BOLD THINKERS DRIVING REAL-WORLD IMPACT

Medicaid Innovation Accelerator Program (IAP): Final Evaluation Report

This project was funded by the Centers for Medicare & Medicaid Services under contract No. HHSM-500-2014-0026I.

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This project was funded by the Centers for Medicare & Medicaid Services under contract no. HHSM-500-2014-0026I, Task Order HHSM-500-T0001. The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. Abt Associates assumes responsibility for the accuracy and completeness of the information contained in this report.

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September 2020

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ACKNOWLEDGEMENTS

The authors gratefully acknowledge the partnership of Bailit Health Purchasing, Kaiser Permanente Washington Health Research Institute, L&M Policy Research, LLC, and Milliman, Inc., who led elements of data collection, analysis, and synthesis that contributed to this evaluation report. In addition, we acknowledge the contributions of the Abt Associates analysts and research assistants who contributed to the data collection and analysis that inform our findings. The authors would like to thank all of the participants in the Medicaid Innovation Accelerator Program who gave generously of their time to inform this evaluation. We also thank staff of the Center for Medicaid and Children's Health Insurance Program Services who provided useful input into this report. We appreciate the careful review of drafts by Lisa LeRoy of Abt Associates. Finally, we thank Steve Blackwell and Suzanne Wensky of the Center for Medicare & Medicaid Innovation for their reviews and guidance.

List of Abbreviations and Acronyms

ACO	Accountable Care Organization
ASAM	American Society of Addiction Medicine
BCN	Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs
CHIP	Children's Health Insurance Program
CI-LTSS	Promoting Community Integration through Long-Term Services and Supports
CMCS	Center for Medicaid and CHIP Services
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
DA	Data Analytics
DUA	Data Use Agreement
EOI	Expression of Interest
HCBS	Home and Community-Based Services
HILC	High-Intensity Learning Collaborative
HRSP	Medicaid Housing-Related Services and Partnerships
IAP	Medicaid Innovation Accelerator Program
ISW	Integration Strategy Workgroup
LTSS	Long-Term Services and Supports
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MIHI VBP	Maternal and Infant Health Initiative Value-Based Payment Technical Support
MLTSS	Managed Long-Term Services and Supports
MMDI	Medicare-Medicaid Data Integration
NAS	Neonatal Abstinence Syndrome
OHI VBP	Oral Health Initiative Value-Based Payment Technical Support
OUD	Opioid Use Disorder
PI	Performance Improvement
PMH	Supporting Physical and Mental Health Integration
PMH Group	Physical and Mental Health Integration Group
SBIRT	SUD Screening, Brief Intervention, and Referral to Treatment Services
SME	Subject Matter Expert
SUD	Reducing Substance Use Disorders
Tenancy	Supporting Housing Tenancy
TLO	Targeted Learning Opportunities
VBP	Value-Based Payment
VBPFS	Value-Based Payment and Financial Simulations
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

Executive Summary

OVERVIEW

The Medicaid Innovation Accelerator Program (IAP) was launched by the Center for Medicaid and Children's Health Insurance Program (CHIP) Services (CMCS) within the Centers for Medicare & Medicaid Services (CMS) with funding from the Center for Medicare and Medicaid Innovation (CMMI). The IAP helped Medicaid agencies with their delivery system reforms at all stages along the implementation continuum.

CMS created the IAP in 2014 "to improve the health and health care of Medicaid beneficiaries and to reduce costs by supporting states' ongoing payment and delivery system reforms."[1] Through this program, CMS delivered technical assistance and resources to participating state teams through individual and group support, tool development, cross-state learning opportunities, and national dissemination of lessons learned and best practices to support Medicaid-focused innovations. The IAP did not provide financial resources to state teams. The IAP experimented with various technical assistance delivery modes and lengths of support, coaching teams with diverse expertise, and groupings of state agencies for peer learning.

The IAP offered support to state teams in four program areas: Reducing Substance Use Disorders; Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs; Promoting Community Integration through Long-Term Services and Supports; and Supporting Physical and Mental Health Integration. The IAP also provided technical assistance to state teams in four functional areas intended to serve as levers in furthering reform: Data Analytics; Value-Based Payment and Financial Simulations; Performance Improvement; and Quality Measurement. The length of support varied from three months to over three years depending on the area and the specific track[2] within the area.

This final report encompasses our findings from the four IAP program areas and two IAP functional areas (i.e., Data Analytics and Value-Based Payment and Financial Simulations) that engaged state teams from the IAP's inception in 2014 through September 2019.[3] Our findings from one additional functional area, Performance Improvement, are woven into the findings from program areas in which Performance Improvement was directly implemented (i.e., the Community Integration through Long-Term Services and Supports, Partnership track Cohort 2; and, Value-Based Payment and Financial Simulations, Maternal and Infant Health Initiative Technical Support and Children's Oral Health Initiative Technical Support tracks).

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[1] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/index.html

[2] The tracks are described in more detail in Chapter 4.

[3] In some IAP areas, new cohorts and/or tracks were added after the evaluation period ended because the IAP continued through September 2020. Cohorts not included this report are: the Reducing Substance Use Disorders Data Dashboard track Cohort 2 and Medication-Assisted Treatment Affinity Group; the Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs Using Data Analytics to Better Understand Medicaid Populations with Serious Mental Illness track; the Promoting Community Integration through Long-Term Services and Supports Housing Partnership track Cohort 3 and Value-Based Payment for Fee-for-Service Home and Community-Based Services track; the Data Analytics Technical Support track Cohorts 3 and 4; the Value-Based Payment and Financial Simulations track Cohort 3; and the Strengthening Partnerships while Developing Data Analytic Capacity to Support Reduction of Maternal Mortality and Severe Maternal Morbidity in Medicaid Technical Assistance track.

These findings will help CMS understand the practices that led to the IAP's successes, and suggest possible directions for future technical assistance program modifications. As specific challenges and suggestions for program improvement emerged from the evaluation data, they were shared with CMS staff in a rapid-cycle feedback process. Using a continuous quality improvement approach, CMS staff refined program elements based on the suggestions received and the learning styles of program participants.

This report presents the final results of Abt Associates' qualitative evaluation of participants' experiences with IAP technical assistance. The report focuses on state participants' responses to the program and the results of participation. The final report is composed of four chapters, beginning with Chapter 1, Introduction. Chapter 2, Key Findings, describes how the IAP provided support to state teams along the continuum of delivery system reform, and discusses the barriers that reduced the impact of the IAP support. Chapter 3, Lessons Learned about Designing Technical Assistance to Respond to State Needs, explores the challenges faced in delivering technical assistance, and presents promising practices that gave state teams the assistance they were seeking in moving forward on delivery system reform. Chapter 4, Delivery System Reform Activities by IAP Program and Functional Area, expands on the experiences of participants in each of the IAP's program and functional areas. Chapter 4 is divided into six sections, corresponding to the four program areas and two functional areas that engaged state teams. Appendix A is a description of the IAP Performance Improvement activities; Appendix B provides links to IAP-developed resources; Appendix C is a presentation of the evaluation framework and methods; and in Appendix D we present the generic data collection tools used in the evaluation.

RESULTS

States'[4] participation in the IAP led to the following results[5]:

- The IAP helped Medicaid agencies with their delivery system reforms at all stages along the implementation continuum. Each IAP track's goals and technical assistance were calibrated to address states' needs in one or more implementation stages. Coaches across the IAP areas noted the importance of "meeting states where they are."
- State teams gained actionable knowledge. State teams in different IAP areas not only learned theory related to delivery system reforms, but also gained specific new knowledge that they could apply to activities such as: analyzing Medicaid data, developing value-based payment (VBP) methodologies, or developing Section 1115 demonstration waiver applications.
- State teams conducted delivery system reform activities along the implementation continuum. For example, teams in the "Learning" stage examined options for more-integrated delivery of Medicaid-covered services. In contrast, teams that had already considered a range of value-based payment options began to design and implement specific strategies.

[4] Throughout this report, we use "states" to include U.S. States, the District of Columbia, and U.S. territories.

[5] Throughout this report, we use the phrase "state teams" when we are presenting a majority or consensus view within an IAP cohort or track. We note mixed views by using terms such as "most" and "some" to illustrate the split in opinions. We use "one" or "a few" when presenting dissenting views that contrast with a majority opinion, or when a subset of state teams made more or less progress than the majority.

- State teams made small but discrete, concrete changes to their Medicaid programs consistent with the implementation stage at which they engaged with the IAP's technical assistance. State teams made changes to their operations, policies, and payment methodologies.
- Most state teams are continuing the delivery system reform efforts they started during the IAP technical assistance period. Teams continue to collect and analyze Medicaid data, and a few state teams developed pilot delivery system reforms during the IAP which they are now testing.
- State teams developed skills and tools for both program improvement and project management that they can adapt and continue to apply both to the projects they began during the IAP support period and to new delivery system reform efforts. For example, teams in several tracks realized the value of driver diagrams and action plans as early steps for defining project goals and communicating about project measures with stakeholders.
- State teams continued to build on relationships they had forged through the IAP within and across agencies in a single state, as well as across states. Some IAP tracks required Medicaid agencies to engage partners from other agencies or outside of state government as a condition of IAP participation. Other IAP tracks encouraged departments within the Medicaid agency to work together in new ways. In both cases, state teams have sustained relationships they built through the IAP, and continue to draw on those connections to further ongoing reform efforts.
- Some state teams faced challenges in fully participating in IAP activities and implementing what they learned through the IAP. In some cases, teams lacked staff with the appropriate skills to benefit from IAP targeted support, or decision-makers empowered to authorize delivery system reform activities. In addition, contextual shifts such as state budgets and turnover among elected and appointed officials influenced state reform priorities. Finally, state teams faced constraints on legal and financial resources to implement delivery system reforms they had developed through the IAP.

CONCLUSIONS

The IAP's technical assistance helped state teams progress toward their delivery system reform goals. IAP coaching and tools offered unique resources that were not otherwise readily available. The IAP helped build state officials' knowledge base and skills related to delivery system reform efforts. The IAP also provided a platform for state officials to build relationships within and across state agencies that could foster future reforms as state contexts continue to evolve.

Chapter 1: Introduction

Medicaid programs serve a diverse array of beneficiaries, some with complex needs, multiple chronic conditions, severe disabilities, or co-occurring behavioral and physical health conditions. These subpopulations account for a disproportionate share of Medicaid costs, and pose the greatest challenges to states in delivering coordinated, cost-effective care to achieve quality outcomes. Addressing these challenges requires innovations in the financing and delivery of care to meet the specific and often multi-dimensional needs of these beneficiaries.

Beginning in 2014, the CMS provided technical assistance and technical resources to state Medicaid programs through the IAP, to assist with their ongoing payment and delivery system reform efforts. The IAP did not provide direct financial support to states. The goals of the IAP were to improve the health and health care of Medicaid beneficiaries and to reduce costs by supporting states' ongoing payment and delivery system reforms through targeted technical assistance.[6] The IAP provided individual support to state teams, cross-state learning opportunities, and national dissemination of lessons learned and best practices to support Medicaid payment and delivery system innovations. CMS directed this nonfinancial support toward key content and technical areas identified as priorities by CMS leaders, state agency representatives, and other stakeholders.

The IAP addressed four program areas:

- Reducing Substance Use Disorders
- Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs
- Promoting Community Integration through Long-Term Services and Supports
- Supporting Physical and Mental Health Integration

The IAP also provided support in four functional areas intended to serve as levers in furthering Medicaid reform:

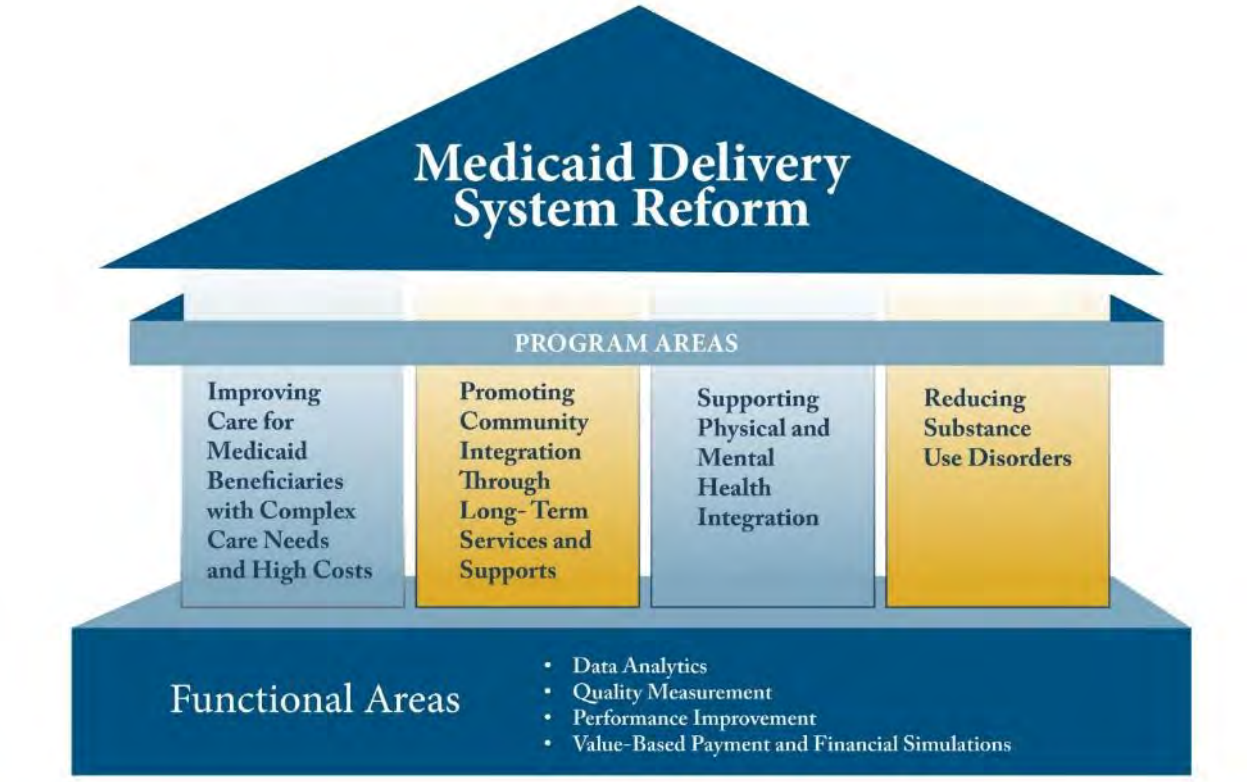
- Data Analytics
- Value-Based Payment and Financial Simulations
- Performance Improvement
- Quality Measurement

Following are two exhibits that illustrate the structure of the IAP. Exhibit 1.1 graphically represents the relationship among the IAP program and functional areas. Exhibit 1.2 details the technical assistance tracks that fall under each program and functional area. The IAP engaged state teams directly in all four program areas and in the Data Analytics and Value-Based Payment and Financial Simulations functional area activities. In addition, state teams participating in Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs, and some tracks within the Promoting Community Integration Through Long-Term Services and Supports and Value-Based Payment and Financial Simulations areas, received direct performance

[6] The CMS website describes the goals, background, and details of the IAP. https://innovation.cms.gov/initiatives/miap/ Accessed 4/8/2020.

improvement (PI) support to develop driver diagrams.[7] Through the Quality Measurement functional area[8], the IAP also developed or refined quality measures related to each of the program area topics.[9]

Exhibit 1.1. IAP Program and Functional Areas



Source. CMS

[7] A driver diagram is a visual display or roadmap of the theory of what drives achievement of a project aim (see Appendix A).

[8] Because the IAP did not select a group of states to engage directly in this area, QM was not included in the evaluation.

