups for use in the application of quasi-experimental evaluation techniques, as described below. For projects that are undertaken by multiple ACHs, a comparative analysis will be undertaken to help determine key drivers of outcomes, dependencies and environmental factors that might contribute to positive or negative outcomes for specific projects.[4] As described in the sections that follow, the state will leverage its nation-leading internal analytic capacity and integrated data environment to support the independent external evaluator and provide a data infrastructure able to:

  - Identify beneficiary-level project participation, including potentially overlapping participation across multiple projects and initiatives;
  - Measure project outcomes at the ACH-project scale using statistically valid quasi-experimental evaluation designs; and
  - Assess differences in outcomes across ACHs within project areas based on factors such as differences in target populations (i.e., actual populations served).

- **Rapid-cycle project implementation support (formative evaluation).** Timely implementation reports will especially be useful to inform efforts early in the project implementation process. These reports will be available to CMS if requested. The design and frequency of these reports will be determined in collaboration with the independent external evaluator and ACH partners. An example set of implementation reports would include monthly or quarterly health risk factor profiles of the populations engaged in specific projects/initiatives, compared to target population benchmarks. Such reports would help assess levels of engagement and potential differences across ACHs in the composition of engaged beneficiaries that could inform the early stages of project implementation. Early implementation reports will be mainly used to identify and mitigate risks or take advantage of opportunities to improve project implementation. Later implementation reports will also be used to inform the broader analysis of project impacts and outcomes, in advance of delivery of STC-required evaluation reports in the fourth and fifth years of the Demonstration. These implementation support activities reflect formative evaluation of the development and early implementation of Demonstration-funded initiatives and component projects.

Detailed project-level specification of required evaluation design components is contained in Section 5 and Appendix 1, including project-level descriptions of:

  - Initiative and project goals and objectives
  - Target populations
  - Evaluation questions and testable hypotheses
  - Data strategies, data sources and data collection frequency
  - Outcome metrics
  - The statistical framework for measuring project impacts
  - Potential subgroup analyses to assess disparities and differences in beneficiary engagement and project impacts.

At the state level, data will be analyzed to determine if the Demonstration has affected the pre-Demonstration trajectory of measures of access to care, quality of care, health and social outcomes, and Medicaid cost measures. This will be based on an assessment of post-demonstration changes in statewide performance levels, relative to pre-demonstration baseline performance levels, across the range of

[4] Note that the CMS response to the prior evaluation design draft assumed that ACHs could choose different outcome measures for the same project. However, we anticipate using the same set (or at least a highly overlapping set) of centrally produced measures for all ACH projects within a given project type.

measurement domains described in the previous section.[5] While project-specific evaluations will use quasi-experimental program evaluation techniques focused on targeted project populations, the statewide analysis will include a broader Medicaid population perspective reflecting the potential combined impact of all activities undertaken under the Demonstration. The statewide impact evaluation will also focus on higher-risk beneficiaries who are expected to be significantly positively impacted by Demonstration initiatives, including but not limited to beneficiaries with SMI or co-occurring disorders, with multiple chronic conditions, with functional needs for LTSS services, living in underserved areas, or experiencing baseline disparities in health outcomes. Washington State has significant experience identifying and measuring disparities in access, quality, and health outcomes across these populations.

While the evaluation may not be able to completely isolate the effects of the Demonstration from other policy and program changes and investments under the SIM Grant, differences in timing, specific areas of impact, and target populations will facilitate the measurement of impacts associated with initiatives under the Demonstration. For example, the financial integration of behavioral and physical health services is being instituted under SIM and is expected to be completed by 2020. The financial integration of behavioral and physical health services is seen as a critical support for the effective integration of clinical care. Financial integration is being phased regionally, which will provide the opportunity to compare the effectiveness of Demonstration projects at the ACH scale across regions at the same stage of financial integration. Through the identification of appropriate comparison groups by region, the evaluation should be able to isolate the impact of Demonstration initiatives from financial integration impacts. As discussed further below, propensity score matching methodologies will be used in project-level analyses to ensure the identification of appropriate comparison groups for measuring impacts.

Section 3. Overview of Major Evaluation Components and Activities

This section provides additional detail about the major evaluation activities expected to be undertaken across all three initiatives by the independent external evaluator and state agency evaluation support teams. We start with a description of qualitative methods used to support project implementation and inform quantitative evaluation analyses, and then turn to describing the rigorous quantitative evaluation methods that will leverage the State's advanced integrated analytical environment. Section 5 and Appendix 1 provide detailed project-specific mapping of demonstration hypotheses (STC 108), domains of focus (STC 109), research questions, testable hypotheses, outcome measures, and data sources, for both quantitative evaluation components, along with mapping of demonstration hypotheses, domains of focus, research questions, and testable hypotheses for qualitative evaluation components.

Qualitative analysis. Evaluation activities will include qualitative analysis of program implementation and operations to support both formative evaluation deliverables and quantitative analysis of program impacts. Qualitative analysis will address program implementation questions such as:

- How programs are designed;
- The level of readiness for the program among stakeholders;
- The effectiveness of VBP readiness support for providers and the impact of use of VBP approaches on provider/plan behavior and patient health outcomes;
- Provider capacity development, including domains such as HIT acquisition and use, VBP use, workforce availability, and workforce readiness/training;

[5] Note that the CMS response to the prior evaluation design draft suggested use of an approach in the spirit of a regression-discontinuity design which would include comparative data on the population "just over the eligibility threshold" for the purposes of state-level evaluation. While this approach may be feasible in the context of evaluating specific projects, it would not be feasible for the evaluation of statewide impacts due to the lack of access to health care encounter data for persons not enrolled in Medicaid.

- How acquisition and use of HIT and health information exchange technologies impact service delivery transformation; and
- Efforts to make the organizational changes necessary to support system transformation.

Qualitative analysis will help inform our understanding of why the Demonstration and its component projects did or did not achieve the expected effects, by exploring:

- Experiences of beneficiaries, providers, and other key stakeholders through focus groups, key informant interviews, and survey methods;
- Contextual changes that might affect outcomes;
- Unintended programmatic side effects; and
- How faithfully projects were implemented.

Qualitative analysis will help make more accessible findings from the quantitative impact analysis, by reinforcing quantitative findings in a non-technical format (e.g., through key-informant quotes, rather than statistics), helping to open the "black box" of program effects.

The design and execution of qualitative methods supporting the evaluation will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Subjects for qualitative data collection and analysis are expected to include beneficiaries, providers, ACH staff/administrators, MCO staff/administrators, and state agency staff. Individual ACH projects are expected to define strata for sampling of subjects for qualitative analyses, to ensure representation from targeted beneficiaries and providers.

Quantitative analyses leveraging integrated administrative data. The evaluation will leverage the integrated administrative data maintained in the Department of Social and Health Services Integrated Client Databases (ICDB) to support quasi-experimental evaluation across all three initiatives, including evaluation at the ACH-project scale. The ICDB was explicitly designed to support quasi-experimental evaluation of health and social service interventions in Washington State, and has been widely used in evaluation studies published in peer-reviewed journals.[6]

The ICDB contains nearly 20 years of individual-level, massively dimensional data for nearly 6 million persons residing in Washington State over that time span. It contains data from approximately 20 administrative data systems, including the State's ProviderOne MMIS data system and all other data sources necessary to implement the quantitative evaluation design described in this document, except in a few areas discussed below where new data collection may be required.

More specifically, the ICDB contains:

- Service event level utilization data across all Medicaid funded delivery systems (physical, mental health, substance use disorder, long-term services and support, and developmental disability services);
- Expenditure data at the service event and per-member per-month level of aggregation by major service modality, for all Medicaid beneficiaries over the time period relevant to this evaluation (with a few caveats related to issues like the methods for applying pharmacy rebates);

[6] For a recent example, see Jingping Xing, Candace Goehring and David Mancuso. Care Coordination Program For Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs Care Coordination Program For Washington State. Health Affairs, 34, no.4 (2015):653-661.

- Risk factors associated with chronic and acute disease conditions, including mental illness and substance use disorders, derived from the CDPS and Medicaid-Rx risk models and related tools;[7]
- Assessment data on functional support needs, cognitive impairment, and behavioral challenges for persons receiving LTSS services;
- Data on "social outcomes" including arrests, employment and earnings, and homelessness and housing stability;
- Client demographics (age, gender, race/ethnicity);
- Medicaid enrollment by detailed coverage category;
- MCO enrollment or fee-for-service Medicaid coverage status;
- Medicare Parts A, B, and D integration for persons dually enrolled in Medicaid and Medicare; and
- Geographic residential location spans which are critical to regional attribution models.
- With regard to CMS reviewer questions pertaining to how frequently data is collected, the ICDB is updated on a quarterly basis. The ICDB analytical data infrastructure is complemented by a suite of HEDIS and related metric measurement algorithms that currently regularly produce most of the quantitative outcome metrics listed in Section 5 and Appendix 1 on at least a semi-annual basis for all Medicaid beneficiaries in Washington State meeting measure specification requirements. Furthermore, the state agency teams maintaining the ICDB have deep expertise in identity management processes that may be necessary to link new ad hoc data sources required for ACH project attribution.

Among the advantages to leveraging the State's nation-leading integrated analytical data environment is the elimination of dependencies on ACHs for data collection and measurement, which otherwise would likely result in variation across projects in data integrity and measurement quality. We also note that the State's analytical environment can readily absorb new and changing measurement concepts, and apply those concepts retroactively for all relevant history to maintain consistent time series for analysis. For example, the addition of "FUA" and "FUM" metrics first implemented in the HEDIS® 2017 provided the state with useful new tools to assess coordination of physical and behavioral health care for persons with co-occurring conditions, and we retroactively produce those measures for prior time periods. Given the active work underway by NQF and NCQA, driven by CMS support, to improve the breadth of quality and outcome measures related to behavioral health conditions, if new measures are developed and released in 2018 or 2019 we would be able to retroactively engineer those measures into baseline time periods for the entire qualifying Medicaid population. This is one of the factors that support the expectation that the measure sets described in this design document may be modified if better performance measurement tools become available in the evaluation window.

Primary data collection for research questions that cannot be addressed using administrative data. Evaluation activities are expected to include key informant interviews, focus groups, stakeholder surveys, document review, and other activities as necessary to inform the qualitative analysis of initiative and project design and implementation. Qualitative analysis will be particularly important in evaluating the impact of DSRIP activities on progress toward meeting VBP penetration targets, the development of workforce capacity, and provider adoption and use of the state's health IT.

Methods such as key informant interviews, focus groups, and stakeholder surveys are expected to be used to assess the extent to which DSRIP funding has enhanced the state's health IT ecosystem to support delivery system and payment reform, with a focus on governance, financing, resolution of policy and legal barriers, and impacts on business operations. As noted elsewhere, the design and execution of qualitative methods supporting the evaluation will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected;

[7] For more information about the CDPS and Medicaid-Rx, visit http://cdps.ucsd.edu/.

determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments.

Subjects for key informant interviews and focus groups will be identified through consultation with State subject matter experts, and are expected to span the range of Demonstration activities and participants. Data will be collected from state agency staff, ACHs, MCOs, provider organizations, local health jurisdictions, tribes, and other key public and private stakeholders as identified.

Documentation will be identified in consultation with subject matter experts within HCA. Documents would include, but not be limited to, annual updates to the VBP roadmap; the annual VBP provider[8] survey; available documentation and data on provider adoption of VBP; consumer experience surveys, such as the CAHPS[9] survey, provided to Medicaid clients; the HIT strategic roadmap and updates to the operational plan; ACH project plans and implementation plans; Independent Assessor assessments of plans, semi-annual review of ACH progress against miles stones and metrics included in approved project plans, any documents associated with at risk projects, mid-point assessment, and other documents created by the Independent Assessor related to the challenge pool and the reinvestment pool including annual assessments of MCO and ACH performance; and all quarterly reports submitted by HCA to CMS.

In addition, caregiver and care receiver survey data collection is planned to support evaluation of the MAC and TSOA programs. Survey data will mitigate the impact on the evaluation of the absence of comparable health service utilization data for non-Medicaid clients, and lack of LTSS-related functional assessment data for Medicaid clients not receiving LTSS services. More detail about the design and data collection and analysis processes for these surveys is contained in Section 5.

Statewide beneficiary project attribution model. Given the scale of the initiatives and projects supported by the Demonstration, a statewide project attribution data infrastructure will be necessary to support evaluation – in particular evaluation of the Demonstration at the ACH-project scale. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration -funded projects across all three initiatives. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs described below.

The attribution model will be based on regularly updated claims, encounters, Medicaid eligibility, and residential location data processed through the ICDB, supplemented where necessary with regularly updated ACH project-specific data streams (e.g., monthly participating beneficiary and/or provider rosters) for ACH projects where claims and encounters processed into the ICDB are not sufficient to identify participating beneficiaries. For initiatives 2 and 3, we have determined that data identifying utilization of Demonstration services will be available through information routinely integrated into the ICDB – for example, supportive housing and supported employment encounters submitted by the third-party administrator (Amerigroup) into the ProviderOne (MMIS) system.

[8] HCA issues an annual value-based payment (VBP) survey to track progress towards the state's paying for value goals, and to identify barriers impeding desired progress. The provider survey will offer valuable insight into the challenges providers face as they consider adopting new payment arrangements and guide state health care purchasing strategies in support of overcoming those challenges. The commercial health plan survey will help HCA track progress towards our paying for value goals, with particular insight into non-state purchased health care programs. The MCO survey will establish a statewide and regional (designated by Accountable Communities of Health) baseline of VBP attainment for requirements under the new Apple Health contracts and VBP incentives under the Medicaid Transformation Demonstration Project, respectively.

[9] The State uses the Adult CAHPS Survey and the Child and Child with Chronic Conditions Survey for Apple Health Medicaid enrollees, with adult and child surveys rotated every other year.

Final evaluation design determination. The statewide evaluation will identify whether the Demonstration impacted key metrics from a macro state-level perspective. However, it remains critical from the long-term sustainability perspective to understand which ACH projects positively impacted outcomes for participants, even if they were not implemented at a scale to produce statistically significant changes at the ACH or statewide geographic scale. This is critical information to identify which interventions should be supported or expanded after the demonstration ends.

Finalizing many components of the detailed evaluation design at the project scale will need to be deferred until after ACH project implementation plans are available in the spring of 2018, and will be done in collaboration with the independent external evaluator. This timing is necessary because much of critical information for finalizing the evaluation design is dependent on knowing what types of projects will be implemented by ACHs. Project-level evaluation designs cannot be completed until we know the answers to questions including:

- Which interventions have been selected?
- How program participants will be targeted?
- Which providers will be participating?
- How much capacity will be developed to serve the targeted population?
- What level of engagement in the target population is likely to be achieved?
- Are other ACHs targeting similar populations for their initiatives?

At this point we can provide a discussion of evaluation design options, with recognition that specific design choices are dependent on currently unknown parameters and guidance from the independent external evaluator.

For example, if we knew that a particular ACH project was going to serve a relatively high proportion of a well-defined target population, and we knew that population was not a target for projects in some of the other ACHs, we would likely consider an intent-to-treat difference-of-difference design where we would compare relative changes in the entire target population in both the implementing ACH and the comparison ACHs that did not target this population. The intent-to-treat aspect of the design and the geographic variation in implementation would be instruments available to us to reduce the impact of selection bias on estimated project impacts.

However, if an ACH project were designed to reach only a small proportion of the potential target population in that ACH, an intent-to-treat approach would wash out the effect of the project on “treated” beneficiaries, by including their experience with the vastly larger number of untreated beneficiaries in the target population. From one perspective, the intent-to-treat approach would answer the question of whether the intervention impacted outcomes in the larger ACH target population. With low intervention penetration, the answer would likely be “no.” But the question of whether the intervention impacted outcomes for those who engaged in the project is still highly relevant from the perspective of determining which interventions should be supported or expanded after the demonstration ends. And to address the question of impacts on the treated population, we would likely use a propensity score matching approach to identify an untreated comparison group. In the context of low intervention penetration, it might be appropriate to draw comparison group members from within the ACH implementing the intervention being evaluated, particularly if the ACH also implemented broad-based health system delivery redesign and community capacity building initiatives that are unique to the region.

These types of considerations will be worked through with the support of the independent external evaluator, after ACH project designs become available. We expect CMS to provide input and concur in the appropriateness of the final evaluation designs.

Propensity-score methods to estimate project-specific impacts. Propensity score matched comparison group designs will be broadly deployed across all project areas that are amenable to impact analysis using

administrative data, including MMIS-derived health service utilization data, LTSS assessment data, and linked "social determinant" outcome data.[10] Evaluation of Transformation project impacts at the ACH level is necessary to:

- Understand variation in outcomes across ACHs,
- Understand the degree to which improvements can be attributed to the specific activities undertaken under the Demonstration, and
- Inform post-Demonstration resource priorities in the state authorizing environment.

A matched comparison group is expected to be created for each ACH project, based on the characteristics of the target population for the specific intervention. The pre-post boundary for the treatment group will be based on the point at which they engage in the intervention. The pre-post boundary for the comparison group will be defined through the matching process, as described below. The matching process will generally proceed through the following steps:

- **Comparison frames for matching are identified by an initial broad set of criteria that align with the project targeting criteria.** For example, if an ACH intervention is targeting persons discharged from a hospital setting for improved care transitions, the starting point in defining the matching frame will be the identification of other qualifying discharges in the intervention "intake window", potentially both within and outside of the ACH (based on overarching evaluation design considerations discussed above). Similarly, if a care coordination intervention targets a particular set of beneficiaries using well-defined risk criteria, this initial stage of the process will identify all person-months for persons not receiving the intervention where the person meets the targeted risk criteria in the relevant baseline window (e.g., has PRISM risk scores within the eligibility range in the prior 12 month period). This approach to building a "person-month" frame for matching against the "person-months" associated with entry into the intervention by persons comprising the treatment group is illustrated in the evaluation of the precursor to the State's Health Home Program (Health Affairs, April 2015).[11] This approach leverages the richness of the State's integrated data environment and design of its analytical data infrastructure, which supports data management techniques that scan all relevant persons at all relevant points in time (months in this case) where they might be a "best" match to a person who entered the specific intervention under study at the time when they entered the intervention. The RDA project team supporting the independent external evaluator has extensive experience using these techniques for producing the high-volume of rigorous project evaluations required by the Demonstration.
- **Key predictors of engagement within the pooled intervention and comparison matching frame are examined to ensure inclusion of appropriate measurement dimensions in the PS model.** This includes creating an extensive set of "engagement predictors" that are determined, ex ante, to be potentially relevant to the matching process. This set of predictors is generally expected to span a wide range of the measurement domains contained with the State's ICDB, which may include:
  - Service utilization data across all Medicaid funded delivery systems (physical, mental health, substance use disorder, long-term services and support, and developmental disability services);
  - Expenditure data at the "major modality" (e.g., IP hospitalization, OP ED visits, etc.) per-member per-month level;
  - Risk factors associated with chronic and acute disease conditions, including mental illness and substance use disorders, derived from the CDPS and Medicaid-Rx risk models;

[10] Examples of propensity-score impact analyses using the types of linked administrative data available for the Demonstration evaluation can be found here: https://www.dshs.wa.gov/sesa/research-and-data-analysis. For a recently published specific example, see: https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-8-33.pdf.

