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_AMC (Legacy) , Contract Rating Years 2019-2027

Metric Name	Baseline Year	Baseline Statistic	Performance Target	Evaluation Data									
				20 16 – 20 16	20 17 – 20 17	20 18 – 20 18	20 19 – 20 19	20 20 – 20 20	20 21 – 20 21	20 22 – 20 22	20 23 – 20 23	20 24 – 20 24	20 – 20
FUH - 30 day, total (statewide)	CY 2024	67.4%	≥ 67.4%	77.1%	78.0%	77.9%	70.6%	71.8%	72.5% (54.5%)	70.1% (58.5%)	68.9% (58.7%)	67.4% (NA)	
PCR - O/E	CY 2024	1.19	≤ 1.19	1.13	1.10	1.11	1.10	1.16	1.11 (0.9)	1.15 (0.9)	1.18 (0.9)	1.19 (NA)	

Table 2. Washington 's Evaluation for WA_Fee_AMC (Legacy)

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 have been trended back to 2016 to reflect performance on the updated measures adopted for MY 2024, providing visibility into the full lifespan of the SDP
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 2025 evaluation plan has been updated to use data limited to participating providers, which resulted in changes to the baselines and targets from previous submissions
Evaluation methodology	
Please identify the entity conducting the evaluation.	Washington Health Care Authority, the state's medicaid agency
Please describe the analytic methods used to understand the impact of the payment arrangement. For example, comparison groups, pre-post study design, etc.	In 2024, the state implemented newly selected quality measures and shifted data calculations from state-level reporting to provider-specific analyses aligned with these measures. New baselines and performance targets were established using this provider-specific data to more accurately capture performance within the intended population. At the same time, efforts were initiated to engage providers and MCOs in this quality initiative, laying the groundwork for focused improvement. As a result, setting the baseline to 2024 performance provides a clear reference point to assess early impacts and guide ongoing enhancements under this strengthened quality framework. Analytic methods will include a pre/post trend analysis to assess performance
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.	For providers delivering professional services in state hospitals, the 30-day follow-up (FUH) and Plan All-Cause Readmission (PCR) measures show distinct patterns over time. FUH 30-day rates have gradually declined from historical highs in 2016–2018 (around 77–78%) to 67.4% in 2024. Despite this decline, 2024 performance still exceeds statewide managed care averages (around 58–59%), demonstrating that these providers maintain relatively strong continuity of care compared with broader trends. PCR has generally trended upward over the same period, moving from 1.10–1.13 in earlier years to 1.19 in 2024. This indicates a higher-than-expected
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