[9] The Medicaid.gov website describes the functional areas including Quality Measurement. https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-functional-areas/index.html

Exhibit 1.2. IAP Technical Assistance Tracks within Each Program and Functional Area (through September 2019)

Program Area	Technical Assistance Tracks
Reducing Substance Use Disorders	• High-Intensity Learning Collaborative • Targeted Learning Opportunities • Data Analytics Cohort • Opioid Data Dashboards Flash track
Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs	• *This program area did not have any subdivisions during the evaluation period.*
Supporting Physical and Mental Health Integration	• Physical and Mental Health Integration Group • Integration Strategy Workgroup
Promoting Community Integration through Long-Term Services and Supports	• Medicaid Housing-Related Services and Partnerships Component - Supporting Housing Tenancy - State Medicaid-Housing Agency Partnerships (Cohorts 1, 2) • Value-Based Payment for Home and Community-Based Services Component - Planning a Value-Based Payment for Home and Community-Based Services Strategy - Implementing a Value-Based Payment for Home and Community-Based Services Strategy - Designing a Value-Based Payment for Home and Community-Based Services Strategy
Functional Area	**Technical Assistance Tracks**
Data Analytics	• Medicare-Medicaid Data Integration • Data Analytics Technical Support (Cohorts 1, 2)
Value-Based Payment and Financial Simulations	• Value-Based Payment and Financial Simulations Technical Support (Cohorts 1, 2) • Maternal and Infant Health Initiative Value-Based Payment Technical Support • Children's Oral Health Initiative Value-Based Payment Technical Support

OVERVIEW OF IAP ACTIVITIES

IAP State Selection Process

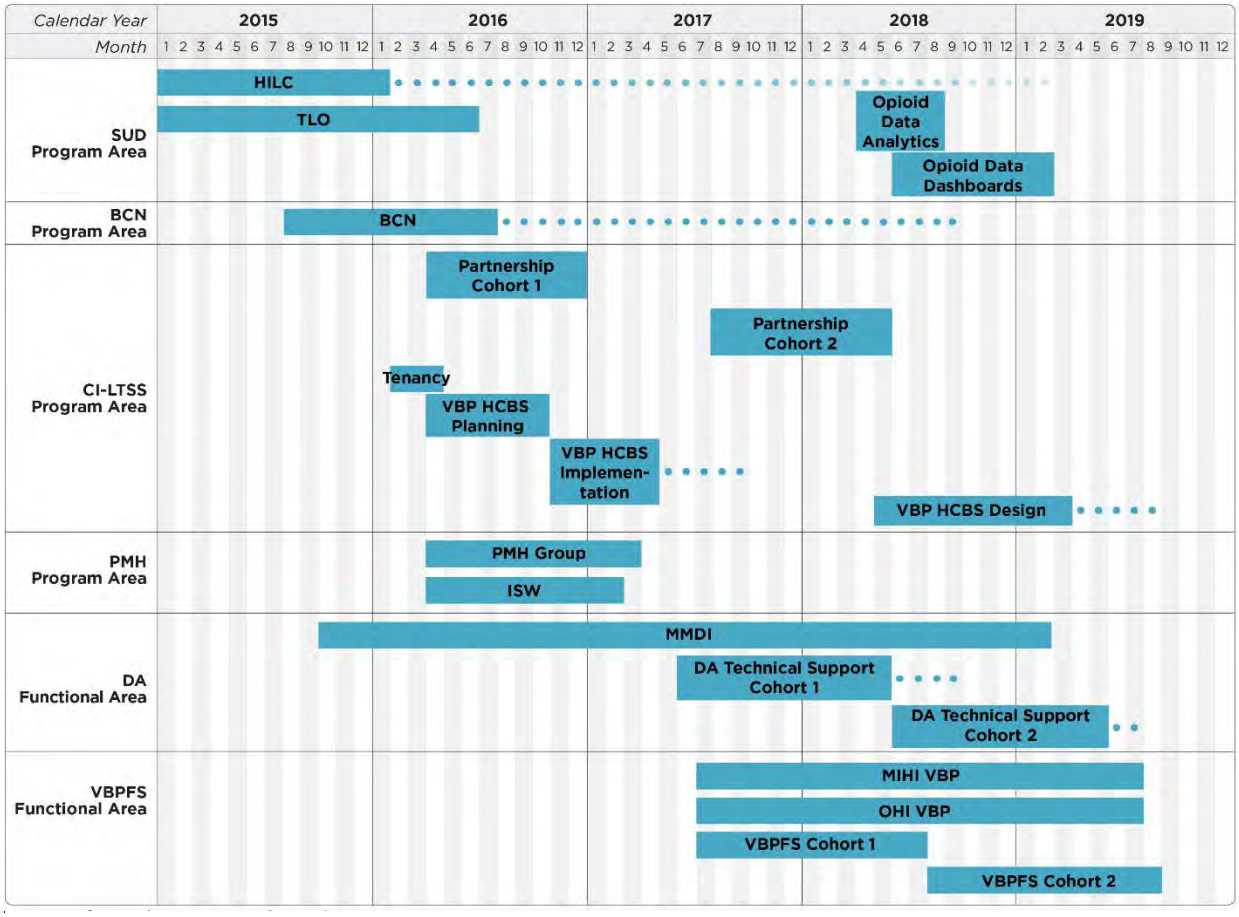
CMS publicized IAP technical assistance opportunities through Medicaid.gov, webinars, and emails to state Medicaid programs. IAP support was available to state Medicaid programs through a brief application process. Interested Medicaid programs submitted Expression of Interest (EOI) forms in response to specific IAP opportunities. CMS then held conference calls with each interested state team to gather more information about that state's needs and readiness for reform, and to answer questions about IAP participation. CMS chose state teams to participate in each program or functional area based on tailored selection criteria. State teams could participate in one or more IAP program and functional areas.

Timeline and Geographic Reach of IAP Support Opportunities

The support opportunities provided by CMS through the IAP varied in focus, length, and intensity. Most of the program and functional areas offered multiple tracks of support. Exhibit 1.3 illustrates the implementation timeline of each of the tracks in the IAP program and functional areas. The map in Exhibit 1.4 shows the total

number of IAP program and functional areas that each state team joined from the inception of the IAP through September 2019[10].

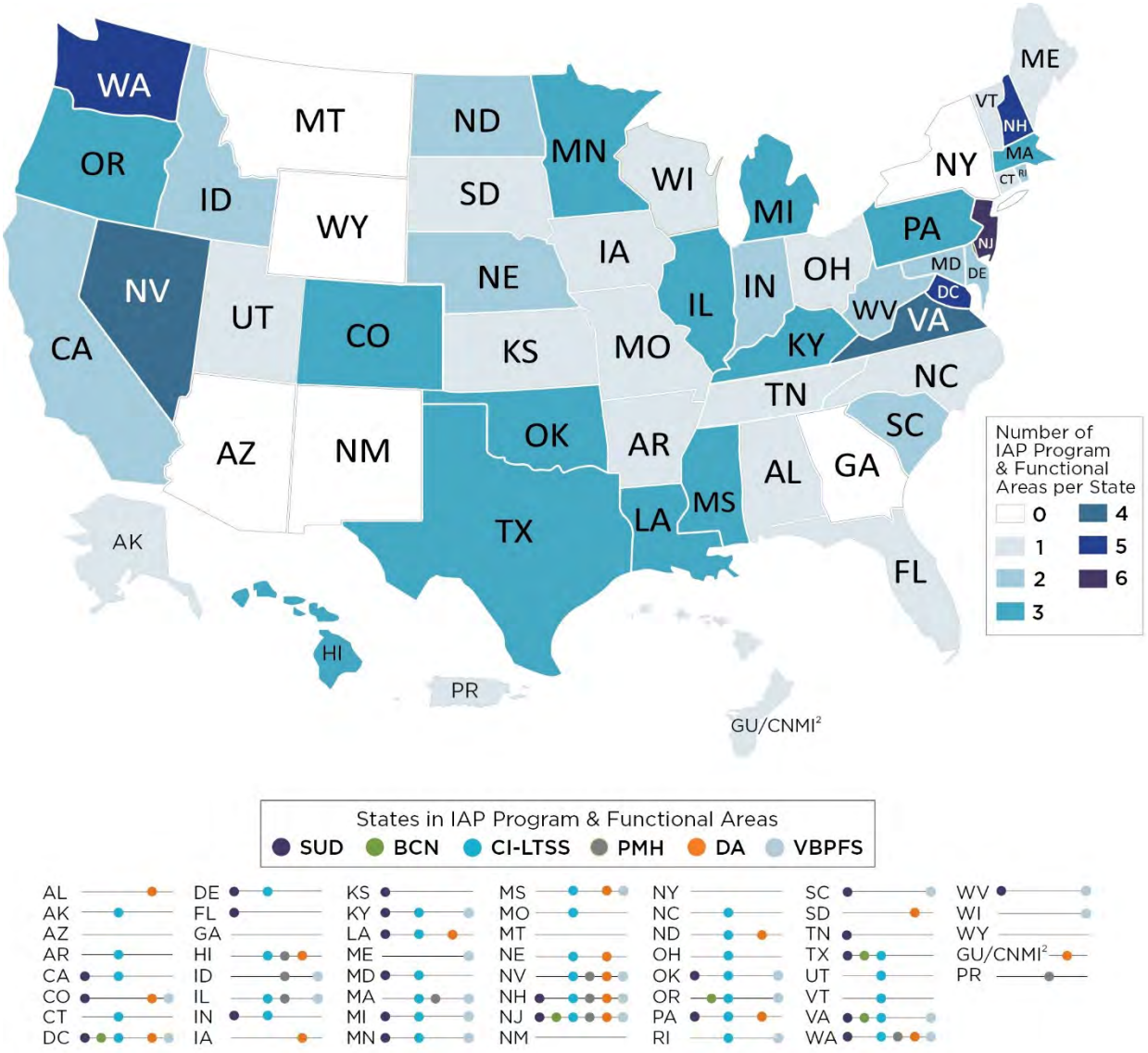
Exhibit 1.3. Timeline of IAP Program and Functional Area Technical Assistance Tracks Included in the Evaluation



Note. Dotted lines refer to unstructured periods; SUD=Reducing Substance Use Disorders; HILC=High-Intensity Learning Collaborative; TLO=Targeted Learning Opportunities; BCN=Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs; CI-LTSS=Promoting Community Integration through Long-Term Services and Supports; Partnership=State Medicaid-Housing Agency Partnerships; Tenancy=Supporting Housing Tenancy; VBP HCBS=Value-Based Payment for Home and Community-Based Services; PMH=Supporting Physical and Mental Health Integration; ISW=Integration Strategy Workgroup; DA=Data Analytics; MMDI=Medicare-Medicaid Data Integration; VBPFS=Value-Based Payment and Financial Simulations; MIHI VBP=Maternal and Infant Health Initiative VBP Technical Support; OHI VBP=Children's Oral Health Initiative VBP Technical Support.

[10] In some IAP areas, new cohorts and/or tracks were added after the evaluation period ended because the IAP continued through September 2020. Cohorts not included this report are: the Reducing Substance Use Disorders Data Dashboard track Cohort 2 and Medication-Assisted Treatment Affinity Group; the Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs Using Data Analytics to Better Understand Medicaid Populations with Serious Mental Illness track; the Promoting Community Integration through Long-Term Services and Supports Housing Partnership track Cohort 3 and Value-Based Payment for Fee-for-Service Home and Community-Based Services track; the Data Analytics Technical Support track Cohorts 3 and 4; the Value-Based Payment and Financial Simulations track Cohort 3; and the Strengthening Partnerships while Developing Data Analytic Capacity to Support Reduction of Maternal Mortality and Severe Maternal Morbidity in Medicaid Technical Assistance.

Exhibit 1.4. Geographic Reach of IAP Program and Functional Areas during the Evaluation Period[1]



Note. SUD=Reducing Substance Use Disorders; BCN=Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs; CI-LTSS=Promoting Community Integration through Long-Term Services and Supports; PMH=Supporting Physical and Mental Health Integration; DA=Data Analytics; VBPFS=Value-Based Payment and Financial Simulations. Throughout this report, we use "states" to include U.S. States, the District of Columbia and U.S. territories.

[1] SUD TLO states are not included in these totals since all 50 states were welcome to attend the open series of webinars. PI and QM functional area participation also is not shown, as state teams were not selected for participation through an application process. PI offered support through other IAP areas; QM did not directly engage state teams.

[2] Guam and the Commonwealth of the Northern Mariana Islands (GU/CNMI) worked as one team.

MODES OF TECHNICAL ASSISTANCE

Technical assistance offered by the IAP included group learning for cohorts of state teams around common themes and challenges as well as, for most tracks, individual assistance provided to each state team. The various modes of technical assistance are defined in Exhibit 1.5. Each of the six IAP program and functional areas provided technical assistance using some combination of these modes. Each IAP program and functional

area also made tools and resources developed through the IAP available to all state Medicaid agencies regardless of their IAP participation.[11]

Exhibit 1.5. Technical Assistance Modes Offered Through the IAP

Mode Name	Description
Group Learning Activities	
Webinar	Online forums that featured expert presentations and discussion between participants and the expert.
Peer learning group	Planned discussions among participants structured or moderated by a facilitator and conducted using web technology or by telephone.
In-person meeting	An in-person meeting that convened participants from multiple states together with experts to receive information and conduct project planning activities.
Email update	Resources provided to participants via email updates (which were also stored on Groupsite).
Online materials library (Groupsite)	Resources for participants posted in a virtual library (which were also distributed via email).
Individual Learning Activities	
Coaching	In-person or virtual meetings with a dedicated technical assistance provider. The coach was an expert or provided introductions to experts.
Access to subject matter experts[12]	Subject matter experts, in addition to coaches, who provided state teams with tailored materials and answered questions.
Access to performance improvement subject matter experts	Subject matter experts, in addition to coaches, who provided state teams with tailored materials and answered questions specifically related to performance improvement.
Site visit	Site visits bringing together the state team, other stakeholders, the coach, and appropriate subject matter experts for a half-day to multi-day workshop.
Project management tools	Project management tools (i.e., work plans or action plans) to help participants track the progress of a project.
Performance improvement tools	Driver diagrams to help participants define project aims and understand the factors that contribute to achieving these aims.

Note. SUD=Reducing Substance Use Disorders; BCN =Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs; CI-LTSS=Promoting Community Integration through Long-Term Services and Supports; PMH=Supporting Physical and Mental Health Integration; DA=Data Analytics; VBPFS=Value-Based Payment and Financial Simulations.

IAP EVALUATION

CMS contracted with Abt Associates to conduct an independent evaluation that assessed participants' experiences with the IAP. The evaluation informed ongoing modification and enhancement of the IAP. The

[11] IAP tools and resources are summarized in Appendix B and are available from CMS at https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/index.html.

[12] In addition, the Office of the National Coordinator for Health Information Technology (ONC) provided limited support to some IAP areas. However, the support provided by ONC was not captured by this evaluation.

evaluation did not assess the performance of state teams receiving technical assistance through the IAP, or the capabilities of technical assistance providers working with the IAP participants. Our evaluation used a qualitative research approach, supplemented with descriptive statistics obtained through web-based surveys. The IAP's target population was state stakeholders (i.e., Medicaid agencies and their partners) who received technical assistance and access to resources under one or more of the IAP program or functional areas. We conducted one-on-one interviews and focus group discussions with state participants and coaches. In most cases, interviews and focus groups were conducted by telephone. We also observed and recorded notes on in-person and virtual (e.g., webinars) IAP group events. Details of our evaluation design and data collection methods can be found in Appendix C. Data collection tools are reproduced in Appendix D.

The findings focus on state participants' responses to the IAP and the results of their participation in the program. The evaluation addressed the following specific research questions. Detailed findings by area and track can be found in Chapter 4.

- Did the IAP offer the technical assistance that state teams were seeking?
- What knowledge did participants acquire from the IAP?
- What Medicaid program activities did state teams undertake as a result of participating in the IAP?
- What happened as a result of participation in the IAP?
- What barriers, if any, reduced the impact of participation in the IAP?
- How did the IAP support any ongoing reforms?

FINAL REPORT

This final report provides the results of our evaluation of participants' experiences with the IAP. The report encompasses our findings from the four IAP program areas and two IAP functional areas in which state teams were actively engaged at some point from the inception of the program in 2014 through the end of the evaluation period in September 2019.

The next chapter, Key Findings, describes how the IAP provided support to state teams, and discusses the barriers that reduced the impact of the IAP support. Chapter 3, Lessons Learned about Designing Technical Assistance to Respond to State Needs, explores the challenges faced in delivering technical assistance, and presents promising practices that gave state teams the assistance they were seeking in moving forward on delivery system reform. Chapter 4, Delivery System Reform Activities by IAP Program and Functional Area, expands on the experiences of participants in each of the IAP's program and functional areas. This chapter is divided into six sections, corresponding to the four program areas and two functional areas that received direct technical assistance. Appendix A describes the IAP Performance Improvement activities; Appendix B provides IAP resources; Appendix C presents the evaluation framework and methods; and Appendix D presents the generic data collection tools used in the evaluation.

Throughout this report, the word "state" applies to the 50 states' Medicaid agencies as well as Medicaid agencies in the District of Columbia and the U.S. territories. The word "coach" refers to individuals who provided or coordinated individual support to IAP state teams, although the teams themselves may have referred to these people by a variety of titles. We use the phrase "state teams" when presenting a majority or consensus view within an IAP cohort or track. We note mixed views by using terms such as "most" and "some" to illustrate the split in opinions. We use "one" or "a few" when presenting dissenting views that contrast with a majority opinion, or when a subset of state teams made more or less progress than the majority.