[11] Jingping Xing, Candace Goehring and David Mancuso. Care Coordination Program For Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs Care Coordination Program For Washington State. Health Affairs, 34, no.4 (2015):653-661.

- Data on functional support needs, cognitive impairment, and behavioral challenges for persons receiving LTSS services when applicable;
- Data on arrests, employment and earnings, and homelessness and housing stability when applicable;
- Client demographics (age, gender, race/ethnicity);
- Medicaid enrollment by detailed coverage category; and
- Urban/rural/frontier characteristics of the beneficiary's residential location.

- Application of machine learning techniques (e.g., stepwise logistic or lasso regression) to determine the final propensity score model.
- Propensity score matching using procedures in the R programming language (e.g., the Matchit procedure). For some interventions, exact matching may be required for key variables.

Project-level utilization and cost analyses generally will be conducted using a difference-of-difference design, where the pre-to-post change in experiences for beneficiaries receiving a particular intervention will be compared against the change experienced by the matched comparison group. As described above, for analyses using a difference-of-difference design the pre-post boundary for the treatment group will be based on the point at which they engage in the intervention. The pre-post boundary for the comparison group will be defined through the matching process, which uses a person-month matching frame for matching against the "person-months" associated with entry into the intervention by persons comprising the treatment group. This approach leverages the richness of the State's integrated data environment and design of its analytical data infrastructure, which support data management techniques that scan all relevant persons at all relevant points in time (months in this case) where they might be a "best" match to a person who entered the specific intervention under study. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. Outcome metrics and measurement approaches will be partially aligned with those used for determining ACH performance payments, where feasible.

In response to comments received on the prior draft of this document, we want to emphasize the appropriateness (and critical importance) of matching based on pre-treatment utilization patterns in evaluating many of the interventions supported by the Demonstration. Past utilization is not endogenous because it cannot be impacted by future treatment. The outcome of interest is <u>future</u> (that is, post treatment entry) utilization, not past utilization. Future utilization is never appropriate for inclusion in the matching process, while past utilization patterns can be essential to control for when interventions are targeted specifically based on prior risk or service utilization patterns, as will likely be the case in many care coordination, care transition, and diversion projects. Controlling for past utilization is one of the key ways to ensure that treatment and comparison groups do not have embedded within them differential expected levels of regression to the mean in utilization and cost metrics.

Data gap identification for each component of evaluation. Evaluation activities will ensure that data will be collected for all Demonstration projects as needed to facilitate the dissemination and comparison of valid quantitative data. Gaps in the extant data sources available to complete proposed evaluation activities will be identified and addressed. Currently known gaps, and the strategies to collect the necessary data, are summarized below:

- Qualitative data necessary for formative evaluation and support of the interpretation of quantitative findings will be collected using methods such as focus groups, key informant interviews, and surveys of beneficiaries and providers.
- New survey data will mitigate the impact on the evaluation of the absence of comparable health service utilization data for non-Medicaid clients, and lack of LTSS-related functional assessment data for Medicaid clients not receiving LTSS services, in the evaluation of the MAC and TSOA programs.

- Qualitative data related to health IT adoption and use by providers, who are and are not eligible for the Medicaid EHR Incentive Program, workforce supports needed to support adoption and use, and barriers to use.
- ACHs may be required to regularly report patient and/or provider rosters associated with specific projects, if that information cannot be obtained through regularly collected claims or encounter data. Reporting of this information may be considered as a potential component of "pay for reporting" criteria of the ACH performance payment formula.

Assessment of data limitations and threats to internal validity and generalizability outside of the Washington State environment. Evaluation products will include an assessment of threats to validity and generalizability. From the perspective of internal validity, a key potential threat is the presence of selection bias in the engagement of beneficiaries in specific projects, in the absence of randomized trial designs for project implementation. Although the propensity matching approach is recognized as a valid evaluation design, frequently accepted in the peer-reviewed program evaluation literature, the approach may not fully mitigate the threat of selection bias. In implementing this design, it will remain critical to understand the process that "selects" clients into projects and to use this knowledge to define a credible "matching frame" for each project.

In particular, we note that the specification of the structure of the matching model can have a large effect on the estimated program impact. For example, if selection into a project is tied to a specific pattern of service delivery (e.g., release from a hospital), or due to extreme baseline utilization, then ensuring that the matched comparison group has a similar "trajectory" of service use into the boundary of the pre/post periods will be critical. The richness of the administrative data available to the evaluation team will help reduce the selection bias threat, by moving more client characteristics from the "unobservable variable" column to the "observable variable" column, including the trajectory of prior health service utilization in the baseline period used for matching.[12] The recent evaluation of the State's "Money Follows the Person" program (Roads to Community Living) illustrates the criticality of matching on pre-period utilization trends in the context of interventions that target clients with specific pre-period utilization patterns. In the context of the RCL evaluation, the intervention requires a pattern of prior nursing facility utilization and client interest in community re-integration. The target population would tend to show significant regression to the mean (future reductions) in LTSS expenditures in the absence of any intervention. Comparing the intervention group against the experience of the broader nursing facility population would vastly overstate RCL program treatment effects. The chart on page 5 of the report referenced below illustrates this phenomenon, and the importance of matching on prior service utilization trends leading into the pre/post time boundary.[13]

Another threat to the internal validity of evaluation findings will be the challenge of controlling for all potential confounding interventions and policy changes – in particular the potential for beneficiaries to experience multiple overlapping treatment effects, both from other Demonstration projects and from other initiatives occurring simultaneously to the Demonstration. This risk will be mitigated through the development and maintenance of the statewide beneficiary project attribution model, as described above. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs.

The threats to the generalizability of project impact findings include the following considerations. First, conditions may be different in Washington State than in other states to which Demonstration-supported interventions might be extended. For example, Washington State has a highly rebalanced Medicaid LTSS delivery system, which has already achieved significant rebalancing of care from institutions to home and community settings. Second, variation in local conditions across Washington State may make it more

[12] For a recently published example of an impact analysis using propensity matching and leveraging detailed information on the trajectory of prior health service utilization, see: https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-8-33.pdf.

[13] See: https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-8-33.pdf.

challenging to generalize the effect of ACH-specific initiatives to other regions of the state. Required evaluation deliverables will speak to the potential to generalize findings outside of the Washington State environment.

Section 4. Process to Select an Outside Contractor

Required qualifications. Washington will select an independent external evaluator that has the expertise, experience, and impartiality to conduct a sophisticated program evaluation that meets all requirements specified in the Special Terms and Conditions including specified reporting timeframes. Required qualifications and experience include multi-disciplinary health services research skills and experience; an understanding of and experience with the Medicaid program; familiarity with Washington State Medicaid programs and populations; experience assessing the ability of health IT ecosystems to support delivery system and payment reforms, including issues related to governance, financing, policy/legal issues and business operations; and experience conducting complex, multi-faceted evaluations of large, multi-site health and/or social services programs.

Potential evaluation entities will be assessed on their relevant work experience, staff expertise, data management and analytic capacity, experience working with state agency program and research staff, proposed resource levels and availability of key staff, track record of related publications in peer-reviewed journals, and the overall quality of their proposal. Proposed deliverables must meet all standards of leading academic institutions and academic journal peer review. In the process of identifying, selecting, and contracting with an independent external evaluator, the State will act appropriately to prevent a conflict of interest with the independent external evaluator. The independent external evaluator will have no affiliation with ACHs or their providers.

Cooperation with potential federal evaluator. Should CMS undertake an independent evaluation of any component of the demonstration, the state shall cooperate fully, to the greatest extent possible, with CMS or the evaluator selected by CMS. To promote efficiency, consistency, and best practices, the State independent external evaluator and any CMS evaluator will share data sources and methodology. There may be cases where the State and CMS evaluator choose to focus in different areas or pursue different modeling and statistical techniques. This will lead to a fuller and more nuanced understanding of the success and challenges of the Demonstration, as long as, both approaches fully consider the unique systems and experience in Washington State.

Collaboration with state agency program and research staff. The core evaluation, to be completed by the independent external evaluator, will include all elements required in the STCs. The state plans to fully leverage the independent evaluation to inform and support implementation, to develop internal reporting capability, to share lessons learned across projects and geography. To ensure that the evaluation work can be fully leveraged by the State; the independent external evaluator will be expected to consult extensively with State research staff to ensure agreement on scope, approach, and interpretation of the Washington context. Careful consultation will be essential to develop an evaluation that is responsive to the Washington experience, while identifying generalizable results.

The independent external evaluator will lead the evaluation and ultimately be responsible for the validity, reproducibility, and interpretation of the results. The State's role is to provide extensive guidance on unique aspects of the State's health system; health system participants; data availability, content, and interpretation; information flows; history and context of service provision, etc. The State will provide guidance on its needs and use cases for materials and results produced for the evaluation. The State will use its expertise and experience to provide the independent external evaluator with model identification and application within the Washington context. While all aspects of the evaluation plan outlined here will be the responsibility of the independent external evaluator, the State will participate in and conduct its own ongoing analysis and evaluation to support success across the Domains of the Demonstration.

The state plans to provide extensive consultation and data support for the independent external evaluator. The independent external evaluator will receive reports described in the STC under section 37 including bi-annual milestone and metric reports submitted by ACHs, quarterly DSRIP operational report protocols submitted by the state, and additional progress milestones for at risk projects. The independent external evaluator will conduct ongoing analyses of these data to inform both the interim and final evaluation reports.

Budget for the independent external evaluator evaluation activities. The total budget for the independent external evaluator is estimated to be over $4 Million for four years (Jan 1, 2018 through Dec 31, 2021). The estimated budget amount will cover all evaluation expenses, including salary, fringe, administrative costs, other direct costs such as travel for data collection, conference calls, etc., as well as, all costs related to quantitative and qualitative data collection and analysis, and report development. More detail and justification for proposed costs will be provided through the independent external evaluator selection process.

The state will also budget for sufficient state agency staff, at both HCA and DSHS, to efficiently and effectively support the independent external evaluator. State support will be similar to the level needed to undertake evaluation on its own. That is, state data, analytic, and research staff will have to undertake data gathering, prepping, and submitting in line with the research goals and objectives. State researchers will provide technical assistance, will create intermediate data products, will share their in-depth knowledge of existing state programs; state populations; Medicaid operations; and will leverage existing relationships with partner organizations. They will also provide information on state IT, local and provider information technology systems as well; data structures, collections, definitions; and compliance with state policies such as privacy and security.

The state will select and enter into a contract with an independent entity to conduct the evaluation of the Demonstration to meet the following timeframes and deliverables.

TABLE 2.
Evaluation Deliverables and Timeline

Deliverable	Responsible Party (from to)	Date
Draft Evaluation Design	State	May 9th, 2017
– Comments from CMS	CMS	60 days from receipt
– Final evaluation design	State	60 days from receipt
DSRIP Deliverables		DY 2, 3, 4, and 5
Quarterly progress reports from independent external evaluator to include quarterly activities, data analysis, reflections and insight on the implementation of projects drawing on key informant interviews, document review, meetings attended, and activity review.	Independent External Evaluator (IE) to State	One month prior to State quarterly and annual reports.
State progress reports will include information on submittals from IE and progress of evaluation.	State to CMS	Include in Quarterly and Annual reports
Semi-annual milestone and metric reports submitted by ACHs, including any additional milestones reported for at-risk projects	ACHs to State/State to IE	Twice a year or according to established schedule
Quarterly DSRIP operational report protocols	State to IE	All available and then quarterly starting with IE contract initiation.

Deliverable	Responsible Party (from to)	Date
Health IT (STC39)	State to CMS	Quarterly
Specification for data required from state including a timeline, data gap analysis, and plan to address data gaps.	IE to State	DY2, Q3
Quarterly, semi-annual, and annual metric updates (depending on metric frequency) for P4P measures	State to IE	Quarterly starting DY 2, Q3
Receipt of annual data submissions from state to support baseline analysis	State to CMS	Annually starting DY 2, Q4
Focus groups and key informant interviews to create baseline information for qualitative analysis	IE to State	90 days after submittal of detailed project plans
Analysis of (2017) baseline state metrics and data	IE	DY 3, Q1
Analysis of VBP materials including existing survey results, data, key informant interviews, and focus groups to create a baseline line assessment of VBP readiness and use in contracting both at the plan and provider level.	IE to State	DY 3, Q1 90 days after receiving focus group data
Review and synthesize documents, data, focus groups, and key informant interviews on baseline workforce capacity	IE to State	DY 3, Q1 90 days after receiving focus group data
Review and synthesize documents, data, focus groups, and key informant interviews on baseline ability and readiness of state HIT/HIE to support health system transformation	IE to State	DY 3, Q1 90 days after receiving focus group data
Qualitative analysis of other aspects of program implementation and operations	IE to State	DY 3, Q1 90 days after receiving focus group data
Identification and baseline analysis of high risk populations expected to be significantly impacted by Demonstration initiatives.	IE to State	DY 3, Q1
Quantitative baseline analysis of overall target populations at the state and ACH levels.	IE to State	DY 3, Q2
Quantitative analysis of project target populations both within and across ACHs.	IE to State	DY 3, Q2
Rapid cycle implementation reports	Joint IE/State products	To be included in quarterly reports to start 90 days after implementation. Quarterly starting DY 3, Q1
Evaluation of specific projects implemented under all three initiatives. Both ACH specific results and Statewide implementation.	IE to State	DY 4, Q1 preliminary results DY 5, Q4 final results
Focus groups and key informant interviews to assess impact of Demonstration on all initiatives	IE to State	DY4, Q2

Deliverable	Responsible Party (from to)	Date
Focus groups and key informant interviews to assess impact of Demonstration on all initiatives	IE to State	DY 5, Q2
Analysis of VBP materials including provider survey results, key informant interviews, and focus groups to assess impact of Demonstration activities on VBP readiness, adoption, and use in contracting both at the plan and provider level.	IE to State	90 days after receiving focus group data (target date DY 5 Q4)
Analyze documents, data, focus groups, and key information interviews to assess Demonstration impact on healthcare workforce capacity	IE to State	90 days after receiving focus group data (target date DY 5 Q4)
Analyze documents, data, focus groups, and key information interviews to assess impact of Demonstration on HIT/HIE investments, use, and impact on health system transformation	IE to State	90 days after receiving focus group data (target date DY 5 Q4)
Qualitative analysis of other aspects of program implementation and operations	IE to State	90 days after receiving focus group data (target date DY 5 Q4)
Draft Interim Evaluation Report	State	April 3rd, 2021
– CMS comments	CMS	TBD
– Final interim evaluation report	State	60 days from receipt of CMS comments
Draft Final Evaluation Report	State	January 30th, 2022
– CMS comments	CMS	TBD
– Final evaluation report	State	60 days from receipt of CMS comments

The independent external evaluator will provide additional analyses and reporting to enable Washington to fully leverage the work of evaluation to inform and improve the implementation of the initiatives under the Demonstration. For this reason, the evaluation will need to be undertaken in stages, with reports and information being produced for internal stakeholders at each stage. Early work will focus on qualitative data gathered from focus groups, key informant interviews, and surveys. As the implementation progresses, analysis and reports will move towards impact and outcomes. Washington will also be interested in an evaluation of the effectiveness of our measurement process and incentive payments in promoting effective project selection and implementation, and the extent to which measure selection promoted a positive impact on the targeted populations.

Washington is undertaking an ambitious set of Medicaid innovation initiatives to continue and build upon current success in transforming the way health services are provided. Washington seeks an independent external evaluator who has the capacity and vision to pursue publication of results in peer reviewed journals. Washington is committed to the value of sharing both positive and negative experiences with innovation in order to inform the broader health care transformation effort.

Section 5: PROJECT-LEVEL DETAIL
DSRIP Program: Transformation through Accountable Communities of Health

Project 2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation (Required)

Component	Description
Goals and objectives	Through a whole-person approach to care, address physical and behavioral health (BH) needs through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need.
Target populations	All Medicaid beneficiaries (children and adults) particularly those with or at-risk for behavioral health conditions, including mental illness and/or substance use disorder (SUD).
Evaluation questions and testable hypotheses	Evaluation questions pertain to understanding whether projects undertaken to better integrate the delivery of physical and behavioral health services: • Increase screening and identification of need for behavioral and physical health care services • Increase access to and engagement in treatment for BH conditions • Improve quality of care for behavioral and physical health conditions • Improve patient behavioral and physical health outcomes • Reduce disparities in health and social outcomes for persons with behavioral health risk factors • Reduce inpatient, psychiatric inpatient, and ED utilization Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will use MMIS-derived physical, behavioral health, and LTSS service utilization data, LTSS assessment data, and linked "social determinant" outcome data. Data are routinely collected through the operation of existing data interfaces, and is generally linked (collected into) into the State's integrated client data environment on a quarterly basis. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments.

Component	Description
	Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Measures	Measures derived from administrative data sources in the State's integrated client data environment will include: • Measures of health service utilization and cost, including ED visits, inpatient admissions, LTSS utilization and overall Medicaid expenditures • Access to mental health and substance use disorder treatment • Other health care quality measures (e.g., psychotropic medication adherence, comprehensive diabetes care) Specific examples of potential measures include (but are not limited to): • Outpatient Emergency Department Visits per 1000 Member Months • Inpatient Admissions per 1,000 Member Months • Plan All-Cause 30-Day Readmission Rate • Psychiatric Hospital 30-Day Readmission Rate • Antidepressant Medication Management • Child and Adolescents' Access to Primary Care Practitioners • Comprehensive Diabetes Care: Eye Exam (Retinal) Performed • Comprehensive Diabetes Care: Medical Attention for Nephropathy • Medication Management for People with Asthma (5 to 64 Years) • Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence • Follow-up After Hospitalization for Mental Illness • Mental Health Treatment Penetration (Broad Version) • Substance Use Disorder Treatment Penetration Analyses may also consider impacts on social outcomes including measures of homelessness and housing stability; employment, hours worked, and earnings levels; and criminal justice involvement (arrests). Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for many of the state-developed outcome measures are provided in Appendix 2.
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care contracts. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-

Component	Description
	post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Provider capacity to effectively deliver integrated care • Implementation fidelity to adopted models of integration (e.g., Bree Collaborative recommendations, Collaborative Care Model principles) • The adoption of EHRs and other systems that support bi-directional data sharing • The extent of clinical-community linkages • Communication flows among care team members • Adoption of care coordination and management processes • Supply of mental health providers, substance use disorder providers, social workers, nurse practitioners, primary care providers • Opportunities for use of telehealth • Workflow changes to support integration of new screening and care processes, care integration, communication • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatments
Subgroup analyses to assess disparities and differences	Analyses will be conducted to assess variation in outcome measures across groups with a history of significant differences and disparities in beneficiary experience. For example, the underlying rationale for prioritizing projects addressing bi-directional integration of physical and behavioral health care includes the observation that there are extreme rates of inpatient and ED utilization for Medicaid beneficiaries with serious mental illness and/or substance use disorders. Adult Medicaid beneficiaries with co-occurring mental illness and SUD experience inpatient hospitalizations and ED utilization at about 3 times the rate observed in the general medical population, and experience similar disparities in rates of arrest and homelessness. Other notable disparities include differences in measures of access and/or quality of care across racial and ethnic groups, between urban and rural/frontier regions of the state, and between persons with significant functional impairments receiving LTSS services and other Medicaid beneficiaries. Based on these considerations, we expect subgroup analyses to assess disparities in access to services and outcomes to include analysis of variation in beneficiary outcomes by: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier)

Component	Description
	• Behavioral health risk characteristics: severity of mental illness, SUD, co-occurring mental illness and SUD • Presence of physical comorbidities or need for functional supports

Project 2B: Community-Based Care Coordination (optional).

