Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measures

State Directed Payment Evaluation Findings Template

As indicated in the preprint, states must "describe prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the states quality strategy" in "any year other than Year 1 of a multi-year effort." By providing evaluation data for each year of the payment arrangement, states will be able to understand the impact of the payment arrangement over time.

States may use the tables below to provide evaluation findings in their renewal preprints. The **tables are optional** but encompass CMS' expectations for what states include when sharing evaluation findings and describing their evaluation methodology.

Table 1. Washington 's Evaluation Findings for WA_Fee_OTH , Contract Rating Years 2021-2027

Metric Name	Baseline Year	Baseline Statistic	Performance Target	Evaluation Data									
				2020 – 2020	2021 – 2021	2022 – 2022	2023 – 2023	2024 – 2024	20 – 20	20 – 20	20 – 20	20 – 20	20 – 20
CCS (statewide)	MY2021	56.6%	≥ 56.6%	NA	56.6% (54.1%)	54.4% (55.0%)	55.0% (51.5%)	52.5% (NA)					
CHL (statewide)	MY2020	65.7%	≥ 65.7%	65.7%	64.4% (50.3%)	63.5% (50.3%)	63.4% (50.7%)	64.1% (NA)					

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measures

Table 2. Washington 's Evaluation for WA_Fee_OTH

Prompt	*Response*
Evaluation metrics	
Please share the data source(s) and year(s) of data used to calculate the evaluation metrics.	The evaluation metrics are calculated using validated claims data from providers participating in the directed payment. The data source is the Medicaid claims system, and results are based on trends using the most recent complete years of data, starting with the selected baseline year.
Please confirm that the data used to calculate the evaluation metrics was limited to Medicaid managed care enrollees.	Yes
Please confirm that the data used to calculate the evaluation metrics was limited to providers participating in the payment arrangement.	Yes, the MY 2026 evaluation plan has been updated to use data limited to participating providers, which resulted in changes to the baselines and targets from the previous submissions
Evaluation methodology	
Please identify the entity conducting the evaluation.	Washington Health Care Authority, the state's medicaid agency, with RN
Please describe the analytic methods used to understand the impact of the payment arrangement. For example, comparison groups, pre-post study design, etc.	Analytic methods will include a pre/post trend analysis to assess performance relative to the established baseline, supplemented by comparisons to statewide rates to provide additional context for evaluating impact
Please share any limitations of the state's evaluation plan.	A key limitation in evaluating the impact of the directed payment is the difficulty in isolating its specific effects from other influences on provider performance. Because the evaluation relies on a pre/post trend analysis and comparisons to statewide performance, results may reflect factors beyond the payment

Prompt	Response
Findings	
Please share the state's assessment of the impact of this payment arrangement.	Both CCS and CHL have demonstrated a consistent downward trend since the selected baseline years, reinforcing the decision to focus on these measures going forward. This decline highlights the importance of targeted investment in this provider group to address gaps in care delivery and to strengthen performance in these critical areas. This SDP has been in effect since 2021; however, the evaluation measures were updated beginning in 2025 to better align with state priorities and identified gaps in care. These revised measures provide a clearer framework for monitoring progress and assessing whether the payment arrangement supports stabilization of performance and eventual reversal of the downward trend. The state will continue to track results over
Please share any relevant context (e.g., changes to the managed care program) that may have impacted the evaluation results	Larger contextual factors exist (e.g., lessening impacts during post-COVID-19 timeframe, transitions of care quality initiatives); however, none were specifically identified as directly impacting this SDP
For all evaluation metrics that did not improve over baseline, please share any plans the state has to address declining performance.	The state's first priority was to select quality measures that are meaningful, reflect identified gaps in care, and align with existing state priorities, while designing data calculations specifically for the targeted provider group to ensure performance is accurately captured. 2024 has been a significant building year for the state's SDP quality program, focused on creating sustainable plans that meet the requirements of the Managed Care Final Rule and lay the groundwork for long-term improvement. Efforts include aligning measures across provider types for collective impact to improve client transitions of care, engaging providers and advocacy groups to strengthen collaboration and support effective implementation, and updating MCO contracts to formally incorporate SDP quality activities into annual QAPI