Chapter 2: Key Findings

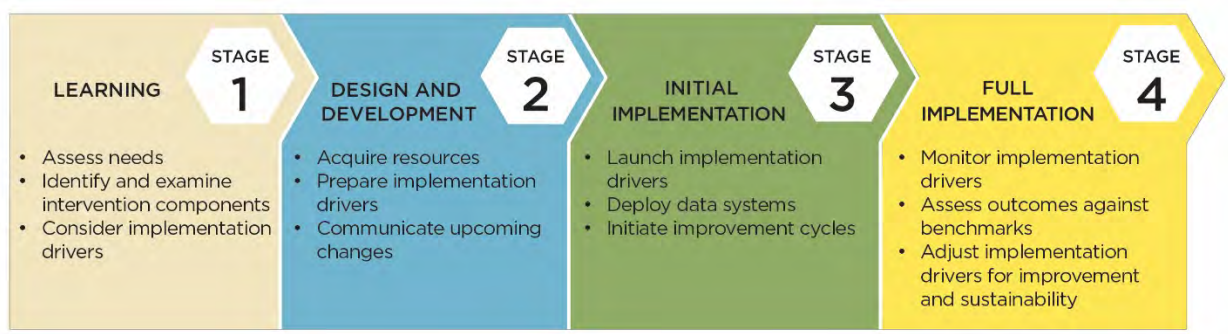
New program implementation, or the adoption of innovations in an existing program, is a multi-stage process. The IAP's technical assistance helped state teams design and implement Medicaid innovations at different stages of their delivery system reform implementation efforts (see Exhibit 2.1).

The IAP defined overall success by three criteria:

- Has participation in IAP led to increased delivery system reform in the IAP areas?
- Has IAP increased states' capacity to make substantial improvements in better care, smarter spending, and healthier people?
- Has IAP built states' capacity in data analytics, quality measurement, performance improvement, payment modeling, and financial simulations?

Each IAP track's goals and technical assistance activities were calibrated to address states' needs in one or more implementation stages. Coaches across the IAP areas noted the importance of "meeting states where they are." Staffing challenges, state context, and resource constraints sometimes impeded states' progress along the continuum. Technical assistance cannot overcome all of these barriers; however, technical assistance providers can be aware of how they may affect intended outcomes, and develop strategies to mitigate some barriers.

Exhibit 2.1. Implementation Stages



Note. Adapted from Betram, RM. Program Implementation Frameworks. Encyclopedia of Social Work. National Association of Social Workers and Oxford University Press USA, 2014.

What knowledge did participants acquire from the IAP?

State teams gained actionable knowledge through their participation in the IAP.

State teams in the different IAP areas not only learned theory related to delivery system reforms, but also gained specific new knowledge that they could apply immediately to making improvements in their state Medicaid programs. For example:

- State teams in the Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs area learned how to define high-need and high-cost beneficiaries in various contexts relevant to their state, and how to apply risk stratification methods to characterize their Medicaid populations.

- State teams in the Reducing Substance Use Disorders area gained insight into Substance Use Disorders (SUD) treatment services and expected use of these services among Medicaid-eligible populations.
- State teams in the State Medicaid-Housing Agency Partnership track increased their awareness of housing tenancy support models and evidence-based practices for supportive housing.
- Teams in the Physical and Mental Health Integration Group track acquired knowledge of alternative payment methodologies, quality measurement for high-need populations. A participating state team used knowledge learned from IAP to address the integration of telemedicine into children's behavioral health settings.
- Participants in the Medicare-Medicaid Data Integration track learned about the process and documentation required to request Medicare data from CMS.
- State teams participating in the Maternal and Infant Health Initiative Value-Based Payment Technical Support track learned about protocols for screening women for risk factors during the prenatal and postpartum period.

> "[Our] work … helped us focus in on particular areas to develop more detailed policy, to target performance measures, and to implement contract changes."
>
> ~ IAP STATE PARTICIPANT

What Medicaid program activities did state teams undertake as a result of participating in the IAP?

State teams conducted delivery system reform activities along the implementation continuum.

The activities state teams conducted with IAP support varied along the implementation continuum. For example, in the Integration Strategy Workgroup track, states in Stage 1 examined options for integrating physical and mental health services. In contrast, the Value-Based Payment for Home and Community-Based Services component of the Promoting Community Integration through Long-Term Services and Supports area was designed to help state teams that had already considered a range of VBP options design and implement specific strategies. Some IAP tracks addressed more than one implementation stage. Some state teams moved through multiple stages while others conducted activities within one stage. None of the participating IAP states reached Stage 4: Full Implementation during the evaluation period.

As shown in Exhibit 2.2, 15 of the 17 IAP tracks included activities targeted at Stage 1: Learning. Example activities in Stage 1 included:

- One state team in the State Medicaid-Housing Agency Partnership track gained a better technical understanding of when and how to leverage Medicaid funding and services when working with beneficiaries at risk of experiencing homelessness.
- One team in the Data Analytics Technical Support track learned both how to use a new health data visualization tool and how the state's data could be best displayed on that tool's dashboard.
- One team in the Value-Based Payment and Financial Simulations Technical Support track learned how to better engage with and maximize feedback from state stakeholders, and incorporated that feedback into the state's financing strategies.

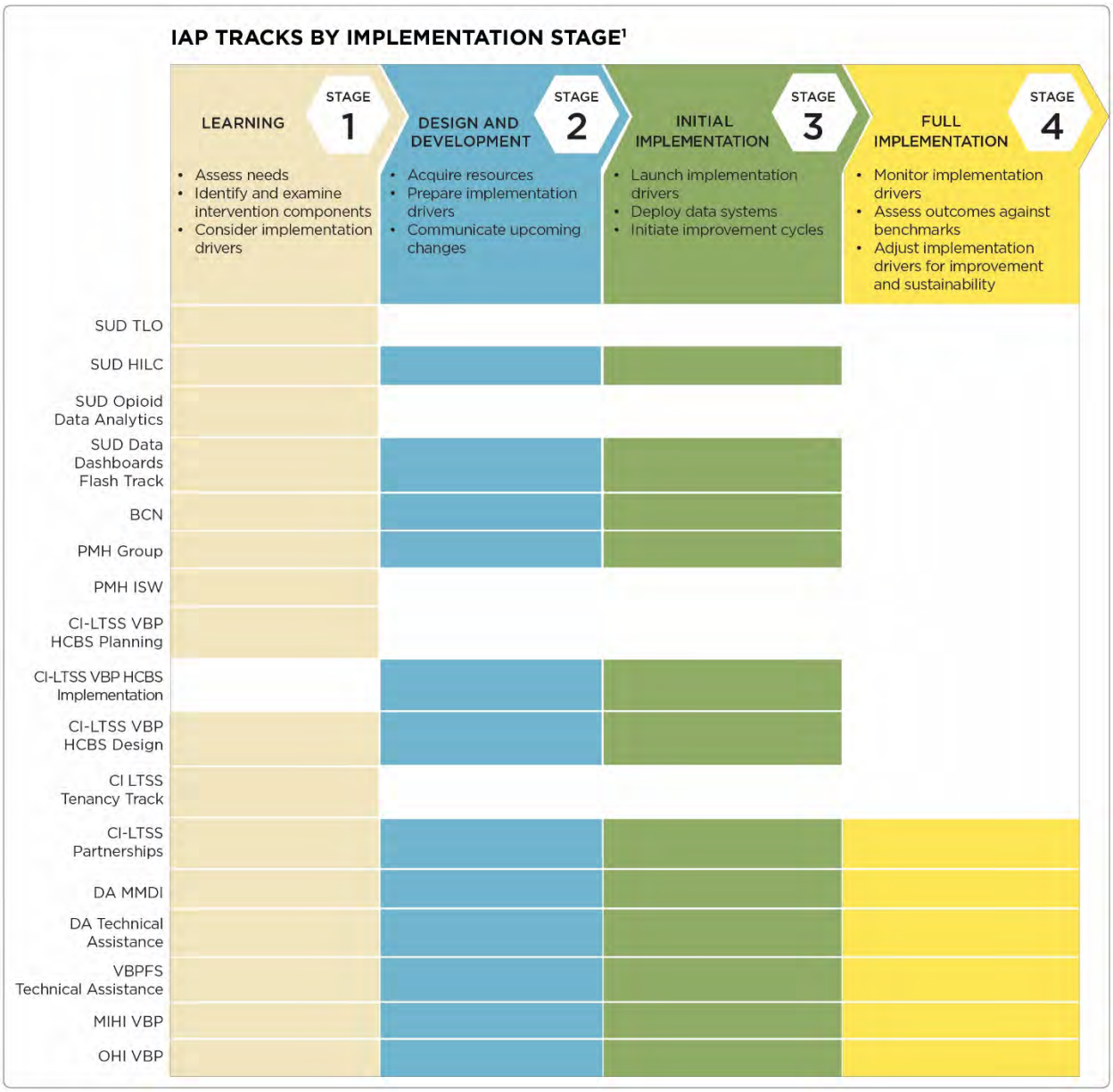
Twelve of the 17 IAP tracks included technical assistance to assist state teams with activities in Stage 2: Design and Development. Example activities in Stage 2 included:

- One Medicaid-Housing Agency Partnership track state team used the information they gathered from IAP participation in the subsequent drafting of a Section 1115 waiver demonstration application.
- A Physical and Mental Health Group track state team used a review of potential tele-psychiatry activities (created by their IAP coach) to inform their development of telehealth performance measures.
- One Opioid Data Analytics track state team used the dashboard data they developed during IAP participation to drive the creation of their applications for subsequent CMMI models (e.g., Integrated Care for Kids, Maternal Opioid Misuse).

Twelve of the 17 IAP tracks included the option to assist state teams with Stage 3: Initial Implementation. While projects did not always progress to this stage, some teams began implementation of their delivery system reform efforts toward the end of their IAP support periods. Example activities in Stage 3 included:

- One Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs state team launched a health home program heavily informed by technical assistance received through IAP coaching.
- One state team participating in the Medicare-Medicaid Data Integration track began implementing new data sharing requirements with their managed care organizations (MCOs).
- A state team participating in the Value-Based Payment and Financial Simulations Technical Support track updated their MCO contract language to reflect new VBP requirements.

Exhibit 2.2. IAP Tracks by Implementation Stages



Note. SUD=Reducing Substance Use Disorders; TLO=Targeted Learning Opportunities; HILC=High-Intensity Learning Collaborative; BCN=Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs; PMH=Supporting Physical and Mental Health Integration; ISW=Integration Strategy Workgroup; CI-LTSS=Promoting Community Integration through Long-Term Services and Supports; VBP HCBS=Value-Based Purchasing for Home and Community-Based Services; Partnerships=State Medicaid-Housing Agency Partnerships; Tenancy=Supporting Housing Tenancy; DA=Data Analytics; MMDI=Medicare-Medicaid Data Integration; VBPFS=Value-Based Payment and Financial Simulations; MIHI VBP=Maternal and Infant Health Initiative VBP Technical Support; OHI VBP=Children's Oral Health Initiative VBP Technical Support. [1] This graphic depicts how CMCS structured the tracks to engage states at different levels, or stages, of health reform implementation. It does not depict whether states moved forward on the continuum during the IAP (Adapted from Bertram, 2014).

What happened as a result of participation in the IAP?

State teams made discrete changes to their Medicaid programs based on their participation in the IAP.

As of the writing of this evaluation report, state teams had made small but concrete changes to their Medicaid programs consistent with the implementation stage at which they had engaged with the IAP's technical assistance. State teams made changes to their operations, policies, and payment methodologies.

Examples of operational changes included:

- One Physical and Mental Health Group track state team developed and began implementing a new performance measure related to follow-up after hospitalization for mental illness.
- One Medicare-Medicaid Data Integration track state team developed and implemented a new algorithm using their state datasets to attribute physicians to beneficiaries.

Examples of policy changes included:

- One High-Intensity Learning Collaborative track state team outlined benchmarks for SUD treatment benefit penetration to inform the state legislature's review of outcomes and costs related to the Medicaid SUD benefit package.
- One Implementing a Value-Based Payment for Home and Community-Based Services track state team added Managed Long-Term Services and Supports (MLTSS) contract language that identifies priority subpopulations on which MCOs should focus in delivering coordinated, cost-effective care.

Examples of payment methodology changes included:

- One Maternal and Infant Health Initiative Value-Based Payment Technical Support track state team established a new billing code for opioid use disorder (OUD) screening to track OUD in claims data and provide reimbursement to providers.
- One Implementing a Value-Based Payment for Home and Community-Based Services track state team announced that it will allow its Medicaid accountable care organizations (ACOs) to be reimbursed for housing support services beginning in 2020.

What barriers, if any, reduced the impact of participation in the IAP?

Some state teams were less well matched than others to the intended IAP activities.

State teams struggled at times to achieve optimal IAP team composition. In some cases, the selected team members lacked the appropriate skills (e.g., data analysis) to benefit from IAP technical assistance. In other cases, teams lacked decision-makers empowered to authorize delivery system reform activities. In these instances, projects were delayed while teams sought buy-in from agency leadership. Finally, some state teams struggled to balance IAP participation with their regular duties. One state participant noted, "We missed a couple of opportunities to get technical assistance … because of our own internal demands from our executive team. There was misalignment from our end."

The state context within which IAP projects took place sometimes shifted.

Each state's delivery system reform priorities were shaped by many forces beyond the control of the state Medicaid agency staff who participated in the IAP. Turnover in elected and appointed officials in the executive and legislative branches of state government impacted the overall emphasis given to delivery system reforms. Some teams experienced staff turnover as individuals left the Medicaid agency or were reassigned to new

priorities. Staff turnover slowed progress on delivery system reform efforts and sometimes caused IAP priorities to be redirected. In addition, state budgets affected health care delivery system priorities. Finally, the perspectives of stakeholders and advocates outside state government influenced reform priorities. These contextual shifts sometimes caused state teams to shift the focus of their IAP projects. As one participant commented, "We have such limited staff resources here, when something isn't a key priority, it is hard for us to keep pursuing it."

State teams faced ongoing challenges involving legal and financial resources to implement delivery system reforms they had developed through the IAP.

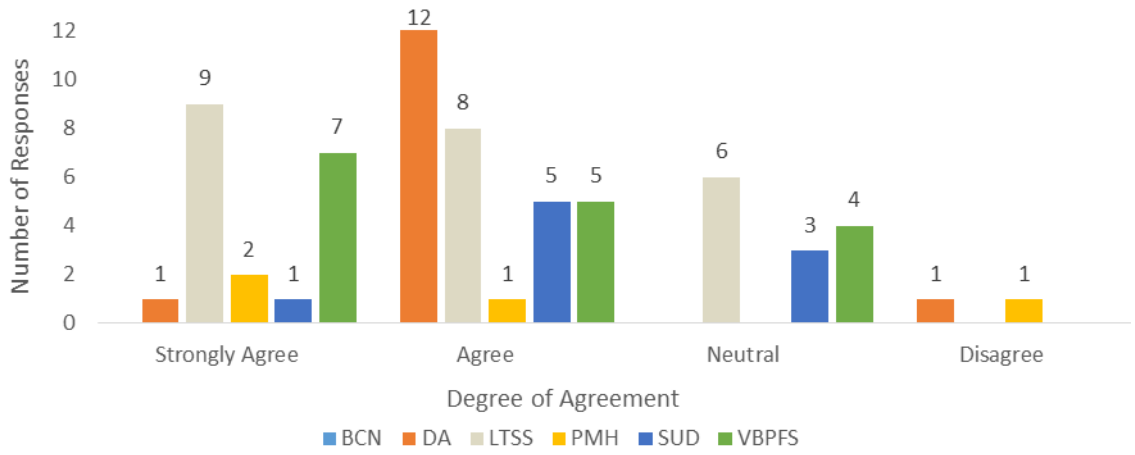
Many state delivery system reforms require approval of the state legislature and/or the federal government. Some IAP state teams applied for Medicaid waivers to implement the delivery system reforms developed through the IAP, requiring time for approvals and possible revisions to the original plans. At times, the delivery system reform proposals generated by IAP state teams required state financial resources for full implementation. State teams needed to demonstrate the cost-effectiveness of their proposed reforms to state decision-makers in order to secure funds and authorization to proceed.

How did the IAP support any ongoing reforms?

Most state teams are continuing the delivery system reform efforts they started during the IAP technical assistance period.

Across IAP tracks, most IAP participants (51 of 66 respondents) agreed or strongly agreed that they have sustained the delivery system reform efforts begun during the IAP (see Exhibit 2.3).

Exhibit 2.3. IAP Participants' Self-Reported Ability to Sustain Delivery System Reform Efforts Begun during the IAP (n=66 respondents[1])



Note. [1]The 66 respondents represented 26 states.

State teams developed skills in performance improvement and project planning and management that they can apply to ongoing reform efforts.