Component	Description
Goals and objectives	Promote care coordination across the continuum of health services for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.
Target populations	Medicaid beneficiaries (adults and children) with one or more chronic disease or condition, or mental illness, or substance use disorder and at least one risk factor (e.g., unstable housing, food insecurity, high EMS utilization).
Evaluation questions and testable hypotheses	General hypothesis—Care coordination is essential for ensuring that children and adults with complex health needs are connected to evidence-based interventions and services that will improve their outcomes. A hub-based (or similar) model provides a platform for communication among multiple care providers, so that each is able to work in a more coordinated fashion. Specific hypotheses - Implementation of a hub-based coordination model is expected to: • Increase access to and engagement in treatment for those with complex and/or co-occurring conditions • Improve quality of care for behavioral and physical health conditions • Improve patient behavioral and physical health outcomes • Reduce disparities in health and social outcomes for persons with behavioral health risk factors and persons needing functional supports • Reduce inpatient, psychiatric inpatient, and ED utilization • Improve access to Home and Community-based LTSS services Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will use MMIS-derived physical, behavioral health, and LTSS service utilization data, LTSS assessment data, and linked "social determinant" outcome data. Data are routinely collected through the operation of existing data interfaces, and is generally linked into the state's integrated client data environment on a quarterly basis. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames

Component	Description
	from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Measures	Measures derived from administrative data sources in the state's integrated client data environment will include: • Measures of health service utilization and cost, including ED visits, inpatient admissions, LTSS utilization and overall Medicaid expenditures • Access to mental health and substance use disorder treatment • Other health care quality measures (e.g., psychotropic medication adherence, comprehensive diabetes care) Specific examples of potential measures include (but are not limited to): • Outpatient Emergency Department Visits per 1000 Member Months • Inpatient Admissions per 1,000 Member Months • Plan All-Cause 30-Day Readmission Rate • Psychiatric Hospital 30-Day Readmission Rate • Antidepressant Medication Management • Child and Adolescents' Access to Primary Care Practitioners • Comprehensive Diabetes Care: Eye Exam (Retinal) Performed • Comprehensive Diabetes Care: Medical Attention for Nephropathy • Medication Management for People with Asthma (5 to 64 Years) • Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence • Follow-up After Hospitalization for Mental Illness • Mental Health Treatment Penetration (Broad Version) • Substance Use Disorder Treatment Penetration • Percent Homeless (Narrow Definition) • Percent Employed (Medicaid) • Home and Community-based Long Term Services and Supports Use • Skilled Nursing and Rehabilitation Facility Use Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for state-developed outcome measures are provided in Appendix 2.
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products.

Component	Description
	The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address issues such as: • Implementation fidelity to the adopted evidence-based care coordination approach (e.g., Pathways Community HUB) • Adequacy of procedures used to identify risk factors • Identification of evidence-based and best practice interventions • Capability of EHRs and other technologies used for identifying high-risk populations, linking to services, tracking beneficiaries, and documenting outcomes • Capacity and shortages for workforce to implement the selected care coordination focus areas • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery
Subgroup analyses to assess disparities and differences	Analyses will be conducted to assess variation in outcome measures across groups with a history of significant differences and disparities in beneficiary experience. Understanding variation in the ability of care coordination interventions to engage and impact outcomes for different populations is an important consideration in assessing the success and extensibility of ACH interventions. Subgroup analyses to assess disparities in outcomes may include: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier) • Type of risk factors, physical health conditions, behavioral health conditions, need for LTSS supports

Project 2C: Transitional Care (optional).

Component	Description
Goals and objectives	Improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.
Target populations	Medicaid beneficiaries in transition from intensive settings of care or institutional settings, including beneficiaries discharged from acute care to home or to supportive housing, and beneficiaries with SMI discharged from inpatient care, or clients returning to the community from prison or jail.

Evaluation questions and testable hypotheses	General hypothesis—Points of transition out of intensive services/settings and into the community are critical intervention points in the care continuum. Individuals discharged from intensive settings may not have a stable environment to return to or may lack access to reliable care. More intensive transitional care and care management can improve access to care for these individuals and reduce avoidable hospital utilization. Specific hypotheses—Implementation of enhanced transitional care is expected to: • Increase access to and engagement in community-based treatment for physical and behavioral health conditions • Reduce inpatient admissions, psychiatric inpatient admissions, ED utilization, and institutional stays • Improve access to Home and Community-based Long Term Services and Supports Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will use MMIS-derived physical, behavioral health, and LTSS service utilization data, LTSS assessment data, and linked "social determinant" outcome data. Data are routinely collected through the operation of existing data interfaces, and are generally linked into the state's integrated client data environment on a quarterly basis. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Measures	Measures derived from administrative data sources in the state's integrated client data environment will include: • Measures of health service utilization and cost, including ED visits, inpatient admissions, LTSS utilization and overall Medicaid expenditures • Access to mental health and substance use disorder treatment • Other health care quality measures (e.g., psychotropic medication adherence, comprehensive diabetes care) Specific examples of potential measures include (but are not limited to): • Outpatient Emergency Department Visits per 1000 Member Months • Inpatient Admissions per 1,000 Member Months • Plan All-Cause 30-Day Readmission Rate • Psychiatric Hospital 30-Day Readmission Rate

	• Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence • Follow-up After Hospitalization for Mental Illness • Percent Homeless (Narrow Definition) • Home and Community-based Long Term Services and Supports Use Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for many of the state-developed outcome measures are provided in Appendix 2.
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Implementation fidelity to the adopted evidence-based or evidence-informed approaches to transitional care (e.g., INTERACT, TCM, CTI, APIC Model) • Capacity of population health management/HIT systems to effectively deliver care transition services • Workforce capacity and shortages • Workflow changes to support integration of care transition processes and communications • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery
Subgroup analyses to assess disparities and differences	Subgroup analyses to assess disparities in access to services and outcomes may include, depending on the specific populations targeted by the selected transitional care initiatives: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier) • Delivery system affiliation (e.g., transfers from Acute inpatient care, SNF, inpatient psychiatric care, prison, or jail • Chronicity of housing instability • Extent of prior criminal justice involvement

Project 2D: Diversion Interventions (optional).

Component	Description
Goals and objectives	Implement diversion strategies to: (1) promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, and (2) redirect low-level offenders engaged in drug or prostitution activity to community-based services, instead of jail and prosecution.
Target populations	Medicaid beneficiaries presenting at the ED for non-acute conditions, Medicaid beneficiaries who access the EMS system for a non-emergent condition, and Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement.
Evaluation questions and testable hypotheses	General hypothesis—Diversion strategies provide opportunities to re-direct individuals away from high-cost medical and legal avenues and into community based health care and social services that can offer comprehensive assessment, care/case planning and management to lead to more positive outcomes. Specific hypotheses—Implementation of these diversion strategies is expected to: • Reduce ED utilization • Improve access to primary care • Improve access to behavioral health services • Reduce homeless rates • Reduce arrest rates Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will use MMIS-derived physical, behavioral health, and LTSS service utilization data, LTSS assessment data, and linked "social determinant" outcome data. Data are routinely collected through the operation of existing data interfaces, and is generally linked into the State's integrated client data environment on a quarterly basis. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Measures	Measures derived from administrative data sources in the State's integrated client data environment will include:

Component	Description
	• Measures of health service utilization and cost, including ED visits, inpatient admissions, and overall Medicaid expenditures • Access to mental health and substance use disorder treatment • Social outcomes including homelessness and criminal justice involvement Specific examples of potential measures include (but are not limited to): • Percent Homeless (Narrow Definition) • Percent Arrested • Outpatient Emergency Department Visits per 1000 Member Months • Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence • Adult Access to Preventive/Ambulatory Care • Mental Health Treatment Penetration (Broad Version) • Substance Use Disorder Treatment Penetration Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for many of the state-developed outcome measures are provided in Appendix 2.
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Implementation fidelity to evidence-supported diversion strategies • Willingness and readiness of stakeholders to participate • Potential shortages of community health workers, social workers, mental health providers, substance abuse disorder providers. • Ability to use electronic health records (EHRs) and Health Information Exchange (HIE) systems to facilitate communication between emergency departments, community paramedics and other health care providers

Component	Description
	• Effectiveness of payment structures and VBP payment models to incentivize effective service delivery
Subgroup analyses to assess disparities and differences	Subgroup analyses to assess disparities in access to services and outcomes may include, depending on the specific populations targeted by the selected diversion initiatives: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier) • Functional risk factors (presence of behavioral risks, severity of physical comorbidities) • Extent of prior criminal justice involvement • Chronicity of housing instability

Project 3A: Addressing the Opioid Use Public Health Crisis (required).

Component	Description
Goals and objectives	Reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, overdose prevention, and recovery supports. Selected specific objectives include: • Reducing opioid use through prevention measures (e.g., adherence to opioid prescribing guidelines, Prescription Drug Monitoring Program promotion) • Increasing opioid use disorder treatment capacity (e.g., numbers of providers certified to prescribe medication-assisted therapies, innovative use of telehealth in rural areas) • Identifying and treating opioid use disorder among pregnant women • Increasing treatment engagement (e.g., promoting projects that offer low barrier access to buprenorphine in emergency departments, correctional facilities, syringe exchange programs, SUD and mental health programs) • Preventing overdoses (e.g. increased availability of naloxone)
Target populations	Medicaid beneficiaries, including youth, who use, misuse, or abuse, prescription opioids and/or heroin.
Evaluation questions and testable hypotheses	Implementation of strategies to reduce opioid-related morbidity and mortality is expected to: • Reduce opioid-related deaths • Reduce non-fatal overdose involving prescription opioids • Increase substance use disorder treatment penetration among opioid users • Reduce the number of patients on high-dose chronic opioid therapy • Increase the numbers receiving Medication Assisted Therapy (MAT) with Buprenorphine and Methadone Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.

Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will use MMIS-derived physical, behavioral health, and LTSS service utilization data, LTSS assessment data, and linked "social determinant" outcome data. Data are routinely collected through the operation of existing data interfaces, and is generally linked into the State's integrated client data environment on a quarterly basis. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Measures	Measures derived from administrative data sources in the State's integrated client data environment will include: • Opioid Related Deaths (Medicaid Enrollees and Total Population) per 100,000 covered lives • Non-fatal overdose involving prescription opioids per 100,000 covered lives • Substance Use Disorder Treatment Penetration, by type of treatment, for persons with opiate use disorder • Outpatient Emergency Department Visits per 1000 Member Months • Inpatient Admissions per 1,000 Member Months Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for many of the state-developed outcome measures are provided in Appendix 2.
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes.

	Qualitative analysis. A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Enhancements in EHRs and other systems to support clinical decisions in accordance with guidelines • Efforts to increase use of the Prescription Drug Monitoring Program (PDMP) • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery • Results of integrating telehealth approaches • Effectiveness of structural supports (e.g. case management capacity, nurse care managers, integration with substance use disorder providers) to support medical providers to implement and sustain medication assisted treatment
Subgroup analyses to assess disparities and differences	Subgroup analyses to assess disparities in access to services and outcomes may include: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier) • Nature of opioid use (heroin injection, prescription opioids) • Presence of co-occurring mental illness, physical comorbidities and functional support needs • Extent of homelessness • Extent of prior criminal justice involvement In response to feedback on the initial evaluation design submission, we note that persons with opiate use disorders (and, more generally, persons with substance use disorders) have extremely high rates of homelessness and criminal justice involvement, relative to the general Medicaid population. As such, understanding the impact of opioid-related initiatives on populations with a history of prior homelessness or criminal justice involvement is of particular concern, as these beneficiaries are at high risk of experiencing adverse future outcomes.

Project 3B: Reproductive and Maternal/Child Health (optional).

Component	Description
Goals and objectives	Broad objective—Ensure that women have access to high quality reproductive health care throughout their lives and promote the health and safety of Washington's children. Specific objectives include: • Ensuring that families have intended and healthy pregnancies that lead to healthy children by promoting utilization of effective reproductive health strategies, healthy behaviors and risk reduction, effective contraceptive use, safe and quality prenatal and perinatal care, and general preventive care • Promoting healthy pregnancy and parenting through evidence-based home visiting models for pregnant high-risk mothers. • Improving child health through improving regional well-child visit rates and childhood immunization rates.

Component	Description
Target populations	Medicaid beneficiaries who are women of reproductive age, pregnant women, mothers of children ages 0-3, and children ages 0-17.
Evaluation questions and testable hypotheses	Implementation of strategies related to reproductive health and maternal/child health are expected to: • Reduce rates of teen pregnancy • Reduce the number of unintended pregnancies • Reduce the rate of low-birth weight deliveries • Increase substance use disorder treatment penetration among pregnant women • Increase Well-Child Visit rates among infants and young children • Increase rates of Chlamydia Screening • Improve access to effective contraceptive care (including LARC) • Increase childhood immunization rates Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will primarily use MMIS-derived physical and behavioral health data, and vital records (birth certificates from the Department of Health Center for Health Statistics individually linked to Medicaid clients in the First Steps Database, a component of the ICDB). Data are routinely collected through the operation of existing data interfaces, and is generally linked into the State's integrated client data environment on a quarterly basis. Measures related to unintended pregnancy and immunization rates will use Department of Health's the Pregnancy Risk Assessment Monitoring System (PRAMS) survey and immunization registry data, respectively. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Measures	Measures derived from administrative and PRAMS survey data sources in the State's integrated client data environment will include: • Rate of Teen Pregnancy (15 – 19) • Rate of Unintended Pregnancies (PRAMS survey) • Rate of Low Birth Weight Births

Component	Description
	• Prenatal care in the first trimester of pregnancy • Mental Health Treatment Penetration (Broad Version) • Substance Use Disorder Treatment Penetration • Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life • Well-Child Visits in the First 15 Months of Life • Chlamydia Screening in Women Ages 16 to 24 • Contraceptive Care – Most & Moderately Effective Methods • Contraceptive Care – Access to LARC • Contraceptive Care – Postpartum • Childhood Immunization Status Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for many of the state-developed outcome measures are provided in Appendix 2.
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Fidelity to evidence-based models (e.g., Nurse Family Partnership, Bright Futures) • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery • Barriers to increasing immunization rates • Adoption of evidence-based interventions to reduce substance abuse during pregnancy
Subgroup analyses to assess disparities and differences	Subgroup analyses to assess disparities in access to services and outcomes may include, depending on the specific projects designed in this domain: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier)

Component	Description
	• Behavioral health risk factors (e.g., maternal depression, other maternal mental illness conditions, substance use during pregnancy)

Project 3C: Access to Oral Health Services (optional).

Component	Description
Goals and objectives	Increase access to oral health services to prevent or control the progression of oral disease and ensure that oral health is recognized as a fundamental component of whole-person care.
Target populations	All Medicaid beneficiaries, especially adults.
Evaluation questions and testable hypotheses	The project focuses on providing oral health screening and assessment, intervention, and referral in the primary care setting, or through the deployment of mobile clinics and/or portable equipment. This is expected to increase access to oral health services for adults, improve prevention and control the progression of oral disease, and reduce reliance on emergency departments for oral pain and related conditions. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will use MMIS-derived physical, behavioral health, and dental service data. Data are routinely collected through the operation of existing data interfaces, and are generally linked into the State's integrated client data environment on a quarterly basis. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Measures	Measures derived from administrative data sources in the State's integrated client data environment will include: • Oral health services utilization among Medicaid beneficiaries • Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers • Outpatient Emergency Department Visits per 1000 Member Months • Ongoing Care in Adults with Chronic Periodontitis

Component	Description
	• Periodontal Evaluation in Adults with Chronic Periodontitis • Caries at Recall (Adults and Children) • Adult Treatment Plan Completed • Sealants - % Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk • Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for many of the state-developed outcome measures are provided in Appendix 2.
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Ability to elicit dental service provider participation • Shortages of dentist, hygienist, and other dental care providers, and primary care providers • Alignment between payment structures and the integration of oral health services • Referral relationships with dentists and other specialists, such as ENTs and periodontists • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery
Subgroup analyses to assess disparities and differences	Subgroup analyses to assess disparities in access to services and outcomes may include, depending on the specific projects designed in this domain: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier), including an assessment of regional variation in the supply of oral health providers • Factors such as behavioral health conditions and functional support needs that might affect ability to access dental services

Project 3D: Chronic Disease Prevention and Control (optional).

Component	Description
Goals and objectives	Integrate health system and community approaches to improve chronic disease management and control.
Target populations	Medicaid beneficiaries (children and adults) with, or at risk for, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity and stroke, with a focus on those populations experiencing the greatest burden of chronic disease(s) in the region.
Evaluation questions and testable hypotheses	The project focuses on integrating health system and community approaches to improve chronic disease management and control. Implementation of evidence-based guidelines and best practices for chronic disease care and management using the Chronic Care Model is expected to: • Improve the quality of care for chronic conditions • Improve patient outcomes • Reduce utilization of inpatient and emergency department services • Increase patient activation/confidence to self-manage chronic conditions Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will use MMIS-derived physical, behavioral health, and LTSS service utilization data, and LTSS assessment data. Data are routinely collected through the operation of existing data interfaces, and are generally linked into the State's integrated client data environment on a quarterly basis. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Measures	Measures derived from administrative data sources in the State's integrated client data environment may include (depending on region-specific target populations): • Outpatient Emergency Department Visits per 1000 Member Months • Inpatient Admissions per 1000 Medicaid Member Months • Child and Adolescents' Access to Primary Care Practitioners

Component	Description
	• Adult Access to Preventive/Ambulatory Care • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Medical attention for nephropathy • Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life • Well-Child Visits in the First 15 Months of Life • Medication Management for People with Asthma (5 – 64 Years) • Influenza Immunizations 6 months of age and older • Statin Therapy for Patients with Cardiovascular Disease • Adult Body Mass Index Assessment Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for many of the state-developed outcome measures are provided in Appendix 2.
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Fidelity to Chronic Care Model (CCM) guidelines • Ability of Health Information Technology systems to support data sharing, clinical-community linkages, timely communication among care team members, and care coordination and management processes • Shortages of Community Health Workers, Certified Asthma Educators, Certified Diabetes Educators, Home Health care Providers • Required workflow changes to support Registered Nurses and other clinical staff to be working to the top of professional licensure • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery

Component	Description
Subgroup analyses to assess disparities and differences	Subgroup analyses to assess disparities in access to services and outcomes may include, depending on the specific projects designed in this domain: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier) • Differences in selected target populations and chronic conditions

PROJECT-LEVEL DETAIL

Long Term Services and Supports (LTSS) - Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)

Component	Description
Goals and objectives	Providing limited-scope LTSS to individuals "at risk" for Medicaid – and to Medicaid beneficiaries who are not currently receiving Medicaid-funded LTSS – to avoid or delay eligibility for and use of full Medicaid LTSS benefits, while preserving quality of life for beneficiaries and reducing costs for the state and federal government.
Target populations	**MAC.** Eligible individuals for the MAC program include current Medicaid beneficiaries who are functionally eligible for LTSS, but have chosen to receive limited-scope services supporting an unpaid caregiver rather than traditional Medicaid-funded LTSS. Further eligibility criteria include: • Age 55 or older; • Eligible for Categorically Needy (CN) or Alternative Benefit Plan (ABP) services; and • Meet functional eligibility criteria for Nursing Facility Level of Care (NFLOC) as determined through an eligibility assessment. **TSOA.** The demonstration establishes a new eligibility category for persons "at risk" of becoming eligible for Medicaid in order to access LTSS. This "At Risk" or "Tailored Supports for Older Adults" (TSOA) eligibility group is comprised of individuals who could receive Medicaid State Plan benefits under 42 CFR §435.236 and §435.217.Under the Demonstration, these persons may access a new LTSS benefit package designed to preserve quality of life while delaying increases in support needs (and the financial impoverishment) required for full Medicaid benefits. The individuals must: • Be age 55 or older; • Be a U.S. citizen or in eligible immigration status; • Not be currently eligible for CN or ABP Medicaid; • Meet functional eligibility criteria for NFLOC as determined through an eligibility assessment; • Be cared for by an unpaid caregiver in need of support services, or be an individual without a caregiver; • Have income up to 300% of the SSI Federal Benefit Rate.

Component	Description
	– To determine eligibility for TSOA services, the state will consider the income of the applicant, not their spouse/dependents, when determining if gross income is at or below the 300% SSI Federal Benefit Rate limit; and – To determine income, Washington will use the Social Security Income (SSI)-related income methodologies currently in use for determining eligibility for Medicaid LTSS. No post-eligibility treatment of income will apply and eligibility will be determined using only the applicant's income. Like the MAC population, Washington will not apply post-eligibility treatment of income to the TSOA populations. • Resource Limits -- Have countable resources below $53,100 for a single applicant and below $53,100 plus the state spousal resource standard for a married couple. – To determine resources, the State will us the Social Security Income (SSI)-related resource rules currently in use for determining eligibility for Medicaid LTSS with the following exceptions: a. Transfer of asset penalties do not apply b. Excess home equity provisions do not apply
Evaluation questions and testable hypotheses	Demonstration hypotheses (STC 108) associated with this initiative pertain to understanding the effects of modifying eligibility criteria and benefit packages for long-term services and supports, and assessing whether providing limited scope LTSS to individuals "at risk" for Medicaid – and to Medicaid beneficiaries who are not currently receiving Medicaid-funded LTSS – will avoid or delay eligibility for and use of full Medicaid LTSS benefits, while preserving quality of life for beneficiaries and reducing costs for the state and federal government. The domains of focus and associated research questions specified in STC 109 are: "What are the effects of modifying eligibility criteria and benefit packages for long-term services and supports?" Detailed project-level mapping of Initiative 2 research questions, testable hypotheses, data sources, and outcome metrics are provided in this section, and are not reproduced in Appendix 1. Specific testable hypotheses will include: • Do caregivers show change from baseline to 6-month follow-up in survey/self-report measures of: – Caregiving burden – Physical/mental health status – Quality of life • Do care receivers, including TSOA individuals without unpaid caregivers, show change from baseline to 6-month follow-up in survey/self-report measures of: – Physical/mental health status – Quality of life • Are caregivers and care receivers satisfied with their experience with the program?

Component	Description
	• Do MAC program participants show similar health outcomes to comparable recipients of traditional Medicaid LTSS services? • Following implementation of the MAC and TSOA programs, are Medicaid-paid LTSS cost trends lower than expected based on forecasts derived from baseline Medicaid-paid LTSS utilization rates and the observed changes in per cap costs and the composition of the Washington State population? Detailed mapping of research questions, outcome metrics, and data sources are provided in the sections below, and are not reproduced in Appendix 1.
Data strategy, sources and collection frequency	**Participant Self-Report Data.** Self-report data from Caregivers (CG) and care receivers (CR) to support evaluation of the MAC and TSOA programs will be collected from participants through two sources: (1) assessments (Tailored Caregiver Assessment and Referral (TCARE®) for caregivers and GetCare for persons without caregivers) and related administrative data and (2) surveys. These two data collection methods are complementary, as some data is best collected in the course of screening, establishing eligibility, service planning and periodic re-screening and re-assessment. Other data elements are best collected through survey methods. Self-report data to be collected are expected to include: • Opportunities and challenges encountered in program implementation (supporting formative evaluation); • Satisfaction with program participation; • Caregiver characteristics, perceived burdens, stressors, relationship with care receiver, quality of life, and physical/mental health issues; • Care receiver living situation, assistance needs, problematic behaviors, cognitive status, quality of life, and physical/mental health; • Values/preferences related to decision-making around these programs; • LTSS placement intentions; and • Qualitative descriptions of caregiver and care receiver experiences, in their own words. Self-report data will mitigate the impact on the evaluation of the absence of comparable health service utilization data for non-Medicaid clients, and lack of LTSS-related functional assessment data for Medicaid clients not receiving LTSS services. ***Self-Reported Administrative Assessment Data.*** IT systems used to administer the MAC and TSOA programs (e.g., TCARE and GetCare) are expected to collect information on a number of domains of interest for evaluation. These data are expected to be gathered by the program in the course of application, planning, and initial and ongoing screenings and assessments. Program IT systems will capture information for the universe of persons served, and are likely to be relied upon to support the range of potential subgroup analyses. In some cases, information captured by administrative data systems are collected at a time that best reflects the circumstances of caregivers and care receivers at the time of decision-making. Data will be collected initially at the time of initial application, screening and assessment. For those receiving ongoing services, re-screening will occur every 6 months and reassessment annually,

Component	Description
	allowing longitudinal analysis. The following measurement domains may be particularly informed by data gathered using program IT systems: • Caregiver characteristics, perceived burdens, relationship with care receiver, issues with caregiving, mental health indicators, and overall health status; • Care receiver living situation, assistance needs, problematic behaviors, cognitive status, and items related to physical/mental health; • LTSS placement intentions ***Survey Data*.** The primary purpose of the surveys will be to describe the experiences, outcomes, and conditions/circumstances of caregivers and care receivers participating in the programs. Survey instruments will be designed to complement the information available in administrative data, and collect additional key data and more in-depth information. Surveys can address questions beyond those involved in screening, establishing eligibility, and assessment. They allow more detailed answers, less opportunity for bias, and precise identification of respondent. The surveys will also collect early feedback on program implementation to support formative evaluation. Survey data are expected to be collected by the survey unit of the DSHS Research and Data Analysis Division (RDA), with the independent external evaluator having primary responsibility for analyzing the collected data. Data to be collected with these surveys are expected to include: • Opportunities and challenges encountered in program implementation (supporting formative evaluation); • Satisfaction with program participation; • Care receiver quality of life; • Values/preferences related to decision-making around these programs; • Qualitative descriptions of caregiver and care receiver experiences, in their own words; and • In-depth data regarding issues addressed in self-report data from assessments and related data (e.g., caregiver quality of life and LTSS placement intentions). **Survey 1.** In the winter of 2018 (at least 4 months after program implementation), RDA will conduct a survey to identify emerging issues from the perspective of caregivers and care receivers. This survey will also serve as a pilot test to refine procedures, survey questions, and data collection cost estimates for subsequent survey waves. Because the primary goal of this survey wave is rapid collection of qualitative data to support program implementation through formative evaluation, the sample size will be relatively small. RDA will complete at least 50 telephone interviews with enrolled CGs and 50 with CRs who have completed full intake assessments of each of the two programs (MAC and TSOA), with a planned total of 232 interviews (accounting for pretesting and expected differences in response rates). **Survey 2.** Between April 2018 and December 2018, RDA will survey a random sample of CG-CR dyads soon after they first receive services/benefits through MAC or TSOA. The time required for reliable identification of all beneficiaries is still unknown, but we anticipate contact attempts starting approximately 30 days after

Component	Description
	first receipt of benefits. Survey 2 will serve as a "baseline" for comparisons of measures representing the domains listed above. **Survey 3**. Between March 2019 and September 2019, RDA will conduct another survey targeting participants interviewed in Survey 2. Contact attempts will begin approximately 12 months after the Survey 2 interview date. Survey 3 will provide a second measurement point that will enable description of how CGs and CRs experience the effects of participation in the MAC and TSOA programs. **Survey design and sampling.** The study population for all three surveys will be caregiver/care receiver dyads enrolled in MAC and TSOA, or TSOA individuals who have a completed care plan to receive first-time stage 3 services. All survey samples will utilize random sampling, and will be stratified by program. If indicated by the pilot results and enrollee characteristics, additional stratification factors may be chosen for surveys 2 and 3. A primary purpose of Survey 1 is to obtain early feedback about implementation. For this reason, selection for survey 1 will focus on early enrollees who are new to LTSS. The specific selection criteria will depend on the pace of enrollment, characteristics and geographic dispersion of early enrollees, and availability of the sampling frame. In general, all members of a group with slowest enrollment will be selected sequentially until a target proportional to that population is reached. Other groups will be sampled systematically from a random start point, with every kth dyad selected according to an interval determined by the expected enrollment of each group over the time period required to complete the slowest group. Surveys 2 and 3 are planned as two longitudinal waves in which respondents to survey 2 will be re-interviewed for survey 3. Depending on pilot results, resources, project needs, we expect to augment survey 3 with a cross-sectional random sample. All participants interviewed in Survey 2 will be eligible to complete survey 3, including those who are no longer receiving services. Based on experience conducting surveys of similar populations, we estimate that 70% of CG/CR dyads can be contacted and will consent to take the survey in the first year, but 25% of CRs will be unable to complete an interview due to cognitive or physical limitations. We estimate 1-year attrition of up to 56%, based on a 2014 RDA analysis of TCARE assessment results for the Family Caregiver Support Program (FCSP). The final plan for survey 2 sample selection will be determined after evaluation of survey 1 results and enrollment patterns in Demonstration Year 1. Sample size estimates are based on paired t-test requirements for 90% power to detect differences of 1 SD ($p < .05$) in a population with $M = 0$ and $SD = 1$, plus a contingency adjustment of 1.25 (minimum n = 30 pairs for each combination of program (MAC or TSOA) and role (CG or CR). In the event of high attrition, augmenting the survey 3 sample with up to 170 additional participants with similar length of participation (85 CG-CR dyads) will allow equivalent power for cross-sectional (two-sample) t-test comparisons. Data will be weighted to reflect selection probabilities and (if needed) adjusted for nonresponse. **Assessment and mitigation of potential biasing factors.** In any longitudinal survey there is potential for bias if nonresponse is correlated with the measurements of interest. The abundance of administrative and program data will allow us to assess this potential in surveys 2 and 3 by analyzing the relationships between survey response and variables from the NFLOC prescreening and TCARE assessments,

Component	Description
	including but not limited to LTSS placement intentions, caregiver ratings of care receiver health and quality of life, caregiver health status and burdens experienced, and demographic characteristics. If these analyses indicate the potential for nonresponse bias, post-stratification weights will be constructed using the factors that are most strongly related to nonresponse. Weighted survey data will be analyzed using routines that adjust for complex designs using the Taylor series method or resampling methods for variance adjustment, such as SAS PROC SURVEYREG. **LTSS utilization and cost impact estimates.** These estimates will use Medicaid-paid LTSS cost and utilization data derived from ProviderOne and related service payment data, linked to Medicare Part A, B and D data for persons dually eligible for Medicare and Medicaid. As described in detail in Section 3, Medicaid data are routinely collected through the operation of existing payment processes, and is generally linked into the State's ICDB environment on a quarterly basis. Washington State is a national leader in the integration of Medicare data to support analytical and care management uses for dual eligibles. Medicaid-paid LTSS cost and utilization data will be combined with Washington State population data derived from US Census Bureau data products (e.g., the American Community Survey), as reflected in the County Population Estimation Model (CPEM) maintained by the OFM Forecasting and Research Division. The CPEM is expected to be updated by the end of CY 2017 with projections through at least 2025, with updates on an approximately annual basis as new American Community Survey data are released.
Measures	**Survey and administrative self-report measures.** As detailed above, administrative assessment data is expected to capture measures related to caregiver characteristics and issues; caregiver condition/circumstances, and LTSS placement intentions. Many of these measures are part of the evidence-based, validated TCARE® screening and assessment system, which has been a component of numerous recognized evidence-based assessments. Survey instruments will be designed to complement the information available in administrative data, and collect additional key data and more in-depth data. As detailed above, the first survey wave is designed to inform program implementation and operation, rather than to measure program impacts on caregiver and care receiver experiences and outcomes. Measures of participant experiences and potential impacts on quality of life, caregiver burdens and health, and participant satisfaction with program participation will be derived from data captured in the second and third survey waves, described above. The precise specifications of wave 2 and wave 3 survey instruments are expected to be determined in consultation with the independent external evaluator. **Comparisons between MAC clients and recipients of traditional Medicaid LTSS services.** This component of the evaluation will focus on health service utilization and related outcomes, including: • Outpatient Emergency Department Visits per 1000 Member Months (NCQA HEDIS® EDU or similar state-defined alternative) • Inpatient Admissions per 1,000 Member Months (NCQA HEDIS® IHU or similar state-defined alternative)

Component	Description
	• Plan All-Cause 30-Day Readmission Rate (NCQA HEDIS® PCR) • Nursing facility entry rate (state-defined measure derived from nursing home claim data currently integrated into the State's ICDB) • Mortality rates (state-defined measure derived from death certificate records currently integrated into the State's ICDB **Overall LTSS utilization and cost impact estimates.** Estimates of impacts on Medicaid-paid LTSS utilization and costs will be derived using the "synthetic estimation projection" approach described in the next section. This analysis will rely on measures of Medicaid-paid LTSS service costs and utilization derived from state agency administrative data, combined with Washington State population data derived from US Census Bureau data products (e.g., the American Community Survey), as reflected in the County Population Estimation Model maintained by the OFM Forecasting and Research Division.
Statistical framework for measuring impacts	**Survey and administrative assessment measures.** Due to the lack of data necessary to create a "comparison sampling frame" for persons meeting comparable eligibility criteria who do not engage in MAC or TSOA services, analysis of survey and assessment data will focus on levels and changes in measures for the intervention group between the second (baseline) and third survey waves described above. This is essentially a pre-test/post-test design, where we recognize that the pre-test survey wave will occur very early in the "treatment period" (e.g., approximately 30 days after first receipt of benefits). Analysis of administrative data from TCARE assessments and related sources will take a similar approach, with changes in caregiver and care receiver circumstances measured from their initial assessment through subsequent assessments. In the absence of comparison groups of similar caregiver and care receiver dyads not receiving MAC or TSOA services, analysis of administrative assessment data is likely to be used primarily to understand participant experiences and differences in experiences across populations. **Comparisons between MAC clients and recipients of traditional Medicaid LTSS services.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. An assessment of the difference between MAC clients and recipients of traditional Medicaid LTSS services will be conducted using difference-of-difference designs where appropriate, wherein the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. The matching process will leverage the available baseline assessment data for MAC clients and recipients of traditional Medicaid LTSS services. The pre-post boundary for each treatment group (MAC and traditional LTSS) will be based on the point at which they first engage in the intervention, with

Component	Description
	the imposition of a minimum prior period with no LTSS service receipt. The PS matching process will proceed through the following steps: • Examination of key baseline predictors of treatment entry within the pooled intervention and comparison matching frame to ensure inclusion of appropriate measurement dimensions in the PS model. This includes creating an extensive set of predictors that are determined, ex ante, to be potentially relevant to the matching process. This set of predictors is generally expected to span a wide range of the measurement domains contained with the State's ICDB, which may include: – Service utilization data across Medicare and Medicaid funded delivery systems (physical, mental health, substance use disorder, long-term services and support, and developmental disability services); – Expenditure data at the "major modality" (e.g., IP hospitalization, OP ED visits, etc.) per-member per-month level; – Risk factors associated with chronic disease conditions, including mental illness and substance use disorders, derived from the CDPS and Medicaid-Rx risk models; – Data on functional support needs, cognitive impairment, and behavioral challenges from the client's initial LTSS assessment at the point of intake into the MAC or traditional LTSS service; – Client demographics (age, gender, race/ethnicity); – Medicaid enrollment by detailed coverage category; and – Urban/rural/frontier characteristics of the beneficiary's residential location. • Application of machine learning techniques (e.g., stepwise logistic or lasso regression) to determine the final propensity score model. • Propensity score matching using procedures in the R programming language (e.g., the Matchit procedure). Exact matching may be required for key variables (e.g., age and gender). As with all Demonstration initiatives, target populations are expected to partially overlap across projects and programs. The statewide project attribution data infrastructure will be leveraged to identify project participation longitudinally at the beneficiary level. Analyses may be limited to subpopulations of clients with "common support" across baseline matching criteria, and subpopulations not engaged in other Demonstration projects or other initiatives. This restriction has parallels to study enrollment restrictions commonly imposed in the randomized clinical trial context. The baseline period for construction of matching variables will typically be the prior 12 months, but may be of longer duration if information from prior periods is determined to be predictive of engagement in MAC or traditional LTSS services. Outcome periods will typically be periods comprised of one or more 12-month segments or intervals, depending on the length of available follow-up time. Impact will generally be estimated in a regression framework using SAS regression procedures and models including controls for baseline characteristics, notably including those characteristics on which exact matching is not imposed.