State participants developed skills and tools for data collection and analysis that they can adapt and continue to apply both to the projects they began during the IAP support period and to new delivery system reform efforts. For example:

- State teams in several tracks realized the value of driver diagrams and action plans as early steps for defining project goals and communicating about project measures with stakeholders. As one participant in the Implementing a VBP for HCBS Strategy track noted, "The action plan was a new process, but once I got familiar with it, it helped my work with our group in identifying gaps in completing tasks. As I got more comfortable with the process, [I] was able to make sure we were hitting all the marks."
- Teams in the Data Analytics Technical Support track developed work plans, and participants in the Data Analytics, Medicare-Medicaid Data Integration track collaborated with IAP coaches to draft and refine use cases.
- Teams in the Integration Strategy Workgroup track received technical assistance memos summarizing key takeaways for each state from the expert webinar presentations.

State teams continued to build on relationships they forged through the IAP within and across agencies in a single state, as well as across states.

Some IAP tracks (e.g., State Medicaid-Housing Agency Partnerships and Maternal and Infant Health and Children's Oral Health Initiative Technical Support) required Medicaid agencies to engage partners from other agencies or outside of state government as a condition of IAP participation. Other IAP tracks encouraged departments within the Medicaid agency to work together in new ways. In both cases, state teams have sustained the relationships they built through the IAP, and have drawn on those connections to further their ongoing reform efforts. At least 19 states have contacted teams from another state they met through the IAP outside of the structured IAP support activities.

"We had a small discussion with [another state] after [an in person meeting] to ask detailed questions to inform the work we're doing. … We tapped into their knowledge and had several follow-up conversations."

~ IAP STATE PARTICIPANT

"Through IAP, we've been able to create a core group of 'worker bees' from Medicaid and behavioral health agencies. When we come to an interagency consensus amongst ourselves, we can go to the higher ups. … Building this cross-agency interaction is another outcome of IAP."

~ IAP STATE PARTICIPANT

CONCLUSION

The IAP's technical assistance helped state teams progress toward their delivery system reform goals. IAP coaching and tools offered unique resources to state teams that were not otherwise readily available. The IAP helped build state officials' knowledge base and skills related to delivery system reform efforts. The IAP also provided a platform for teams to build relationships within and across state agencies that could foster future reforms as state contexts continually evolve.

Chapter 3: Lessons Learned About Designing Technical Assistance to Respond to State Needs

The IAP experimented with how best to offer the technical assistance that state teams were seeking. The IAP tried out various technical assistance delivery modes, lengths of support, coaching team compositions, and groupings of state agencies across the IAP areas and tracks. This chapter explores the challenges faced in delivering technical assistance, and presents promising practices that gave state teams the assistance they were seeking in moving forward on delivery system reform. These lessons learned likely apply broadly to the CMS and to other federal government programs that assist state agencies seeking to improve their operations through program and policy reforms.

LESSONS LEARNED ABOUT THE IAP'S TECHNICAL ASSISTANCE MODES

The IAP employed various technical assistance modes in different combinations (see Exhibit 3.1). IAP participants provided feedback on which modes were most useful for helping them move toward delivery system reforms. IAP coaches offered suggestions for deploying each mode most effectively to offer state teams the technical assistance they are seeking to help them advance their Medicaid delivery system reforms.

Exhibit 3.1. Technical Assistance Modes Offered by the IAP

Mode Name	Description	IAP Areas That Used This Mode
Group Learning Activities		
Webinar	Online forums that featured expert presentations and discussion between participants and the expert.	BCN DA LTSS PMH SUD VBPFS
Peer learning group	Planned discussions among participants structured or moderated by a facilitator and conducted using web technology or by telephone.	BCN LTSS PMH SUD VBPFS
In-person meeting	An in-person meeting that convened participants from multiple states together with experts to receive information and conduct project planning activities.	BCN LTSS SUD
Email update	Resources provided to participants via email updates (which were also stored on Groupsite).	BCN DA LTSS PMH SUD VBPFS
Online materials library (Groupsite)	Resources for participants posted in a virtual library (which were also distributed via email).	BCN DA LTSS PMH SUD VBPFS

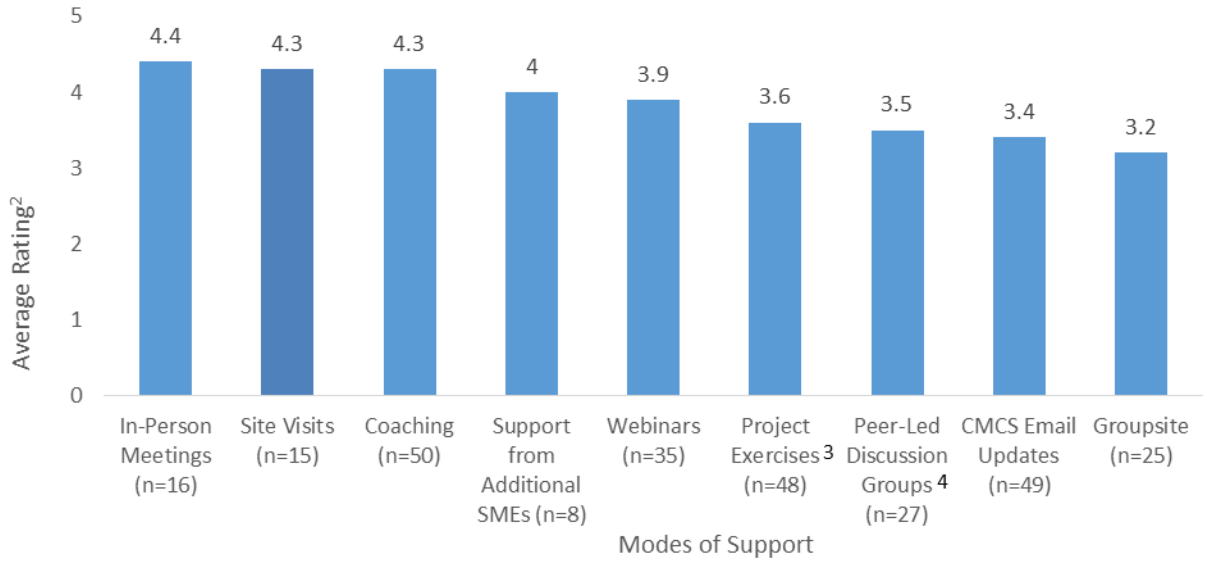
Mode Name	Description	IAP Areas That Used This Mode
Individual Learning Activities		
Coaching	In-person or virtual meetings with a dedicated technical assistance provider. The coach was an expert or provided introductions to experts.	BCN DA LTSS PMH SUD VBPFS
Access to subject matter experts	Subject matter experts, in addition to coaches, who provided state teams with tailored materials and answered questions.	BCN DA LTSS PMH SUD VBPFS
Access to performance improvement subject matter experts	Subject matter experts, in addition to coaches, who provided state teams with tailored materials and answered questions specific to performance improvement.	LTSS VBPFS
Site visit	Site visits bringing together the state team, other stakeholders, the coach, and appropriate subject matter experts for a half-day to multi-day workshop.	BCN DA LTSS VBPFS
Project management tools	Project management tools (i.e., work plans or action plans) to help participants track the progress of a project.	BCN DA LTSS SUD VBPFS
Performance improvement tools	Driver diagrams to help participants define project aims and understand the factors that contribute to achieving these aims.	BCN LTSS SUD VBPFS

Note. Abbreviations: SUD=Reducing Substance Use Disorders; BCN=Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs; CI-LTSS=Promoting Community Integration through Long-Term Services and Supports; PMH=Supporting Physical and Mental Health Integration; DA=Data Analytics; VBPFS=Value-Based Payment and Financial Simulations.

All modes of support were considered useful, with site visits and in-person meetings rated most useful by state participants (see Exhibit 3.2).

Site visits and in-person meetings were rated highest of all modes of support. The online resource library, Groupsite, while developed based on early state participant requests, was rated least useful overall, though one participant found it "really helpful [to] have a consolidated area for all of [the IAP area's] resources." Different modes of support within a technical assistance program work together to reinforce one another. For example, site visits can accelerate coaching progress; peer learning can help participants apply PI tools. Modes perceived as less useful overall that nevertheless help some participants may be "worth it" when the level of effort to add those modes to a technical assistance offering is low.

Exhibit 3.2. Participant Rating of Technical Assistance Modes (n=54 respondents)[1]



Note. [1]The 54 respondents represented 28 states. Each individual n=the number of respondents rating each mode. [2]Repondents were asked to rate each type of support on a 5-point Likert scale from 1 = least valuable to 5 = most valuable. [3]Project Exercises include completion of project management and PI tools. [4]Peer-Led Discussion Groups refer to planned, facilitated discussions among participants.

State participants and IAP coaches valued in-person meetings highly.

Though not always feasible, in-person meetings were highly valued by IAP participants and coaches. These meetings helped participants build connections both across states and within their own teams. State participants and coaches desired a mix of formal learning events and networking opportunities to achieve optimal value from in-person meetings. State participants rated the IAP in-person meetings, on average, a 4.4 out of 5. One state participant noted that the in-person meeting had "a different quality to it" than virtual meetings. A participant from another IAP program area similarly commented that the in-person meeting was "hugely beneficial" to their team.

Site visits can accelerate project progress.

Some IAP tracks included site visits during which coaches met in person with state teams. State participants valued these visits for advancing project activities and allowing creativity to flourish. Coaches noted that progress is made more quickly during one intensive site visit than when comparable activities are conducted virtually over multiple sessions.

To work effectively with state teams, coaches must remain flexible.

IAP participants provided positive feedback about the coaching they received, with an overall average rating of 4.3 out of 5. Coaches identified strategies that increased their effectiveness in assisting state teams:

- Coaches must understand each team's specific expectations and goals for IAP participation in order to adapt technical assistance to the state's needs. For their technical assistance to be effective, coaches must remain flexible to respond to teams' preferences.
- Coaches appreciated coming together with their counterparts within an IAP area, and suggested that additional lessons could be shared by coaches across IAP areas.
- Coaches valued convening in person meetings with teams from their assigned state and with other states and coaches working in their IAP area.

- Coaches encouraged IAP teams to reach out to one another outside of IAP-sponsored activities.

Subject matter experts can supplement coaches' expertise.

IAP participants bring widely divergent skills, background knowledge, and state contexts. IAP coaches must strike a balance between their dual roles: one as a program overseer, responsible for assisting participants with completing project planning tools; and a second as a substantive expert advisor or mentor, offering guidance and resources. Teams of subject matter experts who provided detailed topical resources and helped develop technical assistance strategies for individual state teams helped coaches fill both roles, and supplemented coaches' broad Medicaid expertise with their own detailed knowledge (e.g., of financial simulations or health information technology).

State participants preferred interactive, live webinars, also recorded for asynchronous viewing.

All of the IAP program and functional areas included webinars in which experts provided information and examples. These webinars were consistently well received and well rated by participants. Over time, CMS staff made adaptations to enhance accessibility and state participant engagement during webinars. These adaptations included: recording webinars to allow asynchronous viewing and wider distribution; adding polling questions to make webinars more interactive; and optional post-webinar discussions between a state team and the webinar presenter.

Project exercises, such as project management and performance improvement tools, need to be immediately applicable.

The IAP introduced state participants to a variety of performance improvement and project management tools, including driver diagrams that illustrate causal pathways, use cases that define information technology requirements, crosswalks[13] that compare Medicaid and housing agency resources, and work plans that specify project responsibilities and timelines. Participants' reviews of these tools were mixed, with average ratings of 3.6 out of 5. Most participants found the tools helpful, but some voiced frustrations with the time required to complete the tools. Others did not understand the immediate applicability of the tools to project implementation.

Peer learning was most effective when state participants received in advance materials that helped them prepare questions and discussion points.

CMS staff facilitated peer learning opportunities for state participants via webinars. State participants valued hearing from one another and appreciated having peers provide feedback and suggestions about their delivery system reform approaches. However, state participants were sometimes reluctant to speak spontaneously on calls and webinars. State participants appreciated receiving agendas, thought questions, or other probes in advance of peer discussions so that they could prepare additional questions and consider examples to share with their peers.

[13] The crosswalk, available at https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/program-areas/community-integration-ltss/index.html, maps out programmatic and funding information for currently available housing-related services.

Participants appreciated receiving resources by email, but could not always apply those resources to their projects.

State participants rated resource emails from CMS, on average, a 3.4 out of 5. Participants described these email updates as "very easy and helpful," "full of rich information," and "supplementing our [state's] learning." Participants scanned the updates and retrieved resources relevant to their state's delivery system reform efforts (e.g., clicking through to resource articles or signing up for webinars). IAP participants also forwarded relevant items to colleagues and supervisors.

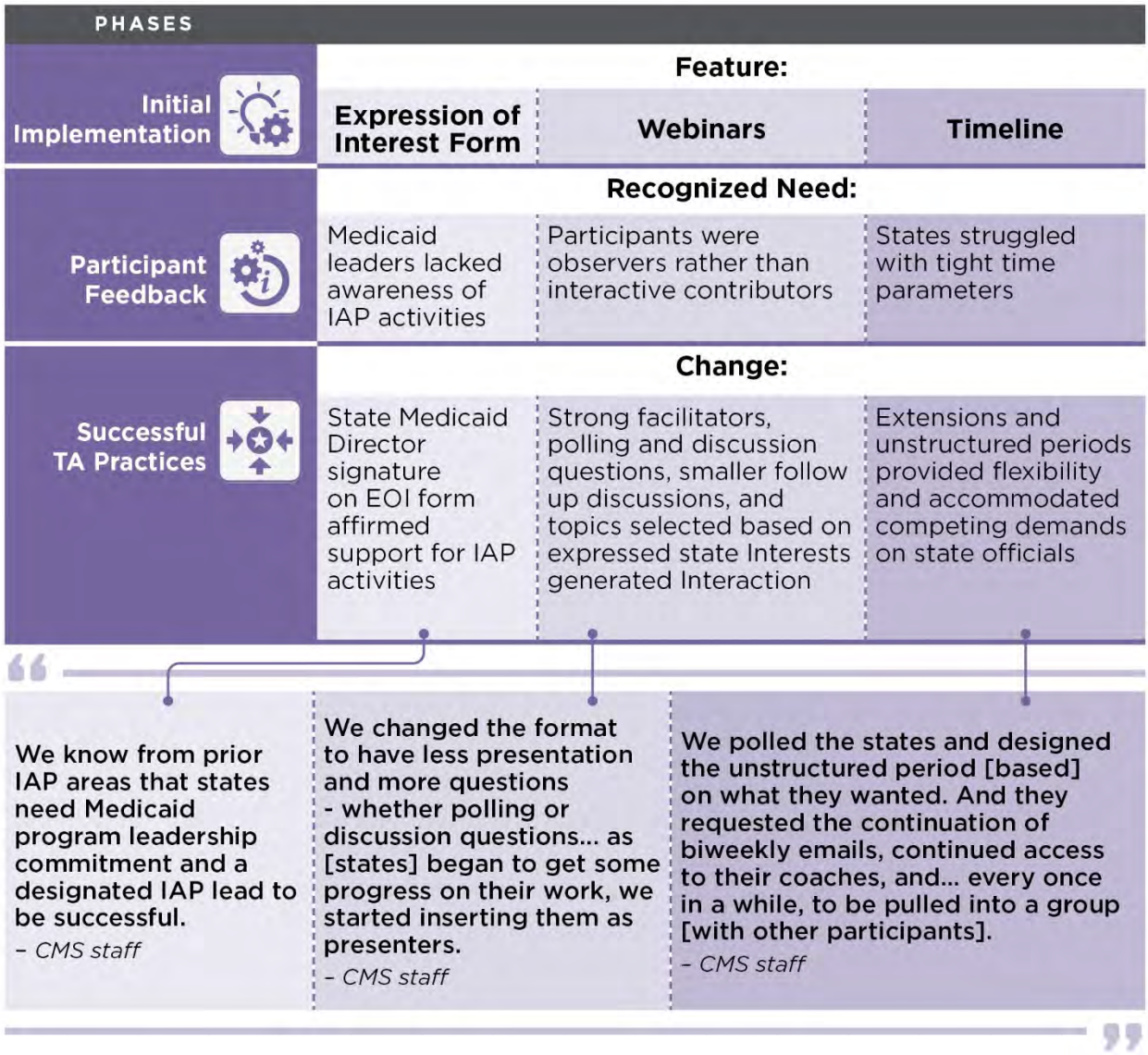
Most participants did not take advantage of the Groupsite online resource repository.

Though many IAP program and functional areas made resources available to state participants via the online resource repository Groupsite, the majority of participants used the website minimally or not at all. Participants cited limited time and difficulty logging into the site as barriers to use. Some participants found the repository helpful, and had downloaded materials from it, particularly when directed to Groupsite via a link in a CMS resource email.