Component	Description
	The ICDB will be the data source all measurement within this component of the evaluation. As was discussed in more detail in Section 3, the ICDB is designed to support quasi-experimental evaluation of health and social service interventions in Washington State, has been widely used in evaluation studies published in peer-reviewed journals, and contains data from the administrative data systems, including Medicare Parts A, B, and D data and the State's ProviderOne MMIS data system, necessary to implement this component of the quantitative evaluation design. **Overall LTSS utilization and state and federal cost impact estimates.** Estimates of impacts on Medicaid-paid LTSS utilization and costs will be done using a "synthetic estimation projection" approach. This approach involves: • Measuring baseline SFY 2017 (pre-Demonstration) Medicaid-paid LTSS utilization in Washington State, by detailed demographic cells defined by age, gender, race/ethnicity, and income level as derived from ACS data for Washington State; • Applying these utilization rates to (1) observed changes in per cap (per service user per month)[14] costs by LTSS service modality and (2) the forecast demographic composition of the Washington State population based on a process maintained by the Governor's Office of Financial Management which leverages ACS data for Washington State; and • Comparing the actual levels of Medicaid-paid LTSS utilization and costs under the Demonstration, including the MAC and TSOA program costs, to the levels of utilization and costs projected from the synthetic estimation model derived from baseline utilization, the observed evolution of per cap LTSS costs, and forecast changes to the composition of the Washington State population.
Subgroup analyses to assess disparities and differences	The dimensions to be considered for analysis of disparities and differences in access to services and outcomes, to the extent feasible using available survey and administrative data, may include: • Age and gender • Race/ethnicity • Geography (urban/rural/frontier) • Functional risk factors (presence of cognitive impairment or dementia, behavioral risks, severity of physical comorbidities) • Care receiver relationship to caregiver • For the TSOA program, clients with caregivers relative to clients without caregivers

PROJECT-LEVEL DETAIL
Foundational Community Supports Program

[14] These are per user per month costs by major LTSS service modality (nursing facility, in-home personal care, and community residential care) that are used as key components of the State's LTSS budget forecast, along with monthly caseload data. In other words, we expect to use the observed evolution of these LTSS cost parameters in this analysis.

Component	Description
Goals and objectives	Provide targeted community transition services, community support services, and supported employment services to help at-risk clients reside in stable community settings and gain and maintain stable employment, helping to improve beneficiary housing stability, employment outcomes, health outcomes, quality of life, and reduce Medicaid program costs[15].
Target populations	Potential changes to the FCS protocol are currently being reviewed with CMS. This table references FCS program descriptions reflected in the originally approved STCs, for purposes of illustrating the proposed evaluation approach. The final evaluation approach will reflect the actual design of the implemented FCS program. As with all Demonstration initiatives, target populations are expected to partially overlap across projects and programs. The statewide project attribution data infrastructure will be leveraged to identify project participation longitudinally at the beneficiary level. Analyses based on the propensity score matching approach may be limited to subpopulations of FCS clients with "common support" across baseline matching criteria, and subpopulations not engaged in other Demonstration projects or other initiatives. This restriction has parallels to study enrollment restrictions commonly imposed in the randomized clinical trial context. Eligible individuals include those who would be eligible under a section 1915(c) waiver program or a section 1915(i) state plan amendment and are determined to be require FCS services in order to obtain and maintain stable housing and/or employment. FCS is comprised of: • **Community Transition Services (CTS).** One-time supports designed to assist eligible clients transitioning out of institutional settings, or prevent eligible clients from entering institutional settings. Supports cover expenses necessary to enable an eligible client to obtain an independent, community-based living setting. • **Community Support Services (CSS).** Ongoing supportive services designed to support placement in an independent, community-based setting, as established in the eligible client's needs assessment and individualized treatment plan. • **Supported Employment - Individual Placement and Support (IPS).** Ongoing supports to participants who, because of their disabilities, need intensive support to obtain and maintain employment in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. CTS eligibility criteria include Medicaid clients age 18 and older, who meet the following criteria:

[15] Potential changes to the FCS protocol are currently being reviewed with CMS. This document references FCS program descriptions reflected in the originally approved STCs, for purposes of illustrating the proposed evaluation approach. The final evaluation approach will reflect the actual design of the implemented FCS program.

Component	Description
	• But for the provision of such services, the client would require admission into an institutional setting, or, • Is transitioning out of an institutional setting and, but for the provision of such services, would not be able to access and maintain a community-based setting; and • Exhibits one or more of the following characteristics: – Chronically homeless, as defined by the US Department of Housing and Urban Development, – Frequent or lengthy institutional or residential care stays, – Frequent turnover of in-home caregivers, or – Has a Predictive Risk Intelligence System (PRISM) score of 1.5 or above PRISM integrates medical, behavioral health and long-term care data to assess an individual's projected service needs. For the purposes of CTS, institutional settings include settings requiring a nursing facility level of care, inpatient medical hospitals, or inpatient behavioral health facilities. CSS eligibility criteria include Medicaid clients age 18 or older who are in need of Community Support Services, as determined by a functional needs assessment. The assessment must determine that one or more of the following characteristics are present: • Chronically homeless as defined by the US Department of Housing and Urban Development, • Frequent or lengthy institutional contacts as defined in the functional needs assessment, • Frequent or lengthy adult residential care stays as defined in the functional needs assessment, • Frequent turnover of in-home caregivers as defined in the functional needs assessment, or • Have a Predictive Risk Intelligence System (PRISM) Risk Score of 1.5 or above. IPS eligibility includes Medicaid clients age 16 or older who are in need of IPS, as determined by a functional needs assessment. The assessment must determine that one or more of the following characteristics are present: • Enrolled in the state Housing and Essential Needs (HEN) or Aged, Blind or Disabled (ABD) program • A diagnosed Serious and Persistent Mental Illness (SPMI) • Multiple instances of inpatient substance use treatment • Co-occurring mental and substance-use disorders • Working age youth, age 16 and older, with a behavioral health diagnosis • Receiving long-term services and supports
Evaluation questions and testable hypotheses	Demonstration hypotheses (STC 108) associated with this initiative pertain to understanding whether the provision of foundational community supports - supportive housing and supported employment - will improve health outcomes and reduce costs for a targeted subset of the Medicaid population. The domains of focus and associated research questions specified in STC 109 include assessing the effectiveness of the providing foundational community supports in terms of health,

Component	Description
	quality of life, and other benefits to the Medicaid program. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. The term "targeted subset" used in the STC refers to the targeted eligibility criteria associated with the FCS program, as indicated in the "target population" section immediately above. Again, we note that as with all Demonstration initiatives, target populations are expected to partially overlap across projects and programs. The statewide project attribution data infrastructure will be leveraged to identify project participation longitudinally at the beneficiary level. Analyses based on the propensity score matching approach may be limited to subpopulations of FCS clients with "common support" across baseline matching criteria, and subpopulations not engaged in other Demonstration projects or other initiatives. This restriction has parallels to study enrollment restrictions commonly imposed in the randomized clinical trial context. Evaluation questions pertain to understanding whether the provision of foundational community supports will improve health outcomes and reduce costs for a targeted subset of the Medicaid population. Specific testable hypotheses, as described in more detail in Appendix 1, will include: • Do CTS or CSS services reduce homelessness and increase housing stability? • Do IPS services increase employment rates and earnings levels? • Do CTS, CSS or IPS services reduce the risk of criminal justice involvement? • Do CTS, CSS or IPS services reduce health service utilization and costs, including ED visits, inpatient admissions, or institutional LTSS utilization and overall Medicaid expenditures? • Is receipt of CTS, CSS or IPS services associated with increased engagement in other supportive preventative care, mental health or substance use treatment services (with increased engagement in such services considered to be a positive outcome)? • Is receipt of CTS, CSS or IPS services associated with increased measures of health care quality, consistent with positive effects on the beneficiary's ability to manage physical and behavioral health conditions? • Is Health IT used to support service delivery on behalf of persons for whom CTS, CSS, or IPS services are provided. For example, does health technology support the exchange of information between programs (such as criminal justice, Homeless Management Information System, Vocational Rehabilitation, and Medicaid) or providers (such as Emergency medical Response, EDs, acute care hospitals, and MH/SUD providers))? If so, how? If not, why not?
Data strategy, sources and collection frequency	Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Impact analyses will use MMIS-derived physical and behavioral health service utilization data, LTSS assessment data, and linked "social determinant" outcome data. Data is routinely collected through the operation of existing data interfaces, and is generally linked into the State's integrated client data environment on a quarterly basis.

Component	Description
	To address a request for clarification from feedback received on the prior draft, we note that LTSS data is one of multiple sources of health risk factor information (e.g., ICD-10 diagnoses, cognitive performance scale scores, ADL functional need scores) integrated into the State's ICDB. Propensity-score models will generally match treatment group members to comparison group members with comparable baseline levels of LTSS utilization. In this context, use of LTSS assessment data ensures balance on assessment-derived risk factors for subpopulations with comparable balance in their exposure to LTSS assessment processes. This is an example of our use of the vast dimensionality of risk information in the ICDB to reduce (i.e., mitigate) the magnitude of selection bias that could occur if the proposed analytical approaches were undertaken in a less information-rich environment.
Measures	Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for many of the state-developed outcome measures are provided in Appendix 2. Measures derived from administrative data sources in the State's integrated client data environment will include: • Measures of homelessness and housing stability • Measures of employment, hours worked and earnings • Measures of criminal justice involvement • Measures of health service utilization and cost, including ED visits, inpatient admissions, nursing facility utilization and overall Medicaid expenditures • Access to mental health and substance use disorder treatment • Other health care quality measures (e.g., psychotropic medication adherence, comprehensive diabetes care)
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. An assessment of the difference between FCS program participants and non-participants with comparable baseline attributes will be conducted using difference-of-difference designs where appropriate, wherein the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. The matching process will leverage the richness of baseline demographic, risk, and utilization data contained in the State's ICDB. The pre-post boundary for each treatment group will be based on the point at which they first engage in the intervention. The PS matching process will proceed through the following steps: • Examination of key baseline predictors of treatment entry within the pooled intervention and comparison matching frame to ensure inclusion of appropriate measurement dimensions in the PS model. This includes creating

Component	Description
	an extensive set of predictors that are determined, ex ante, to be potentially relevant to the matching process. This set of predictors is generally expected to span a wide range of the measurement domains contained with the State's ICDB, which may include: – Service utilization data across Medicaid funded delivery systems (physical, mental health, substance use disorder, long-term services and support, and developmental disability services); – Expenditure data at the "major modality" (e.g., IP hospitalization, OP ED visits, etc.) per-member per-month level; – Risk factors associated with chronic disease conditions, including mental illness and substance use disorders, derived from the CDPS and Medicaid-Rx risk models; – Data on functional (ADL) support needs, cognitive impairment, and behavioral challenges from the client's current LTSS assessment, if applicable; – Prior patterns of housing instability or homelessness; – Prior rates of employment and earnings levels; – Prior arrest experiences; – Client demographics (age, gender, race/ethnicity); – Medicaid enrollment by detailed coverage category; and – Urban/rural/frontier characteristics of the beneficiary's residential location. • Application of machine learning techniques (e.g., stepwise logistic or lasso regression) to determine the final propensity score model. • Propensity score matching using procedures in the R programming language (e.g., the Matchit procedure). Exact matching may be required for key variables (e.g., age and gender). As with all Demonstration initiatives, target populations are expected to partially overlap across projects and programs. The statewide project attribution data infrastructure will be leveraged to identify project participation longitudinally at the beneficiary level. Analyses may be limited to subpopulations of clients with "common support" across baseline matching criteria, and subpopulations not engaged in other Demonstration projects or other initiatives. This restriction has parallels to study enrollment restrictions commonly imposed in the randomized clinical trial context. The baseline period for construction of matching variables will typically be the prior 12 months, but may be of longer duration if information from prior periods is determined to be predictive of engagement in FCS services. Outcome periods will typically be periods comprised of one or more 12-month segments or intervals, depending on the length of available follow-up time. Impact will generally be estimated in a regression framework using SAS regression procedures and models including controls for baseline characteristics, notably including those baseline characteristics on which exact matching is not imposed. The ICDB will be the data source all measurement within this component of the evaluation. As was discussed in more detail in Section 3, the ICDB is designed to

Component	Description
	support quasi-experimental evaluation of health and social service interventions in Washington State, has been widely used in evaluation studies published in peer-reviewed journals, and contains data from the administrative data systems, including Medicare Parts A, B, and D data and the State's ProviderOne MMIS data system, necessary to implement this component of the quantitative evaluation design. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Provider capacity to effectively deliver CTS, CSS and supported employment services • Implementation fidelity to CTS, CSS and supported employment service models • Use of HIT to support delivery of CTS, CSS and supported employment services • The extent of linkages between CTS, CSS and supported employment service providers and other health care providers • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery
Subgroup analyses to assess disparities and differences	Among the dimensions that will be considered for analysis of disparities and differences in access to services and outcomes include: • Race/ethnicity, age and gender • Geography (urban/rural/frontier) • Delivery system affiliation (e.g., physical health, mental health, SUD, LTSS and/or Tribal) • Chronicity of housing instability • Extent of prior employment history • Functional risk factors (presence of cognitive impairment or TBI, behavioral health risk factors, severity of physical comorbidities) • Extent of prior criminal justice involvement • Previously institutionalized populations

APPENDIX 1

Alignment of Demonstration and Project-Specific Testable Hypotheses to Evaluation Metrics and Data Sources

TABLE 1.
Project 2A: Bi-Directional Integration of Care and Primary Care Transformation

H_1		
Demonstration Hypotheses (STC 108)	**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**	
Research Questions Identified in Domains of Focus (STC 109)	**Q**	***Were ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*
Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . increase ***screening*** for physical health conditions, with a focus on eliminating disparities for persons with behavioral health risk factors?
		PERFORMANCE METRICS • NCQA HEDIS® Adults' Access to Preventive/Ambulatory Health Services (AAP) • NCQA HEDIS® Child and Adolescents' Access to Primary Care Practitioners • NCQA HEDIS® Breast Cancer Screening (BCS) • NCQA HEDIS® Cervical Cancer Screening (CCS) • NCQA HEDIS® Colorectal Cancer Screening (COL) • NCQA HEDIS® Chlamydia Screening (CHL) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . increase ***access*** to and ***engagement*** in treatment for mental illness and/or substance use disorders?
		PERFORMANCE METRICS • Mental Health Service Penetration (state-defined, see Appendix 2 for measure specification) • Substance Used Disorder Treatment Penetration (state-defined, see Appendix 2 for measure specification) • NCQA HEDIS® Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.3	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . improve ***quality*** of care for behavioral and physical health conditions?

		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Comprehensive Diabetes Care: Eye Exam (Retinal) Performed • NCQA HEDIS® Comprehensive Diabetes Care: Medical Attention for Nephropathy • NCQA HEDIS® Comprehensive Diabetes Care: Hemoglobin A1c Testing • NCQA HEDIS® Medication Management for People with Asthma (MMA) • NCQA HEDIS® Antidepressant Medication Management (AMM) • NCQA HEDIS® Adherence to Antipsychotics for Persons with Schizophrenia (SAA) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.4	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . improve ***coordination*** of care for persons with co-occurring behavioral and physical health conditions?
		PERFORMANCE METRICS • NCQA HEDIS® Diabetes Screening for People with Schizophrenia/Bipolar Disorder • NCQA HEDIS® Follow-up after Emergency Department Visit for Alcohol or Drug Dependence within 7/30 Days (FUA) • NCQA HEDIS® Follow-up after Emergency Department Visit for Mental Illness within 7/30 Days (FUM) • NCQA HEDIS® Follow-Up After Hospitalization for Mental Illness (FUH) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.5	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . improve beneficiary ***health and social outcomes***?
		PERFORMANCE METRICS • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (see Appendix 2 for measure specification) • Employment Rate (state-defined, see Appendix 2 for measure specification) • Arrest Rate (state-defined, see Appendix 2 for measure specification) • Homelessness Rate (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

	1.6	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .***

Project-Specific Testable Hypotheses		. . . reduce disparities in health and social outcomes for persons with mental illness and/or substance use disorders, relative to Medicaid beneficiaries without behavioral health service needs?
		PERFORMANCE METRICS Stratification of measures listed above related to physical health care, service utilization, and cost into subpopulations based with mental illness and/or substance use disorders. • Presence of mental illness will be defined using the denominator criteria from the state-defined mental health service penetration rate metric. • Presence of substance use disorder will be defined using the denominator criteria from the state-defined Substance Use Disorder Treatment penetration rate metric. • Subpopulations with serious mental illness (SMI) may be defined by use of Chronic Illness and Disability Payment System (CDPS) Psychiatric High, Psychiatric Medium, and Psychiatrics Medium Low risk groups which include persons with schizophrenia, mania/bipolar disorders, major recurrent depression, and conditions of comparable severity. **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_2

Demonstration Hypotheses (STC 108)	**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation effective in achieving lower health care costs?***

Project-Specific Testable Hypotheses	2.1	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . reduce potentially avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.2	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . reduce ED utilization?
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES**

		RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . reduce utilization of nursing facility care for persons requiring long-term services and supports?
		PERFORMANCE METRICS • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.4	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . reduce per-member per-month health care expenditures?
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_3

Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***
	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care

		PERFORMANCE METRICS Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation expand health system capacity?*** HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care
		PERFORMANCE METRICS Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation expand health system capacity?*** Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process • Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation accelerate adoption of value-based payment reform?*** This includes: • Adoption of VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatment
		PERFORMANCE METRICS Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

TABLE 2.
Project 2B: Community-Based Care Coordination

H_1

Demonstration Hypotheses (STC 108)		**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**
Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Community-Based Care Coordination effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*
Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing Community-Based Care Coordination increase access to and engagement in treatment for those with complex and/or co-occurring conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® Adults' Access to Preventive/Ambulatory Health Services (AAP) • NCQA HEDIS® Child and Adolescents' Access to Primary Care Practitioners • NCQA HEDIS® Comprehensive Diabetes Care: Eye Exam (Retinal) Performed • NCQA HEDIS® Comprehensive Diabetes Care: Medical Attention for Nephropathy • NCQA HEDIS® Diabetes Screening for People with Schizophrenia/Bipolar Disorder • Mental Health Service Penetration (state-defined, see Appendix 2 for measure specification) • Substance Used Disorder Treatment Penetration (state-defined, see Appendix 2 for measure specification) • NCQA HEDIS® Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing Community-Based Care Coordination improve quality of care for behavioral and physical health conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Comprehensive Diabetes Care (CDC) • NCQA HEDIS® Medication Management for People with Asthma (MMA) • NCQA HEDIS® Antidepressant Medication Management (AMM) • NCQA HEDIS® Adherence to Antipsychotics for Persons with Schizophrenia (SAA) • NCQA HEDIS® Follow-Up After Hospitalization for Mental Illness (FUH) • NCQA HEDIS® Follow-up after Emergency Department Visit for Alcohol or Drug Dependence within 7/30 Days (FUA) • NCQA HEDIS® Follow-up after Emergency Department Visit for Mental Illness within 7/30 Days (FUM) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.3	***Do ACH projects addressing Community-Based Care Coordination improve patient health and social outcomes?***
		PERFORMANCE METRICS • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative • Employment Rate (state-defined, see Appendix 2 for measure specification) • Arrest Rate (state-defined, see Appendix 2 for measure specification) • Homelessness Rate (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.4	***Do ACH projects addressing Community-Based Care Coordination improve health and social outcomes for persons with behavioral health risk factors and persons needing functional supports (e.g., persons receiving home- and community-based LTSS services)?***
		PERFORMANCE METRICS Stratification of measures listed above related to physical health care, service utilization, and cost into subpopulations with mental illness and/or substance use disorders and use of LTSS services. • Presence of mental illness will be defined using the denominator criteria from the state-defined mental health service penetration rate metric. • Presence of substance use disorder will be defined using the denominator criteria from the state-defined Substance use disorder treatment penetration rate metric. • Subpopulations with serious mental illness (SMI) may be defined by use of Chronic Illness and Disability Payment System (CDPS) Psychiatric High, Psychiatric Medium, and Psychiatrics Medium Low risk groups which include persons with schizophrenia, mania/bipolar disorders, major recurrent depression, and conditions of comparable severity. • LTSS service utilization will be derived from payment data. **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_2

Demonstration Hypotheses (STC 108)	**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Community-Based Care Coordination effective in achieving lower health care costs?***
	2.1	***Do ACH projects addressing Community-Based Care Coordination reduce inpatient, psychiatric inpatient, and ED utilization?***

Project-Specific Testable Hypotheses		**PERFORMANCE METRICS** • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.2	***Do ACH projects addressing Community-Based Care Coordination reduce potentially avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing Community-Based Care Coordination reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	2.4	***Do ACH projects addressing Community-Based Care Coordination reduce utilization of nursing facility care for persons requiring long-term services and supports?***
		PERFORMANCE METRICS • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	2.5	***Do ACH projects addressing Community-Based Care Coordination reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_3

Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***
	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***
Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing Community-Based Care Coordination support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.
Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing Community-Based Care Coordination expand health system capacity?*** HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.
Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing Community-Based Care Coordination expand health system capacity?*** Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process

		• Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing Community-Based Care Coordination accelerate adoption of value-based payment reform?***
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

TABLE 3.
Project 2C: Transitional Care

H_1	
Demonstration Hypotheses (STC 108)	**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Transitional Care effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*

Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing Transitional Care increase access to and engagement in community-based treatment for behavioral health conditions?***
		PERFORMANCE METRICS • Mental Health Service Penetration (state-defined, see Appendix 2 for measure specification) • Substance Used Disorder Treatment Penetration (state-defined, see Appendix 2 for measure specification) • NCQA HEDIS® Follow-Up After Hospitalization for Mental Illness (FUH) • NCQA HEDIS® Follow-up after Emergency Department Visit for Alcohol or Drug Dependence within 7/30 Days (FUA) • NCQA HEDIS® Follow-up after Emergency Department Visit for Mental Illness within 7/30 Days (FUM) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing Transitional Care reduce inpatient admissions, psychiatric inpatient admissions, ED utilization, and institutional stays?***
		PERFORMANCE METRICS • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • Homelessness Rate (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.3	***Do ACH projects addressing Transitional Care improve access to Home and Community-based Long Term Services and Supports?***
		PERFORMANCE METRICS • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.4	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . improve beneficiary ***social outcomes***?
		PERFORMANCE METRICS • Employment Rate (state-defined, see Appendix 2 for measure specification) • Arrest Rate (state-defined, see Appendix 2 for measure specification) • Homelessness Rate (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_2

Demonstration Hypotheses (STC 108)	**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Transitional Care effective in achieving lower health care costs?***

Project-Specific Testable Hypotheses	2.1	***Do ACH projects addressing Transitional Care reduce potentially avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?***

		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.2	***Do ACH projects addressing Transitional Care reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing Transitional Care reduce utilization of nursing facility care for persons requiring long-term services and supports?***
		PERFORMANCE METRICS • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.4	***Do ACH projects addressing Transitional Care reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_3

Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***

	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing Transitional Care support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing Transitional Care expand health system capacity?*** HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing Transitional Care expand health system capacity?*** • Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process • Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing Transitional Care accelerate adoption of value-based payment reform?*** This includes: • Adoption of VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatment
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

TABLE 4.
Project 2D: Diversion Interventions

H_1

Demonstration Hypotheses (STC 108)	**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Diversion Interventions effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*

Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing Diversion Interventions reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing Diversion Interventions improve access to primary care?***
		PERFORMANCE METRICS • NCQA HEDIS® Adults' Access to Preventive/Ambulatory Health Services (AAP) • NCQA HEDIS® Child and Adolescents' Access to Primary Care Practitioners **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.3	***Do ACH projects addressing Diversion Interventions improve access to behavioral health services?***
		PERFORMANCE METRICS • Mental Health Service Penetration (state-defined, see Appendix 2 for measure specification)

		• Substance Used Disorder Treatment Penetration (state-defined, see Appendix 2 for measure specification) • NCQA HEDIS® Follow-up after Emergency Department Visit for Alcohol or Drug Dependence within 7/30 Days (FUA) • NCQA HEDIS® Follow-up after Emergency Department Visit for Mental Illness within 7/30 Days (FUM) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.4	***Do ACH projects addressing Diversion Interventions reduce homelessness rates?***
		PERFORMANCE METRICS • Homelessness Rate (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.5	***Do ACH projects addressing Diversion Interventions reduce arrest rates?***
		PERFORMANCE METRICS • Arrest Rate (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_2

Demonstration Hypotheses (STC 108)	**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Diversion Interventions effective in achieving lower health care costs?***

Project-Specific Testable Hypotheses	2.1	***Do ACH projects addressing Diversion Interventions reduce potentially avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

	2.2	***Do ACH projects addressing Diversion Interventions reduce ED utilization?***

Project-Specific Testable Hypotheses		**PERFORMANCE METRICS** • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing Diversion Interventions reduce utilization of nursing facility care for persons requiring long-term services and supports?***
		PERFORMANCE METRICS • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.4	***Do ACH projects addressing Diversion Interventions reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_3

Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***
	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing Diversion Interventions support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care

		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.
Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing Diversion Interventions expand health system capacity?*** HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.
Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing Diversion Interventions expand health system capacity?*** Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process • Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.
Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing Diversion Interventions accelerate adoption of value-based payment reform?*** This includes: • Adoption of VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatment
		PERFORMANCE METRICS

		• Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

TABLE 5.
Project 3A: Addressing the Opioid Use Public Health Crisis

H_1

Demonstration Hypotheses (STC 108)		**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**
Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects "Addressing the Opioid Use Public Health Crisis" effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*
Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing the Opioid Use Public Health Crisis reduce opioid-related deaths?***
		PERFORMANCE METRICS • Opioid Related Deaths (Medicaid Enrollees and Total Population) per 100,000 covered live (CDC standards used to define opioid related deaths) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing the Opioid Use Public Health Crisis reduce non-fatal overdose involving prescription opioids?***
		PERFORMANCE METRICS • Non-fatal overdose involving prescription opioids per 100,000 covered lives **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.3	***Do ACH projects addressing the Opioid Use Public Health Crisis increase substance use disorder treatment penetration among opioid users?***
		PERFORMANCE METRICS • Substance Use Disorder Treatment Penetration, for persons with opiate use disorder (variation of state-defined metric restricted to persons with identified opiate use disorder – see Appendix 2 2) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.4	***Do ACH projects addressing the Opioid Use Public Health Crisis reduce the number of patients on high-dose chronic opioid therapy?***
		PERFORMANCE METRICS

		• Bree Collaborative: Patients on high-dose chronic opioid therapy by varying thresholds (specification under development) • Bree Collaborative: Patients with concurrent sedatives prescriptions (specification under development) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.5	***Do ACH projects addressing the Opioid Use Public Health Crisis increase the numbers receiving Medication Assisted Therapy (MAT) with Buprenorphine and Methadone?***
		PERFORMANCE METRICS • Bree Collaborative: Medication Assisted Therapy (MAT) for Opiate Use Disorder Using Buprenorphine or Methadone (specification under development) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_2

Demonstration Hypotheses (STC 108)	**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects "Addressing the Opioid Use Public Health Crisis" effective in achieving lower health care costs?***

Project-Specific Testable Hypotheses	2.1	***Do ACH projects addressing the Opioid Use Public Health Crisis reduce potentially avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.2	***Do ACH projects addressing the Opioid Use Public Health Crisis reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing the Opioid Use Public Health Crisis reduce utilization of nursing facility care for persons requiring long-term services and supports?***
		PERFORMANCE METRICS • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.4	***Do ACH projects addressing the Opioid Use Public Health Crisis reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_3

Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***
	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing the Opioid Use Public Health Crisis support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing the Opioid Use Public Health Crisis expand health system capacity?*** HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing the Opioid Use Public Health Crisis expand health system capacity?*** Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process • Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing the Opioid Use Public Health Crisis accelerate adoption of value-based payment reform?*** This includes: • Adoption of VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatment
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

TABLE 6.
Project 3B: Reproductive and Maternal Child Health

H_1		
Demonstration Hypotheses (STC 108)		**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**
Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Reproductive and Maternal/Child Health effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*
Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing Reproductive and Maternal/Child Health reduce rates of teen pregnancy?***
		PERFORMANCE METRICS • State-defined measure rate of teen pregnancy (specification forthcoming) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing Reproductive and Maternal/Child Health reduce the number of unintended pregnancies?***
		PERFORMANCE METRICS • Washington State Department of Health Rate of Unintended Pregnancies (PRAMS survey) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.3	***Do ACH projects addressing Reproductive and Maternal/Child Health reduce the rate of low-birth weight deliveries?***
		PERFORMANCE METRICS • Agency for Healthcare Research and Quality (AHRQ) Rate of Low Birth Weight Births (state-defined, specification forthcoming) • NCQA HEDIS® Prenatal care in the first trimester of pregnancy (PPC) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.4	***Do ACH projects addressing Reproductive and Maternal/Child Health increase engagement in behavioral health treatment penetration among pregnant women?***
		PERFORMANCE METRICS • Substance Used Disorder Treatment Penetration (state-defined, see Appendix 2 for measure specification) • Mental Health Service Penetration (state-defined, see Appendix 2 for measure specification) **DATA SOURCES**

		RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.5	***Do ACH projects addressing Reproductive and Maternal/Child Health increase Well-Child Visit rates among infants and young children?***
		PERFORMANCE METRICS • NCQA HEDIS® Well-Child Visits in the First 15 Months of Life • NCQA HEDIS® Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.6	***Do ACH projects addressing Reproductive and Maternal/Child Health increase rates of Chlamydia screening?***
		PERFORMANCE METRICS • NCQA HEDIS® Chlamydia Screening (CHL) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.7	***Do ACH projects addressing Reproductive and Maternal/Child Health improve access to effective contraceptive care (including LARC)?***
		PERFORMANCE METRICS • U.S. Office of Population Affairs (OPA) Contraceptive Care – Most & Moderately Effective Methods (specification forthcoming) • U.S. Office of Population Affairs (OPA) Contraceptive Care – Access to LARC (specification forthcoming) • U.S. Office of Population Affairs (OPA) Contraceptive Care – Postpartum (specification forthcoming) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.8	***Do ACH projects addressing Reproductive and Maternal/Child Health increase childhood immunization rates?***
		PERFORMANCE METRICS • NCQA HEDIS® Childhood Immunization Status (CIS) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_2

Demonstration Hypotheses (STC 108)	**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Reproductive and Maternal/Child Health effective in achieving lower health care costs?***

Project-Specific Testable Hypotheses	2.1	***Do ACH projects addressing Reproductive and Maternal/Child Health reduce potentially avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.2	***Do ACH projects addressing Reproductive and Maternal/Child Health reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing Reproductive and Maternal/Child Health reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_3

Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***
	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing Reproductive and Maternal/Child Health support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing Reproductive and Maternal/Child Health expand health system capacity?*** HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing Reproductive and Maternal/Child Health expand health system capacity?*** Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process • Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing Reproductive and Maternal/Child Health accelerate adoption of value-based payment reform?*** This includes: • Adoption of VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatment

		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

TABLE 7.
Project 3C: Access to Oral Health Services

H_1

Demonstration Hypotheses (STC 108)	**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Access to Oral Health Services effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*

Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing Access to Oral Health Services increase access to oral health services for children?***
		PERFORMANCE METRICS • Dental Quality Alliance (DQA) Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers (specification forthcoming) • Dental Quality Alliance (DQA) Caries at Recall (Children) (specification forthcoming) • Dental Quality Alliance (DQA) Sealants - % Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk (specification forthcoming) • Dental Quality Alliance (DQA) Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk (specification forthcoming) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing Access to Oral Health Services increase access to oral health services for adults?***
		PERFORMANCE METRICS • State-defined measure of oral health services utilization among Medicaid beneficiaries (specification forthcoming) • National Network for Oral Health Access (NNOHA) Adult Treatment Plan Completed (specification forthcoming) • National Network for Oral Health Access (NNOHA) Caries at Recall (Adult) (specification forthcoming) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.3	***Do ACH projects addressing Access to Oral Health Services improve prevention and control the progression of oral disease?***
		PERFORMANCE METRICS • Dental Quality Alliance (DQA) Ongoing Care in Adults with Chronic Periodontitis (specification forthcoming) • Dental Quality Alliance (DQA) Periodontal Evaluation in Adults with Chronic Periodontitis (specification forthcoming) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.4	***Do ACH projects addressing Access to Oral Health Services reduce reliance on emergency departments for oral pain and related conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative, with stratification to identify oral pain and related conditions **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_2

Demonstration Hypotheses (STC 108)	**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Access to Oral Health Services effective in achieving lower health care costs?***

Project-Specific Testable Hypotheses	2.1	***Do ACH projects addressing Access to Oral Health Services reduce potentially avoidable utilization of inpatient hospital services?***
		PERFORMANCE METRICS • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.2	***Do ACH projects addressing Access to Oral Health Services reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing Access to Oral Health Services reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_3

Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***
	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing Access to Oral Health Services support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing Access to Oral Health Services expand health system capacity?*** HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care

		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing Access to Oral Health Services expand health system capacity?*** Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process • Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing Access to Oral Health Services accelerate adoption of value-based payment reform?*** This includes: • Adoption of VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatment
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

TABLE 8.
Project 3D: Chronic Disease Prevention and Control

H_1

Demonstration Hypotheses (STC 108)		**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**
Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Chronic Disease Prevention and Control effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*
Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing Chronic Disease Prevention and Control improve the quality of care for chronic conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® Comprehensive Diabetes Care: Eye Exam (Retinal) Performed • NCQA HEDIS® Comprehensive Diabetes Care: Medical Attention for Nephropathy • NCQA HEDIS® Medication Management for People with Asthma (MMA) • Statin Therapy for Patients with Cardiovascular Disease • Adult Body Mass Index Assessment **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing Chronic Disease Prevention and Control reduce utilization of inpatient and emergency department services?***
		PERFORMANCE METRICS • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_2

Demonstration Hypotheses (STC 108)		**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**
Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Chronic Disease Prevention and Control effective in achieving lower health care costs?***

Project-Specific Testable Hypotheses	2.1	***Do ACH projects addressing Chronic Disease Prevention and Control reduce potentially avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.2	***Do ACH projects addressing Chronic Disease Prevention and Control reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing Chronic Disease Prevention and Control reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_3

Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***
	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing Chronic Disease Prevention and Control support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care

		• Fidelity to the adopted models of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.
Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing Chronic Disease Prevention and Control expand health system capacity?*** HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.
Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing Chronic Disease Prevention and Control expand health system capacity?*** Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process • Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.
Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing Chronic Disease Prevention and Control accelerate adoption of value-based payment reform?*** This includes: • Adoption of VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatment
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

TABLE 9.
Initiative 3: Foundational Community Supports Program

H_1

Demonstration Hypotheses (STC 108)	**Does the provision of foundational community supports - supportive housing and supported employment - improve health outcomes for a targeted subset of the Medicaid population?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***What impact does the provision of foundational community supports have on beneficiary health and quality of life?***
Initiative-Specific Testable Hypotheses	1.1	***Does participation in the Foundational Community Supports Program increase access to and engagement in treatment for mental illness and/or substance use disorders?***
		PERFORMANCE METRICS • Mental Health Service Penetration (state-defined, see Appendix 2 for measure specification) • Substance Used Disorder Treatment Penetration (state-defined, see Appendix 2 for measure specification) • NCQA HEDIS® Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Initiative-Specific Testable Hypotheses	1.2	***Does participation in the Foundational Community Supports Program improve quality of care for behavioral and physical health conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® Comprehensive Diabetes Care (CDC) • NCQA HEDIS® Medication Management for People with Asthma (MMA) • NCQA HEDIS® Antidepressant Medication Management (AMM) • NCQA HEDIS® Adherence to Antipsychotics for Persons with Schizophrenia (SAA) • NCQA HEDIS® Follow-Up After Hospitalization for Mental Illness (FUH) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Initiative-Specific Testable Hypotheses	1.3	***Does participation in the Foundational Community Supports Program reduce avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Initiative-Specific Testable Hypotheses	1.4	***Does participation in the Foundational Community Supports Program reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Initiative-Specific Testable Hypotheses	1.5	***Does participation in the Foundational Community Supports Program reduce utilization of nursing facility care for persons requiring LTSS services?***
		PERFORMANCE METRICS • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Initiative-Specific Testable Hypotheses	1.6	***Does participation in the Foundational Community Supports Program improve social outcome metrics (reduce homelessness, increase employment, reduce risk of criminal justice involvement)?***
		PERFORMANCE METRICS • Employment Rate (state-defined, see Appendix 2 for measure specification) • Arrest Rate (state-defined, see Appendix 2 for measure specification) • Homelessness Rate (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_2

Demonstration Hypotheses (STC 108)	**Does the provision of foundational community supports - supportive housing and supported employment - reduce costs for a targeted subset of the Medicaid population?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Does the provision of foundational community supports provide other benefits to the Medicaid program?***

Initiative-Specific Testable Hypotheses	2.1	***Does participation in the Foundational Community Supports Program reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Initiative-Specific Testable Hypotheses	2.2	***Do the components of the Foundational Community Supports Program show fidelity to adopted evidence-based models of care?***
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Initiative-Specific Testable Hypotheses	2.3	***Does the Foundational Community Supports Program use HIT to support eligibility determinations and service delivery?***
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Initiative-Specific Testable Hypotheses	2.4	***Does the Foundational Community Supports Program use electronic health information exchange (e.g., providers' use (creation and transmission) of employment/housing assessment templates, OneHealthPort (OHP) services (e.g., registration and use of the Clinical Data Repository (CDR))?***
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

APPENDIX 2

State Developed Specification Definitions

Arrest
Measure Definition (ARREST)

December 27, 2016
Medicaid Version 1.1

Description

The percentage of Medicaid enrollees who were arrested at least once in the measurement year. These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

Eligible Population

Ages	18 – 64
Minimum Medicaid enrollment	A minimum of 7 months of Medicaid enrollment is required in the measurement year.
Anchor date	December 31 of the measurement year for calendar-year reporting
Identification window for Behavioral Health Service Needs	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months) for calendar-year reporting. For quarterly reporting a comparable 24-month period is used, anchored to the end of quarterly reporting period.
Benefit	Medicaid
Service contracting entity attribution	For Behavioral Health Organization (BHO), Area Agency on Aging (AAA) and Managed Care Organization (MCO) reporting, members must meet the additional attribution criteria defined below: • BHO Mental Health populations must reside in the BHO catchment area for at least 7 months in the measurement year, and must meet the denominator mental health need criteria specified in the Mental Health Service Penetration metric. • BHO Substance Use Disorder (SUD) populations must reside in the BHO catchment area for at least 7 months in the measurement year, and must meet the denominator SUD criteria specified in the SUD Treatment Penetration metric. • AAA populations must reside in the AAA catchment area for at least 7 months in the measurement year, and must receive Home- or Community-Based long-term services and supports in at least 7 months in the measurement year. • MCO populations must be enrolled with the MCO in at least 7 months in the measurement year.
Claim status for service contracting entity attribution	Include only final paid claims or accepted encounters for BHO attribution.