CMS INCORPORATED LESSONS LEARNED ABOUT DESIGNING AND STRUCTURING TECHNICAL ASSISTANCE OPPORTUNITIES

CMS received feedback from IAP program participants, coaches, and the evaluation team throughout the evaluation, and adapted its technical assistance in response to that feedback. Overall, state participants agreed or strongly agreed that their feedback was obtained and incorporated into subsequent events within an IAP track. Exhibit 3.3 summarizes the adjustments that CMS made to the design and delivery of IAP technical assistance.

Exhibit 3.3. Evolution of IAP Technical Assistance



CMS incorporated specific lessons learned across the IAP areas and tracks.

- ***State teams should include both staff experts and key decision-makers in appropriate roles.*** Across IAP areas that launched in the early years of the program, some state teams lacked the authority or resources to carry out their IAP projects. To facilitate optimal team configurations, CMS staff revised EOI forms (short applications for IAP support) to explicitly articulate the expectations regarding team composition, including requiring Medicaid leadership to indicate support for the state's project by signing the EOI forms.
- ***Different forums work best for disseminating information versus discussing ideas.*** Webinars that feature an expert presenter are an efficient way to deliver content to a group. However, state teams needed time to digest the new ideas and consider how to incorporate them into their unique state contexts. In response, CMS staff added post-webinar discussions to some IAP

tracks. In these smaller forums, held roughly a week following a group webinar, a state team met individually with the webinar presenter to further discuss the webinar content.

- ***The length of technical assistance can be adjusted after programs begin.*** State participants expressed differing views on the ideal length of IAP technical assistance periods. Some state teams reported that they needed more time to complete IAP activities, particularly when interagency agreements or data use agreements (DUAs) needed to be signed. In contrast, other state teams reported that a compressed timeline created a positive sense of urgency and focused attention on the IAP project. In several IAP tracks (e.g., Reducing Substance Use Disorders, High-Intensity Learning Collaborative; Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs; Promoting Community Integration through Long-Term Services and Supports, Value-Based Payment Home and Community-Based Services Implementation), participating state teams requested longer periods of support. In response, CMS extended the support periods.

Chapter 4: Delivery System Reform Activities by IAP Program and Functional Area

This chapter expands on the experiences of participants in each of the IAP's program and functional areas. This chapter is divided into six sections, corresponding to the four program areas and two functional areas that received direct technical assistance.

REDUCING SUBSTANCE USE DISORDERS

The CMS launched the Reducing Substance Use Disorders (SUD) program area to introduce delivery system and payment reforms that better identify individuals with a SUD, expand coverage for effective SUD treatment, and enhance SUD services delivered to Medicaid beneficiaries. The SUD program area included support on payment and health care delivery models, using data analytics (DA), benefit design, quality measures, provider strategies, and VBP for SUD. Our evaluation of the SUD program area included four tracks[14]:

- High-Intensity Learning Collaborative (HILC)
- Targeted Learning Opportunities (TLO)
- Opioid DA Cohort
- Opioid Data Dashboards Flash track

Summary of Key Findings

HIGH-INTENSITY LEARNING COLLABORATIVE

- HILC state participants increased their knowledge of SUD delivery system reform options as a result of working in the SUD program area.
- HILC state participants established data indicators and tracked outcomes; educated stakeholders; built interagency partnerships; and created repositories to retain IAP information.
- The IAP prompted state teams to assess primary care and behavioral health provider capacity, and led several HILC state teams to apply for Section 1115 SUD demonstration program waivers following their participation in the IAP.
- State participants experienced competing demands and priorities, limited resources, and lack of coordination within the Medicaid agency and between state agencies about how to approach specific problems.
- State teams completed specific SUD reforms as a result of participation in the HILC.

TARGETED LEARNING OPPORTUNITIES

- TLO state participants learned about SUD-related topics through a series of 15 webinars, enhanced by case studies.
- State teams used webinar information and reached out to peer state teams to support program changes and delivery system reforms.
- Participants in the TLO webinar series expressed interest in participating in a new SUD HILC track.
- The evaluation did not assess barriers or ongoing reforms in this track.

[14] In some IAP areas, new cohorts and/or tracks were added after the evaluation period ended because the IAP continued through September 2020. The Reducing Substance Use Disorders Data Dashboards flash track Cohort 2 and Medication-Assisted Treatment Affinity Group are not included in this report.

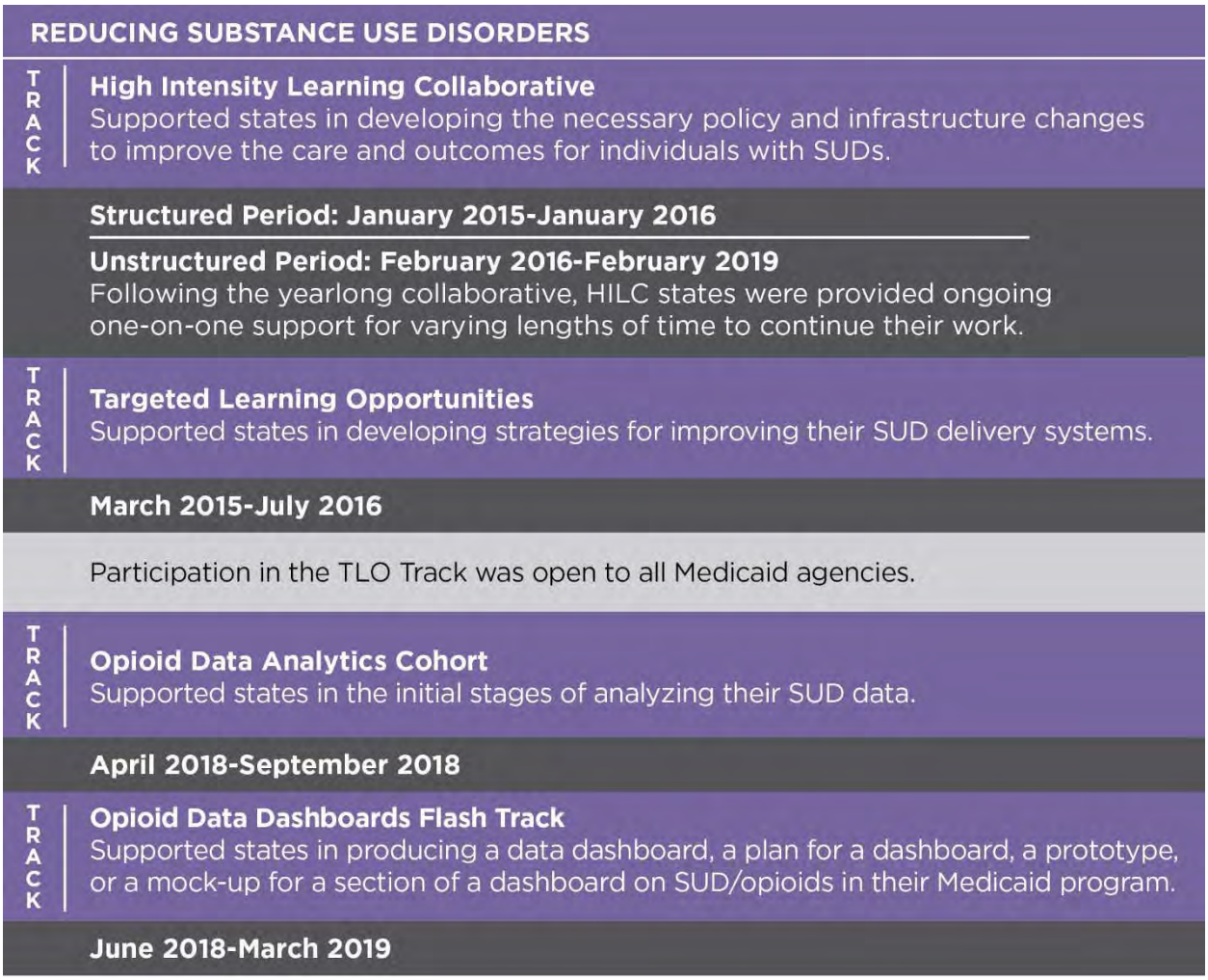
Summary of Key Findings

OPIOID DATA ANALYTICS COHORT

- Participants learned to use DA to understand the scope of SUD in their Medicaid beneficiary populations and to inform policy.
- State teams identified ways to assess OUD program and policy changes, used new analytic approaches to assess the system capacity, and shared new knowledge with Medicaid leadership.
- Participants reported on opioid issues and SUD more readily and accurately, and strengthened communication and collaboration across agencies.
- State teams struggled to find synergies in peer learning, and often needed more time to understand and complete data analyses and apply the findings to their reform efforts.
- Participants increased their DA capacity, and began pursuing reform opportunities, as a result of their participation in the Opioid Data Analytics Cohort.

OPIOID DATA DASHBOARDS FLASH TRACK

- State teams learned the process for designing and developing a data dashboard to share data with the public and other stakeholders.
- State teams established multi-disciplinary teams that created dashboards to monitor multiple opioid-related indicators, and added indicators over time.
- Participants better understand their opioid data, and shared graphical representations of the data with Medicaid leaders and other stakeholders.
- Lack of engagement from stakeholders within the Medicaid agency and at other state agencies limited the type of data state teams were able to present in dashboards. The software needed to build data dashboards also presented a learning curve for some participants.
- State teams captured actionable information and are using their dashboards for real-time decision-making.



High Intensity Learning Collaborative Track

The HILC track was a technical assistance initiative to assist state Medicaid programs in developing policy and infrastructure transformations to improve care and outcomes for individuals with SUD. The HILC track's structured support period began in January 2015 and concluded in January 2016. Following the collaborative, participants received one-on-one coaching support as needed and requested, particularly around strategic design of Medicaid Section 1115 SUD demonstration programs and data analytic support.

HIGH INTENSITY LEARNING COLLABORATIVE TRACK	
GOALS	• Assist Medicaid programs in developing policy and infrastructure transformations to improve care and outcomes for individuals with SUD
LENGTH OF SUPPORT	• Structured Period: January 2015–January 2016 • Unstructured Period: February 2016–February 2019
PARTICIPATING STATES	• Structured Period:  • Unstructured Period: Due to the unstructured nature of the support, a complete record of all participating states is not available.
COMPOSITION OF STATE TEAMS	• Medicaid agency • Single state agency for SUD[1]
MODES OF SUPPORT	• Webinars with subject matter expert (SME) presentations and peer learning (e.g., on SUD quality metrics, payment strategies, SUD care continuum) • Quarterly webinars on emerging SUD reform topics • Coaching (e.g., on developing alternative payment models; American Society of Addiction Medicine (ASAM) criteria, SUD penetration rates) • CMMI PI coach • In-person meetings (e.g., on SUD payment and delivery reform, medication assisted treatment (MAT) for SUD, DA, and quality management) • Email updates (also stored on Groupsite) • Groupsite online resource library (also distributed via email)

[1] The single state agency for SUD is designated by each state's governor to coordinate and ensure the delivery of high-quality services to individuals with SUD. (Substance Abuse and Mental Health Services Administration, "Funding and Characteristics of Single State Agencies for Substance Abuse Services and State Mental Health Agencies, 2015.")

KEY FINDINGS

What knowledge did participants acquire from the HILC track of the IAP?

HILC state teams increased their knowledge of SUD delivery system reform options as a result of working in the SUD program area.

One state's coach prepared a report on SUD penetration rates (i.e., the proportion of Medicaid enrollees with a SUD who receive treatment), and the state team learned from peers in the track how to measure the use of SUD treatment. Another team contacted a peer state directly to learn about their data system and analytic capacity, in order to better apply the Medicaid SUD benefit.

In addition, HILC state participants gained specific technical knowledge from the IAP, including in:

- SUD treatment services and expected use of these services among Medicaid-eligible populations
- Data collection, evaluation, and the benefits of data linking to improve program oversight and clinical quality
- Neonatal abstinence syndrome (NAS) and the impact of SUD on pregnant women

- Incorporating ASAM criteria into the development of a state's Section 1115 SUD demonstration program application
- Framing SUD as a chronic disease
- Alternative payment models, bundled payments, and VBP

> "We gained knowledge and understanding of the importance of collaborating with other state agencies, stakeholders, hospitals and substance use providers to address … needs holistically."
>
> ~ HILC STATE PARTICIPANT

What Medicaid program activities did state teams undertake as a result of participating in the HILC track of the IAP?

HILC states established data indicators and tracked outcomes.

Four HILC state teams identified and implemented SUD quality measures, while one state team identified indicators to track and monitor NAS outcomes. Three HILC state teams began tracking SUD indicators among Medicaid beneficiaries. One state team examined patients' length of engagement with methadone and buprenorphine treatments; this examination revealed inadequate patient engagement rates. The team then selected and used quality metrics to monitor improvement. Another state team identified quality measures around withdrawal management, which informed negotiations with behavioral health organizations during the state's transition to managed care.

HILC participants engaged with and educated stakeholders beyond state agencies.

One state team educated MCOs, hospitals, and other stakeholders through webinars and other learning opportunities about SUD, in a manner modeled after the structure of the IAP's SUD engagement. Another state team used the information they received about MAT to convince stakeholders to implement a MAT benefit.

HILC state teams built interagency partnerships.

The HILC facilitated focused and intentional collaborative efforts among state agencies, including the Medicaid agency and others whose work involves mental health, behavioral health, drug and alcohol programs, corrections, and the Governor's Office. The HILC provided one state's Medicaid officials the opportunity to collaborate with their state's Department of Children and Family Services and Office of Juvenile Justice, and with hospitals and social services agencies throughout the state. A state team member said, "At this point, we can say someone's name, call them, and it's not an awkward conversation. That's a direct result of the IAP initiative."

IAP involvement became an important and valuable lever for engaging and organizing state agencies on SUD. IAP activities such as planning tools and webinars fostered collaborative relationships within HILC states. Webinars served the dual purpose of sharing rich knowledge and also facilitating a communication avenue for internal conversations, as participants were able to include staff members and SMEs with whom they do not typically interact.

HILC state teams created repositories to retain information gained through IAP participation.

Teams from three HILC states created repositories to store information acquired during the course of the IAP, such as the webinar slides, materials from the in-person meeting, internal SUD committee notes, and subcommittee agendas. One state team set up a SharePoint website, and a team from another state stored documents in an internal network folder, so that any interested party could access the information.

What happened as a result of participation in the HILC track of the IAP?

HILC state teams assessed, and took steps to increase, primary care and behavioral health provider capacity.

Several state teams conducted statewide assessments to learn about behavioral health provider capacity. One state team developed a toolkit for clinicians to facilitate SUD Screening, Brief Intervention, and Referral to Treatment (SBIRT)[15] services to address NAS. Another state team implemented Current Procedural Terminology codes to be used in billing for certain SUD treatment services. A third state team designed an approach for credentialing office-based buprenorphine provider treatment criteria that qualifies providers for enhanced payments for care coordination.

IAP participation led to applications for Section 1115 SUD demonstration programs in several HILC states.

Three HILC state teams developed or applied for a Section 1115 SUD demonstration program. One of the three state teams elected to continue to work with their HILC coach for design and strategic guidance to inform the state team's Section 1115 demonstration program application.

IAP technical assistance developed state teams' capabilities in DA.

Teams from five states created, refined, or built capacity in DA. One state team developed a behavioral health "data dictionary" that maps specific codes to outcomes like hospitalization, outpatient therapy, and inpatient admissions.

What barriers, if any, reduced the impact of participation in the HILC track of the IAP?

Participants demonstrated varying levels of readiness to implement SUD reforms.

States were in varying stages of considering SUD reform efforts when the IAP HILC track started. While one state had already addressed many of the issues that the track was designed to cover, another state lacked capacity and resources to implement the IAP support.

State teams experienced competing demands and priorities, limited resources, and lack of coordination within the Medicaid agency and between state agencies about how to approach specific problems.

Coaches needed to customize their support to each state and to acknowledge concurrent reforms occurring within each state. One state team experienced challenges related to the composition of their team. The substance use agency, rather than the Medicaid agency, led the state's HILC effort, and thus was unable to apply the technical assistance offerings to their state Medicaid SUD reform goals.

[15] SUD Screening, Brief Intervention, and Referral to Treatment is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

"If we had been a little more certain of the direction we were moving, we could have asked for additional help. We got offers of help more frequently than we took advantage of them."

~ HILC STATE PARTICIPANT

How did the HILC track of the IAP support any ongoing reforms?

State teams completed specific SUD reforms as a result of participation in the IAP.

HILC state teams completed the following activities that supported ongoing state Medicaid reforms:

- Teams from two states identified relevant measures to assess the impact of the SUD service system, and a team in one state developed structured programming language to facilitate quality measures reporting.
- Teams from two other states expanded covered services to improve access to a full continuum of SUD services for Medicaid beneficiaries based on the ASAM criteria.
- One state team implemented an SUD health home model to improve the initiation and engagement in treatment of individuals with OUD, moving toward integration of behavioral health and physical health in the care and treatment of SUD.
- Another state team engaged with MCOs, providers, consumers, and other stakeholders to identify access barriers and help overcome them.