Denominator

Include in the measure denominator all individuals in the eligible population for the service contracting entity. In particular, note that persons who are dually eligible for Medicare or with Third-Party Liability (coverage) are included in the measure population.

Numerator

Include all denominator-eligible members with at least one arrest in the measurement year recorded in the Washington State Identification System (WASIS) arrest database maintained by the Washington State Patrol. The database is comprised of arrest charges for offenses resulting in fingerprint identification. The database provides a relatively complete record of felony and gross misdemeanor charges, but excludes some arrest charges for misdemeanor offenses that are not required to be reported.

Employment Rate
Measure Definition (EMP)

December 27, 2016
Medicaid Version 1.2

Description

The percentage of Medicaid enrollees with any earnings reported in Employment Security Department (ESD) employment data in the measurement year.

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

Eligible Population

Ages	Separate reporting for age groups 18 – 64 and 65+
Minimum Medicaid enrollment	A minimum of 7 months of Medicaid enrollment is required in the measurement year.
Anchor date	December 31 of the measurement year for calendar-year reporting
Identification window for Behavioral Health Service Needs	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months) for calendar-year reporting. For quarterly reporting a comparable 24-month period is used, anchored to the end of quarterly reporting period.
Benefit	Medicaid
Service contracting entity attribution	For Behavioral Health Organization (BHO), Area Agency on Aging (AAA) and Managed Care Organization (MCO) reporting, members must meet the additional attribution criteria defined below: • BHO Mental Health populations must reside in the BHO catchment area for at least 7 months in the measurement year, and must meet the denominator mental health need criteria specified in the Mental Health Service Penetration metric.

	• BHO Substance Use Disorder (SUD) populations must reside in the BHO catchment area for at least 7 months in the measurement year, and must meet the denominator SUD criteria specified in the SUD Treatment Penetration metric. • AAA populations must reside in the AAA catchment area for at least 7 months in the measurement year, and must receive Home- or Community-Based long-term services and supports in at least 7 months in the measurement year. • MCO populations must be enrolled with the MCO in at least 7 months in the measurement year.
Claim status for service contracting entity attribution	Include only final paid claims or accepted encounters for BHO attribution.

Denominator

Include in the measure denominator all individuals in the eligible population for the service contracting entity. In particular, note that persons who are dually eligible for Medicare or with Third-Party Liability (coverage) are included in the measure population.

Numerator

Include all members with at least one quarter in the measurement year with positive earnings recorded in ESD quarterly wage data. Note that ESD reported earnings data do not include self-employment, federal employment, or unreported earnings.

Homelessness Broad and Narrow Measure Definitions (HOME-N and HOME-B)

December 27, 2016
Medicaid Version 1.2

Description

The percentage of Medicaid enrollees who were homeless in at least one month in the measurement year. These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

Eligible Population

Ages	Separate reporting for age groups 0-17, 18 – 64 and 65+
Minimum Medicaid enrollment	A minimum of 7 months of Medicaid enrollment is required in the measurement year.
Anchor date	December 31 of the measurement year for calendar-year reporting
Identification window for	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months) for calendar-year reporting. For quarterly reporting a

Behavioral Health Service Needs	comparable 24-month period is used, anchored to the end of quarterly reporting period.
Benefit	Medicaid
Service contracting entity attribution	For Behavioral Health Organization (BHO), Area Agency on Aging (AAA) and Managed Care Organization (MCO) reporting, members must meet the additional attribution criteria defined below: • BHO Mental Health populations must reside in the BHO catchment area for at least 7 months in the measurement year, and must meet the denominator mental health need criteria specified in the Mental Health Service Penetration metric. • BHO Substance Use Disorder (SUD) populations must reside in the BHO catchment area for at least 7 months in the measurement year, and must meet the denominator SUD criteria specified in the SUD Treatment Penetration metric. • AAA populations must reside in the AAA catchment area for at least 7 months in the measurement year, and must receive Home- or Community-Based long-term services and supports in at least 7 months in the measurement year. • MCO populations must be enrolled with the MCO in at least 7 months in the measurement year.
Claim status for service contracting entity attribution	Include only final paid claims or accepted encounters for BHO attribution.
Data source for identifying homelessness	The DSHS Economic Services Administration's Automated Client Eligibility System (ACES); used by caseworkers to record information about client self-reported living arrangements and shelter expenses when determining eligibility for cash, food, and medical assistance.

Denominator

Include in the measure denominator all individuals in the eligible population for the service contracting entity. In particular, note that persons who are dually eligible for Medicare or with Third-Party Liability (coverage) are included in the measure population.

Numerator – Narrow

Include all denominator-eligible members with at least one month with a living arrangement status of "Homeless without Housing", "Emergency Shelter" or "Battered Spouse Shelter" recorded in the ACES eligibility data system.

Numerator – Broad

Include all denominator-eligible members with at least one month with a living arrangement status of "Homeless with Housing", "Homeless without Housing", "Emergency Shelter" or "Battered Spouse Shelter" recorded in the ACES eligibility data system.

Mental Health Service Penetration – Broad Measure Definition (MH-B)

July 25, 2017
Medicaid Version 1.8

Description

The percentage of members with a mental health service need who received mental health services in the measurement year.

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

NOTE: Measure specification is currently undergoing revision to account for delivery system changes resulting from BHO and FIMC implementation.

Eligible Population

Ages	Separate reporting for age groups 6 – 17, 18 – 64 and 65+
Continuous enrollment	Applied only to the measurement year
Allowable gap	Member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year
Identification window	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months)
Benefit	Medicaid-only and dual eligibles excluding Part C enrollees Exclude persons with third-party liability (coverage)
Data sources	Medicaid MCO encounters and HCA-paid claims RSN/BHO encounter data and DBHR-paid behavioral health services Medicare Parts A and B claims and Medicare Part D encounters
Event/diagnosis	Members meeting the mental health service need criteria defined below
Claim status	Include only final paid claims or accepted encounters in measure calculation

Mental Health Service Need Definition

Mental health service need is identified by the occurrence of any of the following conditions:

1. Receipt of any mental health service meeting the numerator service criteria in the 24-month identification window
2. Any diagnosis of mental illness (not restricted to primary) in any of the categories listed in MH-Dx-value-set.xlsx in the 24-month identification window. These categories include:
    a. Psychotic Diagnosis Set 101
    b. Mania/Bipolar Diagnosis Set 102

c. Depression Diagnosis Set 103
d. Anxiety Diagnosis Set 104
e. ADHD Diagnosis Set 105
f. Disruptive/Impulse/Conduct Diagnosis Set 106
g. Adjustment Diagnosis Set 107

3. Receipt of any psychotropic medication listed in MH-Rx-value-set.xlsx in the 24-month identification window. These medications comprise the following drug therapy classes:
    a. Antianxiety Rx
    b. Antidepressants Rx
    c. Antimania Rx
    d. Antipsychotic Rx
    e. ADHD Rx
4. Any claim with a service procedure code in the following set: 90791, 90792, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90825, 90826, 90827, 90828, 90829, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90857, 90862, 90889, H0023, H0025, H0027, H0030, H0031, H0032, H0035, H0036, H0037, H0038, H0039, H0040, H0046, H1011, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, H2021, H2022, H2023, H2027, H2030, H2031, H2033, M0064, Q5008, S9480, S9482, S9484, S9485, T1025, T1026, T2038, T2048, 96101, 96102, 96103, 96110, 96111, 96116, 96118, 96119, 96120
5. Any psychiatric inpatient stay in the following facility types: Community Psychiatric Hospital, Evaluation & Treatment Center, Child Long-Term Inpatient, Child Study Treatment Center, Eastern and Western State Hospital
6. A tribal mental health encounter paid through ProviderOne

Denominator

Include in the denominator all individuals in the eligible population with a mental health service need in the 24-month identification window.

Numerator

Include in the numerator all individuals receiving at least one mental health services meeting at least one of the following criteria in the 12-month measurement year:

TABLE 1.
Numerator Service Criteria

Criterion	Value Sets
Mental health service modality from RSN/BHO encounter data	• Brief intervention treatment • Care coordination services • Child family team meeting • Co-occurring treatment • Crisis services • Day support • Engagement & outreach • Family treatment

	• Group treatment services • High intensity treatment • Housing and Recovery Through Peer Support (HARPS) • Individual treatment services • Intake evaluation • Medication management • Medication monitoring • Mental health clubhouse • Residential treatment services • Peer support • Psychological assessment • Offender Reentry Community Safety Program (ORCSP) • Rehabilitation case management • Special population evaluation • Stabilization services • Supported employment • Therapeutic psychoeducation • Community transition • Community based wraparound services Note: Classification of outpatient or residential BHO services is based on procedure code and modifier field values defined in the applicable BHO Service Encounter Reporting Instructions (SERI)
Tribal mental health encounter	A tribal mental health encounter paid through ProviderOne
Mental health provider taxonomy	Primary diagnosis code is a valid value in the MH-Dx-value-set.xlsx set AND Servicing provider taxonomy code is in the set: 101Y00000X, 101YM0800X, 101YP2500X, 103G00000X, 103T00000X, 103TB0200X, 103TC0700X, 103TC1900X, 103TC2200X, 103TF0000X, 103TH0100X, 103TP0016X, 103TP0814X, 103TP2700X, 103TP2701X, 103TR0400X, 104100000X, 1041C0700X, 106H00000X, 163WP0809X, 2080P0006X, 2084A0401X, 2084F0202X, 2084N0400X, 2084N0402X, 2084N0600X, 2084P0015X, 2084P0800X, 2084P0802X, 2084P0804X, 2084P0805X, 2084S0012X, 2084V0102X, 251S00000X, 261QM0801X, 273R00000X, 283Q00000X, 323P00000X, 363LP0808X, 364SP0808X
Mental health procedure code	90791, 90792, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90825, 90826, 90827, 90828, 90829, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90857, 90862, 90889, H0004, H0023, H0025, H0027, H0030, H0031, H0032, H0035, H0036, H0037, H0038, H0039, H0040, H0046, H1011, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, H2021, H2022, H2023, H2035, H2027, H2030, H2031, H2033, M0064, Q5008, S9480, S9482, S9484, S9485, T1025, T1026, T2038, T2048, 96101, 96102, 96103, 96110, 96111, 96116, 96118, 96119, 96120
Mental health condition	Primary diagnosis code is a valid value in the MH-Dx-value-set.xlsx set AND

management in primary care	Procedure code is in the set: 99201-99215 (Office), 99241-99255 (Consultation), or 99441-99444 (telephonic or online) AND (for Medicaid claims/encounters) Servicing provider taxonomy code is in the set: 101YA0400X, 101YM0800X, 101YP2500X, 103T00000X, 103TC0700X, 103TP0016X, 104100000X, 1041C0700X, 106H00000X, 163W00000X, 163WH0200X, 163WP0807X, 163WP0808X, 163WP0809X, 163WW0101X, 193200000X, 193400000X, 207LA0401X, 207LP2900X, 207P00000X, 207Q00000X, 207QA0000X, 207QA0401X, 207QA0505X, 207QG0300X, 207QH0002X, 207QS1201X, 207R00000X, 207RA0000X, 207RA0401X, 207RC0000X, 207RC0001X, 207RC0200X, 207RE0101X, 207RG0100X, 207RG0300X, 207RH0000X, 207RH0002X, 207RH0003X, 207RI0001X, 207RI0008X, 207RI0011X, 207RI0200X, 207RN0300X, 207RP1001X, 207RR0500X, 207RS0010X, 207RS0012X, 207RT0003X, 207RX0202X, 207V00000X, 207VC0200X, 207VG0400X, 207VM0101X, 207VX0000X, 207VX0201X, 208000000X, 2080A0000X, 2080H0002X, 2080P0006X, 2080P0008X, 2080P0201X, 2080P0202X, 2080P0204X, 2080P0205X, 2080P0206X, 2080P0207X, 2080P0208X, 2080P0210X, 2080P0214X, 2080P0216X, 2083P0901X, 2084A0401X, 2084F0202X, 2084N0400X, 2084N0402X, 2084P0015X, 2084P0800X, 2084P0802X, 2084P0804X, 2084P0805X, 208800000X, 208D00000X, 208M00000X, 208VP0000X, 208VP0014X, 251S00000X, 261Q00000X, 261QD1600X, 261QF0400X, 261QM0801X, 261QM1300X, 261QP0904X, 261QP0905X, 261QP2300X, 261QR0200X, 261QR0400X, 261QR0405X, 261QR1300X, 261QU0200X, 273R00000X,282N00000X, 282NC0060X, 282NC2000X, 282NR1301X, 283Q00000X, 320800000X, 324500000X, 363LA2100X, 363LA2200X, 363LC1500X, 363LF0000X, 363LG0600X, 363LP0200X, 363LP0808X, 363LP1700X, 363LP2300X, 363LW0102X, 363LX0001X, 363LX0106X, 364S00000X, 364SF0001X, 364SP0808X, 367A00000X For Medicare paid claims, allow any servicing provider taxonomy code under this criterion

Substance Use Disorder Treatment Penetration Measure Definition (AOD)

December 27, 2016
Medicaid Version 1.3

Description

The percentage of members with a substance use disorder treatment need who received substance use disorder treatment in the measurement year.

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

NOTE: Measure specification is currently undergoing revision to account for delivery system changes resulting from BHO and FIMC implementation.

Eligible Population

Ages	Separate reporting for age groups 12 – 17, 18 – 64 and 65+

Continuous enrollment	The measurement year
Allowable gap	Member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year
Identification window	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months)
Benefit	Medicaid-only and dual eligibles excluding Part C enrollees Exclude persons with third-party liability (coverage)
Data sources	Medicaid MCO encounters and HCA-paid claims RSN/BHO encounter data and DBHR-paid behavioral health services CARE assessment diagnoses for identification of SUD treatment need Medicare Parts A and B claims and Medicare Part D encounters
Event/diagnosis	Members meeting the substance use disorder treatment need criteria defined below
Claim status	Include only final paid claims or accepted encounters in measure calculation

Substance Use Disorder Treatment Need

Substance use disorder treatment need is identified by the occurrence of any of the following in the identification window:

1. Diagnosis of a drug or alcohol use disorder in any health service event (SUD-Tx-Pen-Value-Set-1.xlsx)
2. Receipt of a substance use disorder treatment service meeting numerator criteria:
    a. Procedure, DRG, revenue and related codes: SUD-Tx-Pen-Value-Set-2.xls
    b. NDC codes: SUD-Tx-Pen-Value-Set-3.xlsx
3. Receipt of brief intervention (SBIRT) services (SUD-Tx-Pen-Value-Set-4.xlsx)
4. Receipt of medically managed detox services (SUD-Tx-Pen-Value-Set-5.xlsx).

Denominator

Include in the denominator all individuals in the eligible population with a substance use disorder treatment need.

Numerator

Include in the numerator all individuals receiving at least one substance use disorder treatment service meeting at least one of the following criteria in the 12-month measurement year (SUD-Tx-Pen-Value-Set-2.xlsx and SUD-Tx-Pen-Value-Set-3.xlsx):

1. Inpatient or residential substance use disorder treatment services
2. Outpatient substance use disorder treatment services
3. Methadone opiate substitution treatment services
4. Other medication-assisted treatment using medications indicated in SUD-Tx-Pen-Value-Set-3.xlsx

Classification of BHO services is based on procedure code and modifier field values defined in the applicable Service Encounter Reporting Instructions (SERI).

Emergency Department Utilization Measure Definition (ED)

July 25, 2016
Medicaid Version 1.1

Description

Outpatient Emergency Department (ED) Visits per 1,000 Member Months

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

Eligible Population

Ages	Separate reporting for age groups 10 – 17, 18 – 64 and 65+
Medicaid enrollment	Continuous Medicaid coverage in the 6 months up to and including the denominator-compliant member month
Anchor date	December 31 of the measurement year
Identification window	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months)
Benefit	Full benefit Medicaid-only and dual eligibles excluding Part C enrollees Exclude persons with third-party liability (coverage)
Data sources	Medicaid MCO encounters and HCA-paid claims RSN/BHO encounter data and DBHR-paid behavioral health services CARE assessment diagnoses for identification of mental illness and substance use disorder Medicare Parts A and B claims and Medicare Part D encounters Long-term care service data for AAA affiliation
Service contracting entity attribution	For Behavioral Health Organization (BHO), Area Agency on Aging (AAA) and Managed Care Organization (MCO) reporting, members must meet the additional attribution criteria defined below: • Resided in the BHO service area continuously in the 6 months up to and including the qualifying service month AND presented an indication of a mental health treatment need in the 24 months leading up to and including the denominator-compliant member month • Resided in the BHO service area continuously in the 6 months up to and including the qualifying service month AND presented an indication of a substance use disorder treatment need in the 24 months leading up to and including the denominator-compliant member month • Resided in the AAA service area continuously in the 6 months up to and including the qualifying service month AND received ALTSA-funded in-home personal care services continuously in the 6 months up to and including the denominator-compliant member month • Enrolled with the MCO continuously in the 6 months up to and including the denominator-compliant member month
Event	Outpatient ED visits meeting the numerator criteria defined below
Claim status	Include only final paid claims or accepted encounters in measure calculation

Denominator

Medical coverage months in the eligible population in the measurement year.

Numerator

Outpatient ED visits during medical coverage months in the eligible population in the measurement year.