Targeted Learning Opportunities Track[16]

The TLO track was a 15-part webinar learning series. The track was designed to support states in developing strategies for improving their SUD systems. Participation in TLO was open to all Medicaid agencies, and ran from March 2015 to July 2016.

TARGETED LEARNING OPPORTUNITIES TRACK	
GOALS	• Provide states with information needed to design and implement SUD service delivery system reforms
LENGTH OF SUPPORT	• March 2015–July 2016
PARTICIPATING STATES	Participation in the Targeted Learning Opportunities track was open to all Medicaid agencies (49 states participated in at least one webinar).
COMPOSITION OF STATE TEAMS	• Medicaid agency • Single state agency for SUD • State mental health agency
MODES OF SUPPORT	• Series of 15 webinars (e.g., on increasing provider capacity, information sharing under 42 Code of Federal Regulations Part 2, integrating SUD into primary care settings, recovery and supportive housing, opioid crisis, managed care contracts) • Post-webinar discussions • Email updates

[16] Data presented in this section were collected, analyzed and reported by Truven Health Analytics, an IBM Company, in a report titled Targeted Learning Opportunity Services Evaluation Results, September 2016. Abt Associates did not conduct an independent assessment of the TLO track.

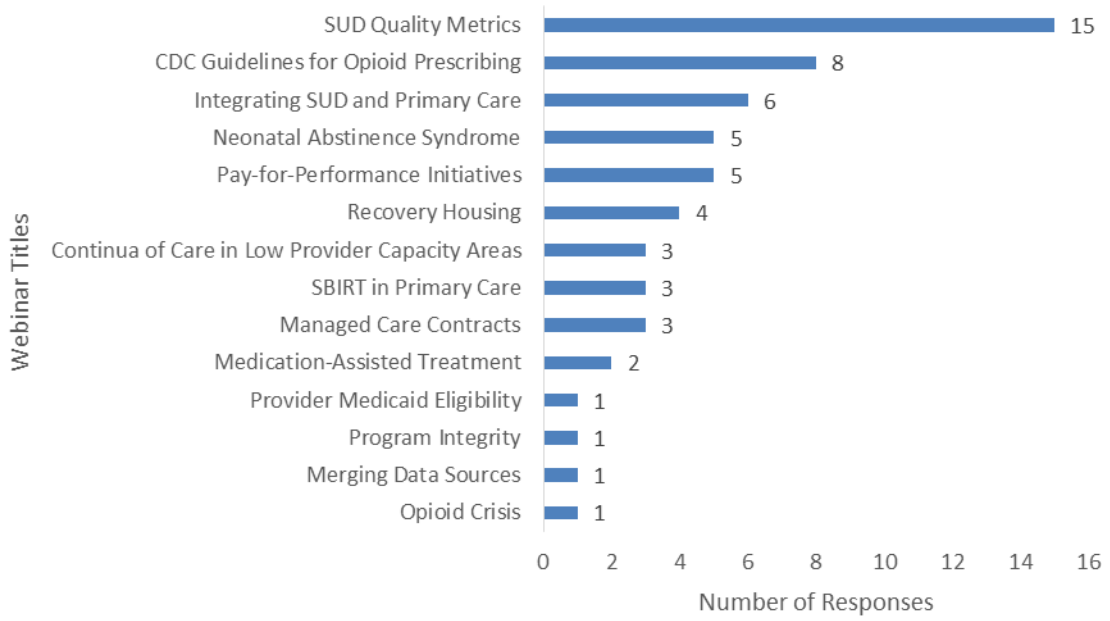
KEY FINDINGS

What knowledge did participants acquire from the TLO track of the IAP?

TLO state participants learned about SUD-related topics through 15 webinars.

Webinar titles are listed in Exhibit 4.1 Nearly one-third of respondents[17] (n=58 respondents) selected the webinar about SUD quality metrics as the most useful presentation in the series. Other topics often rated most useful included: Centers for Disease Control and Prevention guidelines for opioid prescribing, and integrating SUD services into primary care (see Exhibit 4.1). These topics were timely and relevant to states' needs, and the webinars provided information on other states' initiatives and lessons learned that TLO participants could immediately apply to their own activities.

Exhibit 4.1. Most Useful Rated Targeted Learning Opportunities Webinars (n=58 Respondents)



Source: Truven Health Analytics, an IBM Company, in a report titled Targeted Learning Opportunity Services Evaluation Results, September 2016.

Case studies enhanced participants' understanding of specific SUD topics.

The majority of survey respondents (82%) agreed that the case studies presented during the TLO webinars enhanced their understanding of specific SUD topics. The case studies provided strategies that state teamscould use to expand Medicaid programs focused on SUD, and to enhance care for their beneficiaries with SUD.

[17] The report, Targeted Learning Opportunity Services Evaluation Results, September 2016, prepared by Truven Health Analytics, an IBM Company, did not include information on the number of states that responded to the TLO survey.

State teams used the information to support program changes and delivery system reforms.

Fifty percent of survey respondents took actions toward developing performance metrics informed by TLO webinars and resources. The track also informed respondents' activities for expanding access to MAT (48%), integrating SUD and primary care services (46%), and enhancing SUD benefit design (38%).

What happened as a result of participation in the TLO track of the IAP?

Some state participants reached out to other states.

Almost half of survey respondents (48%) said that they engaged with other state participants to share information and learn more about their experiences regarding specific SUD initiatives.

Participants in the TLO webinar series expressed interest in participating in a new SUD HILC track.

At the end of the TLO webinar series, nearly one-third of survey respondents (32%) indicated that they had applied for other IAP tracks. In addition, the majority (62%) demonstrated interest in a new SUD HILC track, if offered.

Opioid Data Analytics Cohort

Based on feedback from HILC track participants, CMS developed the Opioid Data Analytics Cohort to support states' SUD DA needs. The Opioid Data Analytics Cohort supported state teams in the initial stages of examining their SUD data. The track, which ran from April 2018 to September 2018, included three sequential, interrelated components. The components were designed to better inform data-driven strategies and support development of targeted interventions:

1. OUD – The purpose of this component was to conduct analyses to describe the opioid epidemic within the Medicaid population, understand expenditure patterns, and identify the characteristics of the affected population. State teams received a data template, diagnosis and procedure codes for identifying OUD in Medicaid claims, and ongoing technical assistance.
2. MAT – This component focused on assessing the distribution and availability of MAT within the state's Medicaid program, and understanding the characteristics of MAT across key dimensions. State teams received resources such as value sets to identify use of MAT in Medicaid claims, table shells, a list of all buprenorphine-waivered practitioners in the state, and ongoing technical assistance.
3. NAS and OUD care for pregnant women – The third component's aim was to understand the prevalence of NAS and delineate the components of opioid-related maternity care in the Medicaid program. It was also designed to understand where treatment occurs, what type of OUD maternity care and NAS treatment are used, and costs to Medicaid. Participating state teams received table shells and value sets to identify NAS care to infants and OUD maternity care to women.

State teams were encouraged, but not required, to participate in all three components of the track.

OPIOID DATA ANALYTICS COHORT	
GOALS	• To support state teams in analyzing SUD data to inform data-driven strategies and development of targeted interventions around each of the three focus areas (i.e., OUD, MAT, and NAS)
LENGTH OF SUPPORT	• April 2018–September 2018
PARTICIPATING STATES	
COMPOSITION OF STATE TEAMS	• Medicaid agency • Single state agency for SUD • State public health agency • State office of health data and analytics • State DA contractor
MODES OF SUPPORT	• Webinars on OUD, MAT, and NAS (e.g., on availability and distribution of MAT, describing the magnitude of the opioid epidemic within the Medicaid population, assessing the prevalence of NAS, delineating the components of opioid-related maternity care) • Peer-to-peer discussions • Coaching on OUD, MAT, and NAS (e.g., on understanding the characteristics of MAT/OUD/NAS in the state across key dimensions, participation in Medicaid of buprenorphine-waivered practitioners, penetration rates) • Tools and resources (e.g., value sets, table shells)

KEY FINDINGS

What knowledge did participants acquire from the Opioid Data Analytics Cohort of the IAP?

Participants learned new ways to use DA to understand the scope of SUD in their Medicaid beneficiary populations.

Five state teams more closely examined their data to better understand their beneficiary populations and focus their future approaches to the opioid epidemic.

- The MAT cohort informed one state's opioid treatment program by helping the state Medicaid agency identify which of their beneficiaries were receiving treatment.
- Another state team learned how to best identify their population with SUD by gathering lists of diagnosis and procedure codes.

- One state team increased their understanding of buprenorphine use for OUD treatment in the Medicaid program.
- Two state teams increased their knowledge of opioid, alcohol, and methamphetamine use in their Medicaid population.

State teams gained knowledge about how to use data to inform policy.

Participating state teams learned how other states use data to inform policy. Specifically, participants learned ways to record, track, and present information on SUD to stakeholders. They also learned new approaches to evidence-based, fiscally responsible payment.

> "I think this [knowledge] assisted our data analytics team with refining how they were able to drill down into the data and also maybe code the queries in different ways."
>
> ~ OPIOID DATA ANALYTICS COHORT STATE PARTICIPANT

What Medicaid program activities did state teams undertake as a result of participating in the Opioid Data Analytics Cohort of the IAP?

State teams developed measures to assess possible OUD program and policy changes.

State teams identified metrics to monitor and assess different aspects of OUD.

- State teams revised their statistical analyses and data dashboards to glean new information about opioid-related issues.
- One state team shared OUD data with an external evaluator for their MAT expansion project.
- One state team examined measures that could be used for OUD in incarcerated populations.
- One state team used specifications from the IAP to assess readmissions for NAS and created a lifetime cost measure for infants born with NAS.

Participants used new evaluation and analytic approaches to assess the capacity of their systems, identify gaps, and highlight successful programs that can be replicated.

- Participants reviewed their data and applied analytic values.
- State teams tracked their data and showed changes over time.
- State teams identified their internal data analytic capabilities and limitations.
- State teams used data to inform resource allocation.

Participants shared the knowledge they acquired with Medicaid leadership and other stakeholders.

Participants created internal talking points for senior executives (e.g., Medicaid directors) to refer to in meetings on opioids and SUD. They helped their leadership understand SUD trajectories and treatment options across the continuum of care. In turn, the leadership was better equipped to talk about the population in need with other stakeholders. State Medicaid officials also expanded their partnerships with other state agencies as a result of identifying new and improved ways of working with their data.

"Our leadership has access to tools for evaluating impact and effectiveness of interventions that were not previously available."

~ OPIOID DATA ANALYTICS COHORT STATE PARTICIPANT

What happened as a result of participation in the Opioid Data Analytics Cohort of the IAP?

Participants reported on opioid issues and SUD more readily and accurately.

State teams developed reporting mechanisms, including data dashboards, to share SUD statistics with Medicaid leadership and stakeholders.

- One state team learned probabilistic data matching methods. They increased matching of mother-infant dyads from 50–70% to 99%.
- One state team created a process for quarterly reporting to monitor progress in their Section 1115 demonstration project.
- Some state teams produced informational reports to share with providers and Medicaid beneficiaries.

"We've been able to look back at data from 2012 up to last November. That will allow us to look at outcomes not only for babies born this year, but older children as well. It will not only impact this work, but other work that focuses on the family as a whole."

~ OPIOID DATA ANALYTICS COHORT STATE PARTICIPANT

Participation in the cohort strengthened communication and collaboration across agencies within states.

The structure of the track led state teams to meet almost weekly, and encouraged coordination within Medicaid agencies as well as across other state agencies.

What barriers, if any, reduced the impact of participation in the Opioid Data Analytics Cohort of the IAP?

State teams needed more time to understand and complete the data analyses for each component.

Several state teams would have liked more time to work on their DA as a cohort and to connect with other states regarding their policies and outcomes. State teams spent most of the IAP support period understanding their data and did not have time to apply the analyses to their reform efforts.

- One state team suggested that a greater number of coaching calls across a longer period of time would have been helpful as they were working through each component.
- The timing of the cohort presented challenges in some states because many of their team members were out of the office during the summer months.

State teams struggled to find synergies in peer learning.

Variation in characteristics, skillsets, and experience among state team members presented challenges for participating states. State teams reported that the program could be improved by categorizing states into subsets based on level of experience and the technical assistance needs of their team members. In particular,

the examples provided by smaller states were not relevant to larger states because of the challenges with access to care common in large, primarily rural states.

> "Our IAP was not focused on delivery reform. It was focused on getting a handle on the data, which is difficult."
>
> ~ OPIOID DATA ANALYTICS COHORT STATE PARTICIPANT

How did the Opioid Data Analytics Cohort of the IAP support any ongoing reforms?

Increased DA capacity set states on the road to implementing delivery system reforms.

Two-thirds of respondents (n=9 respondents) strongly agreed or agreed that that the Opioid Data Analytics Cohort helped them move toward delivery system goals. For some state teams, a major outcome of IAP participation was having talking points to bring to leadership, so that they could start the conversation about reforms. Other state teams created a dashboard or a quarterly report to share DA more widely. Some state teams moved from mastering data production skills during the IAP to practicing data interpretation skills that could be sustained beyond the period of technical assistance. Other state teams were hampered along that pathway by lack of access to data or internal data analytic capacity.

> "Having data solutions doesn't mean we have policy, funding, or legal solutions. It gets us on the right track. But with finite resources and competing priorities, understanding the data and the problem is a wonderful first step, but certainly not the last."
>
> ~ OPIOID DATA ANALYTICS COHORT STATE PARTICIPANT

The data helped some state teams prepare to take the next step toward policy and program reforms as a result of participation in the Opioid Data Analytics Cohort.

State teams began pursuing reform opportunities as a result of their participation in the cohort.

- The IAP helped one state team think about how to transform their SUD system into a continuum of services rather than a patchwork set of services.
- The IAP provided two state teams with innovative approaches to SUD treatment modalities and statistical analysis.
- Two state teams discussed how the DA skills they gained will inform their application for and implementation of Section 1115 demonstration waivers.

Opioid Data Dashboards Flash Track

The Opioid Data Dashboards Flash track, which ran from June 2018 to March 2019, provided state officials with information, resources, and support related to developing a data dashboard. The six participating state teams were tasked with producing one of the following: a data dashboard, a plan for a dashboard, a prototype, or a mock-up for a section of a dashboard on opioids and/or OUD in their Medicaid program. The Opioid Data Dashboards Flash track addressed how to build and use a data dashboard, provided technical assistance, facilitated state-to-state discussions to review progress and discuss challenges, and shared examples of data dashboards developed by other states.

Opioid Data Dashboards Flash Track	
Goals	• To support states in developing dashboards to display their SUD and/or opioids data and performance
Length of Support	• June 2018–March 2019
Participating States	
Composition of State Teams	• Medicaid agency • Single state agency for SUD • State mental health agency • State health department • State data and evaluation contractors
Modes of Support	• Webinars (e.g., on how to construct and use a data dashboard) • Coaching support (e.g., on how to construct and use a data dashboard)

KEY FINDINGS

What knowledge did participants acquire from the Opioid Data Dashboards flash track of the IAP?

State teams learned the process of designing and developing a data dashboard.

Participants learned how to define opioid-related metrics, as well as how to develop and implement a data dashboard. The coaches created a step-by-step process for developing a dashboard mock-up that was tailored for each state based on their level of understanding and previous experience with dashboards. State teams learned how to identify priority data, specify the data, and run and refine the data. State teams also learned how to create data visualizations.

Participants learned, from each other, options for sharing data with the public and other stakeholders.

Participants traded notes about the design of their dashboards, talked through challenges other states encountered, and discussed which stakeholders within and outside their Medicaid agencies to engage at various stages of the dashboard development process.

> "I am a policy person, and policy makers and data people speak different languages. I had to quickly learn that how you look at the data changes the outcome. ... How you ask to pull the data and the parameters really affect the outcome. We have to start speaking the same language in some sort of sense. That's what I have learned the most from the IAP."
>
> ~ OPIOID DATA DASHBOARDS FLASH TRACK STATE PARTICIPANT

What Medicaid program activities did state teams undertake as a result of participating in the Opioid Data Dashboards flash track of the IAP?

State teams established multi-disciplinary teams to plan, develop, and execute their dashboards.

The state teams considered what skillsets were needed on their dashboards teams. For example, one team included pharmacy analysts, information technology staff, a physician champion, and a Medicaid policy analyst. The role of the physician champion was to build buy-in for the dashboard among other stakeholders.

State teams created dashboards to monitor multiple opioid-related indicators, and added indicators over time.