ED visits are defined by the following criteria:

- Claim or encounter is a hospital outpatient claim type AND
- One or more of the following criteria is met:
  - Revenue code in the set ('0450', '0451', '0452', '0456', '0459')
  - Procedure code in the set ('99281' ,'99282' ,'99283' ,'99284' ,'99285', '99288')
  - Place of service code = Emergency Department

Measure is expressed as a rate per 1,000 denominator member months in the measurement year.

Home- and Community-Based Long Term Services and Supports Use Measure Definition (HCBS)

July 25, 2016
Medicaid Version 1.1

Description

Proportion of months receiving long-term services and supports (LTSS) associated with receipt of services in home- and community-based settings during the measurement year.

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

Eligible Population

Ages	Separate reporting for age groups 18 – 64 and 65+
Medicaid enrollment	Enrolled in Medicaid coverage in the denominator-compliant member month
Anchor date	December 31 of the measurement year
Identification window for Behavioral Health Risk factors	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months)
Benefit	Full benefit Medicaid-only and dual eligibles excluding Part C enrollees Exclude persons with other third-party liability (coverage)
Data sources	Medicaid MCO encounters and HCA-paid claims RSN/BHO encounter data and DBHR-paid behavioral health services CARE assessment diagnoses for identification of mental illness and substance use disorder Medicare Parts A and B claims and Medicare Part D encounters Long-term care service data

Service contracting entity attribution	• For Behavioral Health Organization (BHO), Area Agency on Aging (AAA) and Managed Care Organization (MCO) reporting, members must meet the additional attribution criteria defined below: • Resided in the BHO service area in the qualifying service month AND presented an indication of a mental health treatment need in the 24 months leading up to and including the denominator-compliant member month • Resided in the BHO service area in the qualifying service month AND presented an indication of a substance use disorder treatment need in the 24 months leading up to and including the denominator-compliant member month • Resided in the AAA service area in the denominator-compliant member month • Enrolled with the MCO in the denominator-compliant member month
LTSS service criteria	Receipt of any one or more of the following service modalities in the index month: • Home- and community-based services – In-home personal care services – Adult family home services – Adult residential care services – Assisted living services • Nursing home services
Claim status	Include only final paid claims or accepted encounters in measure calculation

Denominator

Person-months associated with receipt of LTSS services by persons in the eligible population in the measurement year (includes HCBS and nursing home services).

Numerator

Person-months associated with receipt of home- and community-based LTSS by persons in the eligible population in the measurement year (excludes nursing home services).

Measure may be expressed as a rate per 1,000 member months or, equivalently, as a percentage of denominator-compliant member months.

Psychiatric Inpatient Readmissions – Medicaid Measure Definition (PCR-P)

Description

For members 18 years of age and older, the proportion of acute inpatient psychiatric stays during the measurement year that were followed by an acute psychiatric readmission within 30 days. Data are reported in the following categories:

1. Count of Index Hospital Stays (IHS) (denominator).
2. Count of 30-Day Readmissions (numerator).

NOTE: Measure specification is currently undergoing revision to account for delivery system changes resulting from BHO and FIMC implementation.

Definitions

IHS	Index hospital stay. An acute psychiatric inpatient stay with a discharge on or between January 1 and December 1 of the measurement year. Include stays that meet the inclusion criteria in the denominator section. A client may have multiple qualifying discharges in the measurement period.
Index Admission Date	The IHS admission date.
Index Discharge Date	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.
Index Readmission Stay	An acute psychiatric inpatient stay with an admission date within 30 days of a previous Index Discharge Date.
Index Readmission Date	The admission date associated with the Index Readmission Stay.
Classification Period	365 days prior to and including an Index Discharge Date.

Eligible Population Administrative Specification

Denominator	The eligible population.
Step 1	Identify all acute inpatient psychiatric stays with a discharge date on or between January 1 and December 1 of the measurement year. Include only acute admissions to behavioral healthcare facilities, as identified in Table 1 below.
Step 2	Acute-to–acute transfers: Keep the original admission date as the Index Admission Date, but use the transfer's discharge date as the Index Discharge Date.
Step 3	Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.
Step 4	Exclude stays with discharges for death from the observation set.
Step 5	Calculate continuous enrollment and determine whether the observation meets continuous enrollment criteria.

Table 1. Eligible Acute Inpatient Psychiatric Events

Event	Source
Community Psychiatric Hospital Admissions	ProviderOne
Evaluation & Treatment Center Admissions	ProviderOne, supplemented by DBHR Consumer Information System
Child Long-Term Inpatient Admissions	DBHR Consumer Information System
Child Study Treatment Center Admissions	DBHR Consumer Information System

Eastern and Western State Hospital Admissions	DBHR Consumer Information System

Numerator

At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date from the facilities identified in Table 1.

Appendix D: Summary of EQRO Reports

EQRO 2019 Technical Report

Link to the full report

Introduction

Information in this report was collected from MCOs and BHOs through review activities based on Centers for Medicare & Medicaid Services (CMS) protocols. Additional activities may be included as specified by contract, including Wraparound with Intensive Services (WISe) program review.

Note: Under the direction of Senate Bill E2SSB 6312, Washington HCA and the MCOs continue to integrate physical and behavioral health benefits within the Apple Health managed care program. This multi-year integration process, designed so that Medicaid enrollees have access to both physical and behavioral health services through a single managed care program, will be achieved by January 2020. When reviewing the report, it is important to note this integrated system was operational in just two regions of the state, Southwest Washington and North Central, during the 2018 performance measure period.

Description of EQR Activities

EQR federal regulations under 42 CFR Part 438 specify the mandatory and optional activities that the EQRO must address in a manner consistent with CMS protocols. The 2019 report includes strengths, opportunities for improvement and recommendations reflecting the results of the following:

- MCOs
    - Validation of performance measures, including Healthcare Effectiveness Data and Information Set (HEDIS®) measures
    - Compliance monitoring, including follow-up of the previous year's corrective action plans
    - Validation of performance improvement projects (PIPs)
    - Consumer Assessment of Healthcare Providers and Systems (CAHPS®2) consumer surveys
- BHOs
    - Compliance monitoring o Follow-up of the previous year's corrective action plans
    - Validation of PIPs o Validation of statewide performance measures

Summary of Recommendations

In its assessment of the degree to which MCOs and BHOs provided Medicaid enrollees with accessible, timely, quality care, this 2019 Annual Technical Report explains to what extent the state's managed care plans are meeting federal and state regulations, contract requirements, and statewide goals, and where they need to improve. Comagine Health's recommendations to the state are intended to help improve Washington's overall Medicaid system of care. Subsequent sections offer further discussion.

Physical Health Recommendations and Opportunities for Improvement

1. In this year's review, MCO scores indicated that complying with the grievance system standard was difficult for some plans. Coverage and authorization, historically problematic, showed some improvement but remains a challenge.

    a. As the Apple Health program moves closer to a fully integrated managed care model, the state should maintain its focus on the areas of coverage and authorization, continuing to provide technical assistance to MCOs; supporting collaborative efforts between physical and behavioral health services; and implementing initiatives that will help ensure quality care for enrollees.

2. MCOs demonstrated need for improvement on PIP performance in 2019 RY, achieving more Not Met scores and fewer Met scores than in 2018 RY.

    a. To enhance the MCOs' ability to design a sound PIP, HCA should continue to provide MCOs with both ongoing training, specifically on the overall study design, and ongoing technical assistance with a focus on defining, streamlining and simplifying study questions.

    b. HCA should encourage MCOs to utilize rapid-cycle process improvement where feasible to accelerate change and results.

3. The following measures continue to fall under the 50th percentile nationally. These measures address prevention and access and are widely considered central to population health.

    a. Children's Access to Primary Care Providers (CAP) (7–11 and 12–19 year age groups)

    b. Prenatal and Postpartum Care (PPC)

    c. Adolescent Well-Care Visits (AWC)

    d. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)

    e. Adults' Access to Ambulatory/Preventive Health Services (AAP)

    f. Breast Cancer Screening (BCS)

See the Summary of HEDIS Performance Measure Results section for more information on current and prior year rates.

4. As the MCOs focus on outcomes improvement efforts over the coming year, Comagine Health encourages the Washington State MCOs to continue to align quality improvement efforts and design initiatives with a concurrent goal of reducing provider burden and unintended variation at the practice level.

    a. In designing initiatives, the MCOs should find ways to minimize the need for providers to navigate variation in MCO processes. The behavioral health integration initiative has necessitated alignments of MCO programs; we recommend using lessons from behavioral health integration as a starting point for a similar initiative to improve outcomes on a limited number of high-priority HEDIS measures by aligning MCO quality efforts.

    b. We recommend the MCOs collectively identify a small number of closely related high-priority HEDIS measures around which to align improvement efforts, with the goal of reducing provider burden and care delivery variation.

Behavioral Health Recommendations

1. The BHOs have reported that the BHAs have been affected by workforce shortages in their respective regions due to the increased enrollee capacity and their need for services.

    a. We recommend the state ensures the BHOs are analyzing network providers and specialties to show their networks are sufficient in number, mix and geographic distribution to meet the needs of the current and anticipated number of enrollees in the service area until the BHOs cease operations.

2. All three BHOs have policies, procedures and contract language regarding the coordination of care and services provided by the BHAs. However, the review of the BHOs' randomly chosen clinical records indicated that care coordination within all three BHO networks is poorly documented. In addition, there was little to no evidence of progress notes documenting correspondence, exchanges of information and plans for collaboration between clinical staff and other relevant treatment supporters.

    a. We recommend the state ensures the BHOs are monitoring the BHAs on adherence to care coordination contract requirements, which includes but is not limited to 2019 Annual Technical Report Executive Summary Comagine Health

        i. Providing and documenting coordination of care for all enrollees with their clinical providers, specialty and allied providers, and PCPs

        ii. Documenting correspondence, exchanges of information, and a plan for collaboration between clinical staff and other relevant treatment supporters

3. For all three BHOs, the use and identification of needed practice guidelines varied. Variation included the collection and assessment of utilization data pertaining to prevalence of diagnoses as well as the identification of the types of services utilized within populations with intensive or specialized needs. Ongoing training to providers on implementation and usefulness of the clinical practice guidelines was limited or non-existent.

4. Additionally, one BHO did not submit evidence of annual monitoring on the effective use of the practice guidelines adopted by the BHO or evidence of interface between the QAPI program and the practice guidelines adoption process.

    a. We recommend the state ensures the identification and adoption of practice guidelines are based on analysis of utilization data pertaining to prevalence of diagnoses as well as the identification of types of services used by populations with intensive or specialized needs.

    b. Additionally, we recommend the state ensures training on the implementation of guidelines and monitoring for adherence to the guidelines continues for the behavioral health providers.

5. BHOs are required to submit a yearly evaluation to the state on the impact and effectiveness of the care and services provided to Medicaid enrollees. Although all three BHOs submitted a 2018 program evaluation, one BHO's report significantly lacked the key elements of an effective program review. The year-end evaluation included the aggregated results for the agencies without including the methodology or the criteria used to score the records, and listed only one item in the evaluation: measuring the interval between the request for service and the first offered intake.

a. If the BHOs were to continue operating, we would recommend the state develop a formal method for ensuring the BHOs evaluate, on a yearly basis, the impact and effectiveness of the care and services provided to Medicaid enrollees by the BHAs. The evaluation should include the results of administrative and clinical reviews performed by the BHOs. Additionally, the evaluation should include review criteria, methodologies, outcomes, committee descriptions/priorities and an executive summary outlining the individual BHO's priorities for the upcoming year based on analysis and evaluation of the previous year's data.

6. If the BHOs were to continue operating, we would recommend the State ensure the BHOs develop PIPs that are designed, conducted and reported in a methodologically effective manner. The BHOs should consider the following:

    a. During the PIP selection process, a thorough review and analysis of data should be conducted. Furthermore, when developing a data analysis plan, the methodology must be appropriate to the study question and adhere to a statistical analysis technique that indicates the statistical significance of any differences between the baseline and remeasurement periods.

    b. When assessing the statistical significance, the confidence level needs to be stated.

    c. To produce successful PIP outcomes, it is important to identify and implement robust interventions. Also, to aid in removing barriers to successfully achieving improvement for the PIP interventions, consider utilizing a range of quality tools and techniques, such as root-cause analyses, driver diagrams, process mapping, failure modes and effects analysis (FMEA) and find, organize, clarify, uncover and start (FOCUS).

    d. Various committee meetings with stakeholders should be used as opportunities to identify and address regional barriers to the PIP interventions, which may be impacting the ability to achieve meaningful improvement.

7. Some of the BHOs struggled with determining next steps after data analysis revealed unintended outcomes or absence of statistically significant change.

    a. If the BHOs were to continue operating, we would recommend the State ensure the BHOs develop robust, system-level interventions responsive to barriers/challenges that may arise during the PIP process, which may include changes in guidelines, employing additional resources and/or establishing collaborative external partnerships with key stakeholders.

    b. Consideration should be given to testing changes on a small scale: o Rapid-cycle learning principles should be utilized where appropriate over the course of the PIP.

        i. Undertaking shorter remeasurement periods allows adequate time for modifications to be made until the desired outcome is achieved and sustained.

        ii. Steps should be taken to identify improvement opportunities including, but not limited to, conducting barrier analyses to derive the improvement strategies to be implemented.

        iii. Adjusting intervention strategies early on leads to improvement occurring more efficiently, which can have longer term sustainability.

iv. Data, both qualitative and quantitative, should be reviewed at least quarterly to ensure the PIP is moving in a successful direction.

Quality Strategy Status and Summary

State Medicaid agencies that contract with managed care organizations are required under federal regulations to have a quality strategy in place to assess and improve the quality of managed health care services.

Since its last quality strategy submission, reviewed by CMS in October 2017, the Washington Medicaid program has undergone significant changes. HCA has completed the statewide implementation of physical and behavioral health managed care, expanded value-based payment strategies, and realigned internally to support increased managed care oversight. Given these changes, it was determined by HCA that a major revision to the strategy was necessary.

Prior to updating the quality strategy, HCA staff conducted extensive document research and review, addressing both regulatory requirements and Washington initiatives. The revised strategy will focus attention on managed care oversight initiatives and activities, not just agency-wide initiatives, and demonstrate clearly defined goals and objectives for managed care oversight.

At the time of this report, HCA is thoroughly reviewing the updated strategy to ensure it reflects behavioral and physical health managed care integration, alignment and compliance with the CFR. After finalizing, the quality strategy will be submitted to CMS, distributed to all MCOs and posted on the state's website. HCA intends to ensure the plan is evaluated for effectiveness yearly.

EQRO 2019 Comparative and Regional Analysis

Link to the full report

Introduction

Under the direction of Senate Bill E2SSB 6312, Washington HCA and the MCOs continue to integrate physical and behavioral health benefits within the Apple Health managed care program. This multi-year integration process, designed so that Medicaid enrollees have access to both physical and behavioral health services through a single managed care program, will be achieved by January 2020. When reviewing the report, it is important to note this integrated system was operational in just two regions of the state, Southwest Washington and North Central, during the 2018 performance measure period.

This report illustrates trends in managed care performance across the HEDIS measure set, focused on performance against benchmarks and year-over-year trends. It is intended for review at the state, regional, and MCO level as a description of year-over-year performance. Over the course of 2019, the state has, in a separate and parallel effort, engaged in an extensive effort to align and focus its measurement efforts in response to the budget proviso. Specifically, earlier in 2019, it employed a largescale data analysis to provide a basis for selecting measures in support of its value-based payment (VBP) efforts. That analysis focused on opportunities for improvement, evaluating and prioritizing measures in terms of their ability to:

- Improve the health of a defined population
- Impact immediate or long-term costs
- Demonstrate substantive and clinically meaningful effects in promoting health

The performance measures used for monitoring the progress of behavioral health integration and access to mental health and substance use disorder treatment services are not included within this report as they are not HEDIS measures. The HCA and Department of Social and Health Services' Research and Data Analysis monitor the progress of these non-HEDIS behavioral health measures. Specifically, this report provides the following levels of analysis:

- Statewide performance compared to national benchmarks (when available)
- Individual MCO performance compared to national benchmarks (when available)

- Regional performance on select measures (not all measures provide a sufficient volume of data for regional analyses)

Summary of Results

1. Summary results from an analysis of statewide performance compared to national 50th and 75th benchmarks are presented below.

    a. The following measures had statistically significant improvement statewide.

        i. Childhood Immunization Status

        ii. Lead Screening in Children

        iii. Measures of Antibiotic Use

        iv. Opioid Use

2. Measures with Stagnant or Declining Performance Statewide

    a. The following measures continue to fall under the 50th percentile nationally, and have either remained stable or had a negative trend for most of the MCOs. These measures address prevention and access, including prenatal and postpartum care and access to primary care providers for children and adolescents. These are all measures that are widely considered central to population health.

        i. Children's Access to Primary Care Providers (CAP) (7–11 and 12–19 year age groups)

        ii. Timeliness of Prenatal Care

        iii. Postpartum Care

        iv. Adolescent Well-Care Visits

        v. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

        vi. Adults' Access to Ambulatory/Preventive Health Services

        vii. Breast Cancer Screening

Recommendations

1. Managed Care Alignment on Quality Improvement Efforts:

In designing initiatives, the MCOs should find ways to minimize the need for providers to navigate variation in MCO processes. The behavioral health integration initiative has necessitated alignments of MCO programs; we recommend using lessons learned from behavioral health integration as a starting point for a similar initiative to improve outcomes on a limited number of high-priority HEDIS measures by aligning MCO quality efforts.

2. Choose a Subset of Measures for Impacting the Quality of Care:

We recommend the MCOs collectively identify a small number of closely related high-priority HEDIS measures around which to align efforts, with the goal of reducing provider burden and care delivery variation. Measures not showing improvement are listed on the previous page.

Specifically, Comagine Health sees a particular opportunity for MCOs to impact quality in areas where providers have a limited view of their performance, for example with the Adult Access to Ambulatory/Preventive Health Services

(AAP) measure. A provider seeking to improve quality on this measure may only see a segment of the patient's care journey, while the MCOs have the opportunity to see the full journey. This creates an opportunity for the MCO to add valuable information to the quality improvement process that would otherwise not exist in the system.

3. Possible activities MCOs should consider for achieving alignment:

- A commitment to identify existing efforts in the domain of focus, understand and report back on the patient and provider perspective, and commit to an approach to reduce clinician burden for the selected measures that engages all MCO programs.

- Mutual development of a framework for quality improvement on the chosen measure that allows the state to monitor progress across MCOs using: o Process measures that are closely linked to an ability to move a HEDIS measure o Rapid tests of interventions that move the process measure o Statewide spread of successful interventions

- Monthly working meetings of the MCOs that include input from patients and providers to maintain momentum for the quality improvement initiative.

Using the yearly Quality Forum as a venue to review progress from the prior year and set strategic goals for the following year.