State teams included in their dashboards data on morphine milligram equivalency, overdoses, number of prescription opioids, and methadone use. One state team used the dashboard to demonstrate to Medicaid leadership that opioid overdose and NAS rates had increased from the previous year. Another state team built several opioid measures into their Medicaid enterprise system, which they used to pull data for their new dashboards and to track changes over time.

What happened as a result of participation in the Opioid Data Dashboards flash track of the IAP?

State teams shared graphical representations of data with Medicaid leadership and select stakeholders.

State teams used the dashboard visuals to give information to colleagues and leadership in the Medicaid office and other state agencies to help them make informed decisions about substance use programming. One state team developed a heat map to show opioid data by county. Another state team sent dashboard screen shots to physicians that had morphine milligram equivalency greater than 240 to inform them about how their prescribing patterns compare with the state average. Participating state teams worked toward building dashboards to share with state Medicaid agency leadership, which some were able to do.

> "Having these visuals has really helped. For non-clinicians, having examples to see helps them understand."
>
> ~ OPIOID DATA DASHBOARDS FLASH TRACK STATE PARTICIPANT

Participants can better understand and interpret their opioid data.

State teams spent a considerable amount of time in the initial phase of the track selecting measures to prioritize. State teams developed a streamlined process for updating their data on a monthly schedule, allowing them to monitor progress and compare data over time. Some state teams focused on data linking and are now able to link mother and child birth records as well as understand SUD in their general Medicaid beneficiary population.

"Methadone is a very controversial medication in [the state]… now Medicaid covers it. There was word that it would double now that it is covered. [The coach] helped us concentrate on that measure and show that methadone use didn't move more than 100 up and down every month. It helped us disprove that rumor and show real data with methadone use. ... I think that it helped us 1) clarify policy and 2) educate providers."

~ OPIOID DATA DASHBOARDS FLASH TRACK STATE PARTICIPANT

What barriers, if any, reduced the impact of participation in the Opioid Data Dashboards flash track of the IAP?

Lack of engagement within the Medicaid agency and between other state agencies limited the type of data states were able to present in dashboards.

State teams faced challenges pulling the dashboard data from different Medicaid units in a timely manner. Some state teams were not able to get participation from other state agencies. As a result, their dashboards contained data from only the Medicaid agency and did not reflect opioid-related data from other agencies, such as overdose deaths. One state team was not able to link Medicaid claims data to the state's prescription drug monitoring program data to obtain prescribing patterns for buprenorphine-waivered practitioners, as originally planned.

"Getting participation from our sister agencies has been a challenge. I had to make the decision to move forward, so this dashboard only contains data from our agency…"

~ OPIOID DATA DASHBOARDS FLASH TRACK STATE PARTICIPANT

The software needed to build data dashboards presented a learning curve for some participants.

Many participants were not familiar with the technology necessary to build a dashboard and did not have access to the software needed to build and access the dashboards. Those who had recently purchased the software did not fully understand how to use it.

How did the Opioid Data Dashboards flash track of the IAP support any ongoing reforms?

State teams captured actionable information that helped to inform other projects and programs.

State teams that were furthest along in their understanding and development of a dashboard were able to move forward with system reforms. One state team applied the principles learned in the track to their Healthcare Effectiveness Data and Information Set dashboard to present the data from the past few years. The dashboard techniques learned in the track allowed a streamlined process of comparing data from different years and flagging where changes are being made.

State teams are using their dashboards for real-time decision-making.

- One state team developed a standardized method of analyzing SUD prevalence in its Medicaid population.

- One state team developed a
  effectively match records of infants born exposed to opioids with their mothers' records.
- Two state teams used data to identify buprenorphine-waivered practitioners and analyze provider capacity for serving Medicaid members.
- One state team's dashboard allows for a quick comparison of morphine milligram equivalency in real time.

Conclusion

Key findings from the SUD program area suggest that the IAP addressed states' technical assistance needs and advanced states' SUD reforms. State involvement in the IAP became an important and valuable lever for sharing knowledge, facilitating communication, and collaborating between agencies and stakeholders around the issue of SUD. Due to competing demands and priorities, state teams varied in their degree of participation with SUD technical assistance, which may have affected the extent and types of activities and changes that they undertook during and following the conclusion of each track. Medicaid program changes take time, but concrete, material actions occurred that facilitated progress toward states' longer-term goals.

IMPROVING CARE FOR MEDICAID BENEFICIARIES WITH COMPLEX CARE NEEDS AND HIGH COSTS

The IAP worked with five state Medicaid programs to design, plan, and implement strategies to improve care coordination for Medicaid beneficiaries with complex care needs and high costs (BCN). Staff from participating states had access to a range of resources to assist with meeting their delivery system reform goals, including monthly webinars, discussion group calls with participants from other BCN states, an in-person workshop, and tailored support from coaches. These activities helped the BCN states launch various reforms and lay the groundwork for future implementation efforts.[18]

Summary of Key Findings

- State teams learned ways to define and identify their BCN populations and use data to describe them.
- Teams employed enhanced DA to understand their BCN populations, and refined payment and program models that serve their BCN populations.
- Teams designed programs aimed at improving health and reducing costs for the BCN population, renewed Medicaid Section 1115 demonstration waivers targeting their BCN populations, and engaged partners.
- Time constraints limited the data available for analyses and state teams' ability to garner partners' support for reforms.
- Teams shared the knowledge they had acquired through their IAP participation with additional stakeholders in their states, and formed ongoing relationships.

BCN Area

The BCN program area structured period began in October 2015 and concluded in August 2016. Following the structured period, state teams received access to technical assistance on an as-requested basis from August 2016 through September 2018. The BCN program area supported states' efforts to improve care coordination for their BCN populations by: (1) enhancing participants' capacity to use DA, (2) developing/refining payment reforms to provide better care to their BCN populations, and (3) assisting participants in identifying, replicating, or spreading promising programs. The BCN program area constituted a single technical assistance activity, and was not subdivided into tracks.

[18] In some IAP areas, new cohorts and/or tracks were added after the evaluation period ended because the IAP continued through September 2020. The Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs Using Data Analytics to Better Understand Medicaid Populations with Serious Mental Illness track is not included in this report.

IMPROVING CARE FOR MEDICAID BENEFICIARIES WITH COMPLEX CARE NEEDS AND HIGH COSTS PROGRAM AREA	
GOALS	• Enhance participants' capacity to use DA • Develop or refine payment reforms to provide better care to BCN populations • Assist teams in identifying, replicating, or spreading promising programs
LENGTH OF SUPPORT	• Structured period: October 2015–July 2016 • Unstructured period: August 2016–September 2018
PARTICIPATING STATES	
COMPOSITION OF STATE TEAMS	• Medicaid agency
MODES OF SUPPORT	• Webinars (e.g., on PI, targeting beneficiaries, data sharing and identification of data sets, alternative payment strategies, monitoring and measurement, population profiling and analytics, care transitions) • Discussion groups • Coaching (e.g., on SAS coding, quality performance and outcome measurement) • PI SMEs • Site visits • In-person meetings (e.g., on linking data across multiple systems for enhanced profiling and monitoring, using social determinants data, DUAs, monitoring and measurement, alternative payment strategies) • Email updates (also stored on Groupsite) • Groupsite online resource library (also distributed via email)

KEY FINDINGS

What knowledge did participants acquire from the BCN program area of the IAP?

State teams learned to define, identify, and use data to describe their populations of super-utilizers.

State teams received information from their coaches about how other states define "super-utilizers," Medicaid beneficiaries with high service use and high costs. This information helped them create an appropriate super-utilizer definition for their own state. Additionally, teams learned specific, actionable information related to:

- Social determinants of health data
- Risk stratification methods
- Creating predictive models
- Indicators for emerging risk
- Software packages[19] for super-utilizer analyses

[19] CMS did not fund the purchase of software.

Six out of seven summative survey respondents agreed or strongly agreed that in-state knowledge of BCN delivery system reform options increased as a result of their participation in the IAP and that they were able to apply the knowledge they gained toward delivery system reforms.

> **"I think that the best thing about this model is getting level information about what other states are doing, and then taking that back and talking about it internally and deciding if this is what we want to do as a Medicaid program."**
>
> ~ BCN STATE PARTICIPANT

What Medicaid program activities did state teams undertake as a result of participating in the BCN program area of the IAP?

State teams employed enhanced DA to understand their BCN populations.

- Participants from two states conducted data analyses to support programs aimed at improving health outcomes for their BCN populations.
- Participants from one state gained expertise in combining and analyzing data from separate data sources; with this expertise, they better identified and described their priority population.
- Participants from one state began developing a program that focuses on reducing preventable events such as emergency department visits or re-admissions, development of complications, and use of ancillary services.

State teams refined payment and program models that serve their BCN populations.

Examples of activities state participants completed include:

- Development of a prorated reimbursement rate using diagnosis codes and other available data
- Construction of an incentive payment structure
- Support of MCOs to address the health of BCN populations
- Completion of a study on billing services for adult Medicaid beneficiaries
- Development of an ambulatory detoxification program; the coach conducted data analyses and provided information about quality measures needed for the program

What happened as a result of participation in the BCN program area of the IAP?

Participants designed programs aimed at improving health and reducing costs for the BCN population.

Using the resources gained through BCN, participants from two states pursued programs to address the needs of their BCN populations. Participants in one state leveraged the support of coaches and SMEs to design and implement a health home program during BCN. Together with the coaches, these participants conducted interviews and trainings with home health providers to identify initial implementation challenges and capture lessons learned. As one team member reported, "It was a really good exercise to go visit the practices [and to have] prompts to get them thinking slightly differently."

State teams renewed Medicaid Section 1115 demonstration waivers targeting their BCN populations.

Teams from two participating states received renewals of their Section 1115 demonstration waivers targeting BCN populations. IAP coaches provided strategic design support that helped state teams conceptualize their waivers. One state team designed a project that provides a continuum of SUD services to Medicaid beneficiaries who reside in residential treatment facilities. The other state team included a provision in its waiver to passively enroll individuals eligible for both Medicare and Medicaid into its coordinated care model.

The IAP provided a structure for engagement between state Medicaid agencies and their partners.

Being involved in the IAP's BCN program area highlighted participating states' BCN work. This attention had the unanticipated benefit of encouraging more interest across the state and with partners; it also enhanced stakeholder interest and engagement. As one participant said, "Us doing this project has helped us get [our payer partners] focused on it, because we were in a multi-state collaborative, and they had a chance of getting some national spotlight."

What barriers, if any, reduced the impact of participation in the BCN program area of the IAP?

The time necessary to obtain Medicare and Medicaid data, coupled with the IAP support period, limited state teams' ability to conduct data analyses and garner partners' support for reforms.

The time lags for obtaining Medicare and Medicaid datasets from CMS limited BCN participants' access to up-to-date data and their ability to align timelines for gathering key metrics with the IAP TA period. One state participant reported, "*We could have learned a lot more had we had another year's worth of [Medicare claims] data. That one more year of experience on what was happening with our plans and outcomes could have enhanced the study a little bit.*" In addition, BCN participants had limited time upon completing their analyses to gain support from partners for proposed payment model reforms.

How did the BCN program area of the IAP support any ongoing reforms?

BCN participants shared the knowledge they acquired through their IAP participation with additional stakeholders in their states.

- One of the BCN teams shared the CMS biweekly email updates with health services organizations that work with super-utilizers.
- One BCN team shared program materials with legislative auditors who were reviewing how the state manages BCN patients. This team also shared BCN program materials with a small workgroup of hospital administrators who are working with the state Medicaid agency on BCN-related issues.

Several BCN teams used the resources and information produced and disseminated through the IAP to spur conversations among their constituents at the state and local levels. One BCN team invited all of their MCOs to listen to IAP national dissemination webinars. Other BCN teams used the resources and technical assistance to: make policy decisions; learn and adopt evidence-based practices; draft and publish reports; and inform the design, strategy, and direction of their programs and initiatives. One state participant reported, "We have used the data in our waiver process … participating in the IAP helped elevate the issue so that it became a focus of our waiver."

Participants formed cross-state and within-state relationships that have persisted since the end of the IAP support period to enable ongoing reforms.

BCN teams formed relationships with other states' Medicaid agencies through the IAP. Teams leveraged other states' experience and knowledge in BCN and applied it to advance their own initiatives. One BCN participant, when asked how they applied IAP information, replied, "I think collaborating and linking data. We have been able to reach out to other [of our] state agencies and departments."

> "We were able to set up calls with three other states … [these] conversations helped us figure out how to design our incentive structure, as well as how to forecast our budget based on uptake assumptions … listening to what states projected compared to what they actually saw, and identifying the similarities between their programs and ours was … hugely beneficial."
>
> ~ BCN STATE PARTICIPANT

Conclusion

Overall, the BCN program area was successful in helping to move delivery system reform efforts forward. Teams employed enhanced DA to understand their BCN populations, refined payment and program models that serve their BCN populations, and designed programs aimed at improving health and reducing costs for the BCN population. Coaches initiated sustained relationships across states that fostered helpful information sharing and supported ongoing reforms.

PROMOTING COMMUNITY INTEGRATION THROUGH LONG-TERM SERVICES AND SUPPORTS

The Promoting Community Integration through Long-Term Services and Supports (CI-LTSS) program area was structured as two components, with multiple tracks within each. The CI-LTSS components and tracks are organized as follows[20]:

- Medicaid Housing-Related Services and Partnerships (HRSP) Component
  - Supporting Housing Tenancy (Tenancy track)
  - State Medicaid-Housing Agency Partnerships (Partnership track)
- Value-Based Payment for Home and Community-Based Services Component (VBP for HCBS)
  - Planning a VBP for HCBS Strategy
  - Implementing a VBP for HCBS Strategy
  - Designing a VBP for HCBS Strategy

Summary of Key Findings

MEDICAID HOUSING-RELATED SERVICES AND PARTNERSHIPS COMPONENT

SUPPORTING HOUSING TENANCY

- State teams gained an understanding of Medicaid strategies and funding options to support housing tenancy (i.e., services that support the individual in being a successful tenant).
- State teams developed crosswalks to guide their housing-related Medicaid strategies.
- State teams that participated in this track later participated in additional IAP tracks (i.e., Partnership, Planning a VBP for HCBS Strategy, Implementing a VBP for HCBS Strategy, and Designing a VBP for HCBS Strategy).
- Lack of detail inhibited state teams from implementing what they learned.

STATE MEDICAID-HOUSING AGENCY PARTNERSHIPS

- State Medicaid and housing agency staff acquired strategic knowledge and skills for designing tenancy supports using appropriate Medicaid authorities, such as waivers that allow for additional flexibilities.[21]
- State teams offered inter-agency training about Medicaid community-based LTSS, found new ways to apply Medicaid and housing funds, used data across systems, and joined additional collaboratives focused on health and housing.
- As a result of their participation in the Partnership track, state participants had more confidence to advocate for reform.
- Limited resources and staff turnover inhibited state teams' ability to implement their action plans.
- IAP participation facilitated partnerships between Medicaid (and other health care agencies) and housing agencies; some state teams applied for Medicaid waivers that support their reform goals, following participation in the cohort.

[20] In some IAP areas, new cohorts and/or tracks were added after the evaluation period ended because the IAP continued through September 2020. The Promoting Community Integration through Long-Term Services and Supports Housing Partnership track Cohort 3 and Value-Based Payment for Fee-for-Service Home and Community-Based Services track are not included in this report.

[21] Section 1115 demonstrations and the waiver authorities in section 1915 of the Social Security Act are vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid and CHIP. https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html (Accessed April 23, 2020).

Summary of Key Findings

Value-Based Payment for Home and Community-Based Services Component

Planning a Value-Based Payment for Home and Community-Based Services Strategy

- State teams that attended the webinar series gained a better understanding of quality outcome measurement for VBP for HCBS payment options.
- Some state teams pursued implementation of VBP for HCBS, or defined concrete next steps.
- One-third of participants later also completed other CI-LTSS tracks (i.e., Implementing a VBP for HCBS Strategy and Designing a VBP for HCBS Strategy).
- Resource limitations, staffing constraints, and difficulty gaining stakeholder agreement limited implementation.

Implementing a Value-Based Payment for Home and Community-Based Services Strategy

- State teams learned about different VBP for HCBS models and approaches to incentives, which helped them articulate desired VBP outcomes.
- State teams identified and selected CI-LTSS performance measures. One state team designed a process for data sharing.
- Participants anticipated that operational challenges would slow their reform efforts.
- Participants continued to work on ACO waivers and MLTSS finance restructuring.

Designing a Value-Based Payment for Home and Community-Based Services Strategy

- Participants gained foundational knowledge to support development of a VBP for HCBS strategy, and coaches' feedback helped state teams think strategically.
- State teams engaged providers in strategic discussions, assessed data, performed analyses, and organized peer learning forums.
- Participation raised awareness of VBP and HCBS activities among state agency staff.
- Varying state readiness for reform affected states' ability to apply IAP learning.
- State teams gained capacity in DA, quality measurement, VBP and financial simulations, and using performance indicators, but were unsure whether they could apply these concepts to delivery system reform efforts.

Note. [1]Formerly called Incentivizing Quality Outcomes (IQO) Planning track; [2]Formerly called IQO Implementation track; [3]Nine of the 10 states received extensions, four through July 2019, five through August 2019.

Medicaid Housing-Related Services and Partnerships Component

The HRSP component of the CI-LTSS program area aimed to increase adoption of individual tenancy sustaining services that assist Medicaid beneficiaries, and to expand housing development opportunities for Medicaid beneficiaries through facilitation of partnerships between state Medicaid and housing agencies. The HRSP component consisted of two tracks: the Supporting Housing Tenancy Track and the State Medicaid-Housing Agency Partnerships Track.

Supporting Housing Tenancy Track[22]

The goal of the Tenancy track, which ran from February to May 2016, was to provide participants with strategies, such as leveraging or expanding case management to include tenancy services or working with community providers, to provide housing tenancy supports for community-based LTSS Medicaid beneficiaries. Tenancy supports help individuals understand their responsibilities as tenants, such as finding and leasing suitable housing, paying rent on time, maintaining an apartment, or resolving issues with a landlord or neighbors.[23]

HRSP Component, Supporting Housing Tenancy Track	
Goals	• Provide participants with strategies to support housing tenancy services for community-based LTSS Medicaid beneficiaries.
Length of Support	• February 2016–May 2016
Participating States	• Open to all 32 applicants1
Composition of State Teams	• State Medicaid Agency • State Housing Agency (required) • State Behavioral Health Agency • State Developmental Disabilities Agency • State Aging Agency
Modes of Support	• Series of three webinars (e.g., on Medicaid authorities for housing-related services, state Medicaid coverage examples, keys to implementation success)

Note. [1]Thirty states (AL, AK, CA, CT, DE, DC, HI, IL, IN, KY, LA, MA, MD, MN, MO, MS, NC, ND, NE, NH, NJ, NV, OH, OR, PA, RI, TX, UT, VA, WA) participated in at least one webinar.

KEY FINDINGS

What knowledge did participants acquire from the Tenancy track of the IAP?

The webinars helped representatives from state agencies understand how Medicaid can support tenancy.

More than 76% of survey respondents (n=31 respondents representing 17 states)[24] agreed or strongly agreed that the webinars offered new, or more-in-depth, information about Medicaid tenancy supports. In addition, the majority of respondents (80%; n=33) agreed that the webinars clarified which housing-related services can be covered by Medicaid, and which Medicaid authorities can be used to pay for housing-related services.

> "This [the first] webinar gave me a better understanding of Medicaid programs that may cover housing-related services… [and] this one gave a foundation for the others."
>
> ~ TENANCY TRACK STATE PARTICIPANT

[22] The evaluation of this track was based solely on participant responses to a post-webinar series survey. Ongoing reforms were not assessed in the evaluation of the Tenancy track.
[23] See, for example, Medicaid and CHIP Payment and Access Commission, "Medicaid's Role in Housing." October, 2018. Available at: https://www.macpac.gov/wp-content/uploads/2018/10/Medicaid%E2%80%99s-Role-in-Housing.pdf
[24] Multiple respondents from a state may have responded differently to the same survey item.

State participants appreciated clear, concrete examples of how funding options could be used in their states.

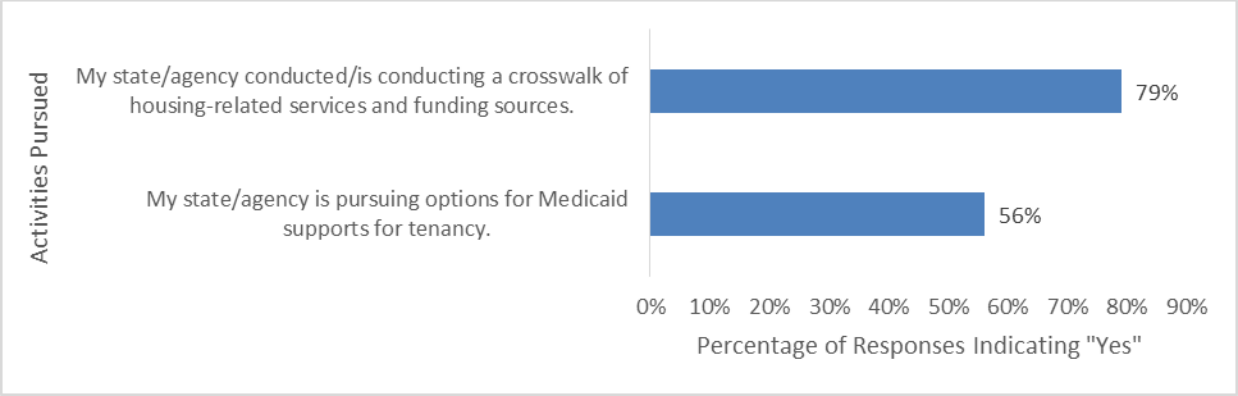
Participants rated the webinar that offered state examples of Medicaid coverage of housing-related services most useful to their agency. The second-highest rated webinar described housing-related services and identified Medicaid authorities that may cover some of the services.

What Medicaid program activities did state teams undertake as a result of participating in the Tenancy track of the IAP?

State teams developed crosswalks and pursued Medicaid supports for tenancy.

As Exhibit 4.2 illustrates, 78% of respondents (n=29 respondents representing 15 states) were developing a crosswalk of housing-related services and funding sources. The crosswalk helped state teams understand what services are being provided, to which populations, and under what Medicaid authorities or non-Medicaid sources, and how costs are reimbursed. It was used to identify gaps in services and funding streams that might help fill those gaps. The crosswalk mapped programmatic and funding information for available housing-related services. In addition, 56% of respondents (n=24 respondents representing 12 states) pursued Medicaid supports for tenancy.

Exhibit 4.2. Activities Pursued as a Result of Participating in the CI-LTSS HRSP Tenancy Track (n=48 respondents)[1]



Note. [1]The 48 respondents represented 22 states. Three respondents did not provide a state affiliation.

What happened as a result of participation in the Tenancy track of the IAP?

Participation in the Tenancy track webinar series led state teams to participate in other CI-LTSS tracks.

Seventy-six percent of respondents (n=33) to the post-webinar series survey indicated that their agency would be interested in participating in another Partnership track cohort. Of the 30 states that participated in the Tenancy track, 23 states (76%) went on to participate in one or more other CI-LTSS tracks. Fifteen Tenancy track states participated in one or more Partnership track cohorts. Further, 17 Tenancy track states participated in one or more of the VBP HCBS tracks.

What barriers, if any, reduced the impact of participation in the Tenancy track of the IAP?

Lack of detail and specifics inhibited state teams from implementing what they had learned.

Webinars presented an overview of general information, and some participants reported they would have benefited from more detail. Some participants suggested that a one-on-one or peer-to-peer follow-up discussion after each webinar would have been valuable.

State Medicaid-Housing Agency Partnerships Track – Cohorts 1 and 2

The goal of the Partnership track was to facilitate Medicaid collaboration with key housing partners. Cohort 1 ran from April through December 2016; Cohort 2 began in August 2017 and continued through May 2018. Through this track, the IAP promoted partnerships between state Medicaid agencies, state housing finance agencies, public housing authorities, and other state agencies. CMS staff worked closely on planning and coordination of this track with federal partners, including: the U.S. Interagency Council on Homelessness, the U.S. Department of Housing and Urban Development, the Office of the Assistant Secretary for Planning and Evaluation, and the Substance Abuse and Mental Health Services Administration.

HRSP Component, State Medicaid-Housing Agency Partnerships Track	
Goals	• Provide intensive support to facilitate Medicaid collaboration with key housing partners
Length of Support – Cohort 1	• Cohort 1: April 2016–December 2016
Participating States – Cohort 1	
Length of Support – Cohort 2	• Cohort 2: August 2017–May 2018
Participating States – Cohort 2	
Composition of State Teams	• State Medicaid Agency • State Housing Agency • State Mental or Behavioral Health Agency
Modes of Support	• Webinars with subject matter experts and peer learning (e.g., on data matching and data use strategies, tools for developing partnerships, MCOs and supportive housing, cross-state learning) • Discussion groups • Coaching (e.g., on housing assessments and crosswalks) • PI SMEs • In-person meeting (e.g., on services and partnerships, aligning policy with target populations, creating action plans, data use, innovative payment methods) • Email updates (also stored on Groupsite) • Groupsite online resource library (also distributed via email)

KEY FINDINGS

What knowledge did participants acquire from the Partnership track of the IAP?

Participation in the Partnership track increased state knowledge of tenancy supports.

Ninety-two percent of state survey respondents across both Partnership cohorts (n=13 respondents, representing 13 states) agreed that participation increased state knowledge of tenancy supports and other housing-related service options for LTSS recipients.

Participants acquired knowledge about Medicaid authorities and processes, such as models of tenancy supports, evidence-based practices, and implementation of housing supports.

Participants learned about:

- Section 1915c waivers[25]
- Models of tenancy supports and evidence-based practices
- Implementation of housing supports by Medicaid MCOs
- Types of housing-related services covered by Medicaid
- Information on establishing data matching policies and procedures to help inform data use decisions

Participants gained knowledge about data sources, data sharing, and data matching. One participant described becoming more data "fluent" as a result of their participation in the Partnership track. Sharing of specific information across states, such as examples of data sharing agreements, specific program models, MCO contract language, and housing assessment and contractor performance metrics, helped to inform participants' strategies and activities, including their federal Medicaid waiver submissions. The knowledge acquired helped one participant "with the groundwork" for a Medicaid state plan amendment.

Participants gained skills for implementing tenancy supports in Medicaid.

Participants gained skills for communicating with stakeholders, training staff, and sharing data. Specifically, state participants gained skills in:

- Building a business case for supporting housing
- Inserting housing incentives into MCO contracts and mandating that MCOs engage housing coordinators
- Engaging stakeholders
- Providing training for case managers
- Starting a Homeless Management Information System DUA

Medicaid and housing agency staff reported reciprocal learning about program operations.

Bringing together housing and health care agencies increased teams' literacy on housing-related health services and their understanding of the other agency's operations, culture, and language, helping to build a foundation for more-effective and more-productive partnerships. State team members with Medicaid services backgrounds learned how housing programs operate; conversely, those with housing backgrounds learned about Medicaid services.

State teams gained greater appreciation for the differences in housing and Medicaid terminology and the challenges these differences pose to collaboration. Some state teams became more cognizant of the terms used and the need to define them clearly. One state official reported, for instance, that if a housing specialist is talking about pre-tenancy supports, a Medicaid specialist is unlikely to know what that is. The participant added that tenancy supports should instead be described as, "supports and services that will help someone

[25] Within broad Federal guidelines, states can develop HCBS waivers (Section 1915c waivers) to meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting.

develop skills in the community so that they have greater chances at recovery." Even general terms such as case support and case management can have different meanings in housing and Medicaid circles, underscoring the importance of clarifying meaning to ensure consensus understanding.

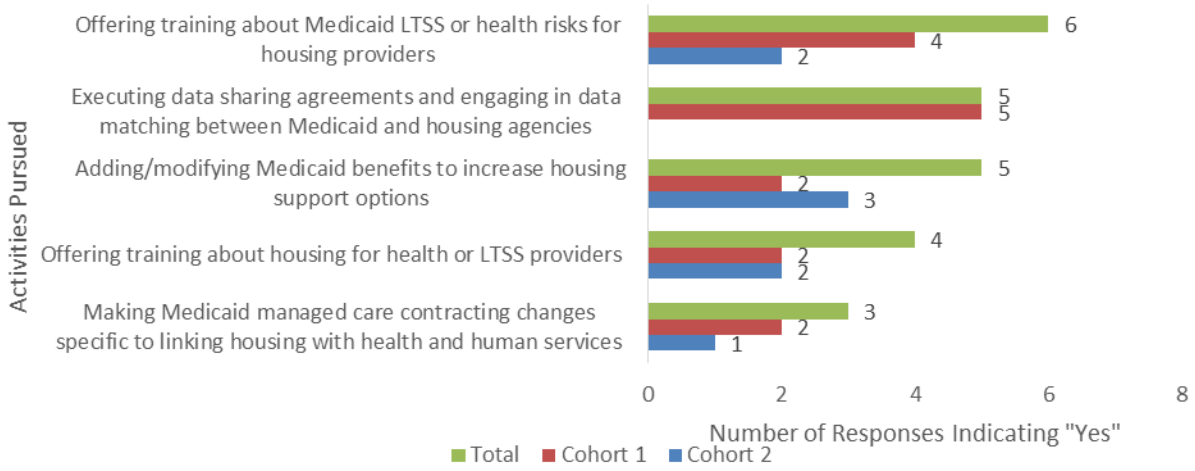
One participant reported that the "IAP put all the stakeholders together [to] better understand who is doing what, see the commonalities, and form a strategic plan of how to work together." Another reported that "it helped to cement our relationships with public housing authorities."

What Medicaid program activities did state teams undertake as a result of participating in the Partnership track of the IAP?

State participants commonly reported establishing or strengthening existing interagency relationships as a result of their participation in the IAP.

In some states, participants from Medicaid and housing agencies met one another for the first time as part of their IAP involvement. In other states, participants built on existing inter-agency relationships by working together in the IAP. In addition, as shown in Exhibit 4.3, state teams pursued numerous other activities to enhance and expand housing-related supports in the six months following participation in the Partnership track, including data sharing, training, and updating Medicaid benefits.

Exhibit 4.3. Activities Pursued by Cohort 1 (n=8 respondents)[1] and Cohort 2 (n=6 respondents)[2] CI-LTSS HRSP Track States Following IAP Participation



Note. Activities pursued as of August 2017 for Cohort 1 and March 2018 for Cohort 2. [1] Each respondent represented one state (n=8 states). [2]Each respondent represented one state (n=6 states).

State teams found new ways to apply Medicaid and housing funds.

One state team partnered with the housing finance agency on new housing initiatives, and another developed next steps for making better use of homeless/housing grant dollars. A team from a third state sought leadership buy-in for a pilot project to assess different ways to apply Medicaid benefits to help recipients maintain their housing, while lowering Medicaid costs.

State teams provided training related to housing needs, services, and supports.

One state team partnered with housing agencies to provide training on housing tax credit programs. Another state team expanded the list of services that Medicaid ACOs may provide to high-risk enrollees to include

housing applications, tenancy services, and home modifications. Finally, one state team trained nonprofits, other governmental agencies, and service providers on affordable housing needs for Medicaid beneficiaries.

One state team was able to better understand and use available data across multiple systems.

This team reported cross-referencing multiple state data sources to make better-informed decisions about Medicaid beneficiaries' service needs. Not only did the team work with Medicaid Management Information System and health care services data, but they also began talking with representatives of the Department of Corrections about obtaining data.

IAP participation inspired state teams to join other collaboratives focused on health and housing.

Following the IAP Partnership Track, one state team participated in the National Association of States United for Aging and Disabilities technical assistance initiative on health and housing. A team from another state subsequently participated in the local Continuum of Care, joined the team working on changes to the homeless services delivery system, and worked with service providers who are creating affordable housing.

What happened as a result of participation in the Partnership track of the IAP?

As a result of their participation in the Partnership track, state teams had more confidence to advocate for reform.

State teams gained a better mutual understanding of the Medicaid and housing issues in their states. Some state teams reported that they had initiated efforts prior to participating in the track, but lacked the support and resources to continue without the IAP. One team described the Partnership track as "the catalyst" to convening important dialogues. Another team reported it had had a breakthrough in data sharing when state Medicaid and housing leaders set up a formal agreement to share Medicaid Management Information System data. The team can now link data to form a better picture of population needs.

> "When we [housing agency staff] did a policy academy three years ago, someone said a good outcome would be to meet with someone in Medicaid. Now we're side by side working on waiver applications."
>
> ~ PARTNERSHIP TRACK PARTICIPANT

What barriers, if any, reduced the impact of participation in the Partnership track of the IAP?

Limited resources and staff turnover inhibited state teams' ability to move forward with their action plans.

Many state teams are moving forward with their plans cautiously because of a lack of state funding. State teams often need to show cost-effectiveness for any initiative under consideration, and participants faced challenges in presenting their ideas to leadership as cost-effective solutions.

Staff turnover among IAP coaches and state leaders sometimes posed a barrier. In these instances, turnover stalled daily operations, and teams had difficulty reallocating duties and leadership roles. Coaches suggested that future iterations of the Medicaid Housing Partnership track identify state co-leads as well as co-coaches to lessen the impact if one individual were to leave.

How did the Partnership track of the IAP support any ongoing reforms?

IAP participants formed or strengthened intra-state health and housing staff partnerships.

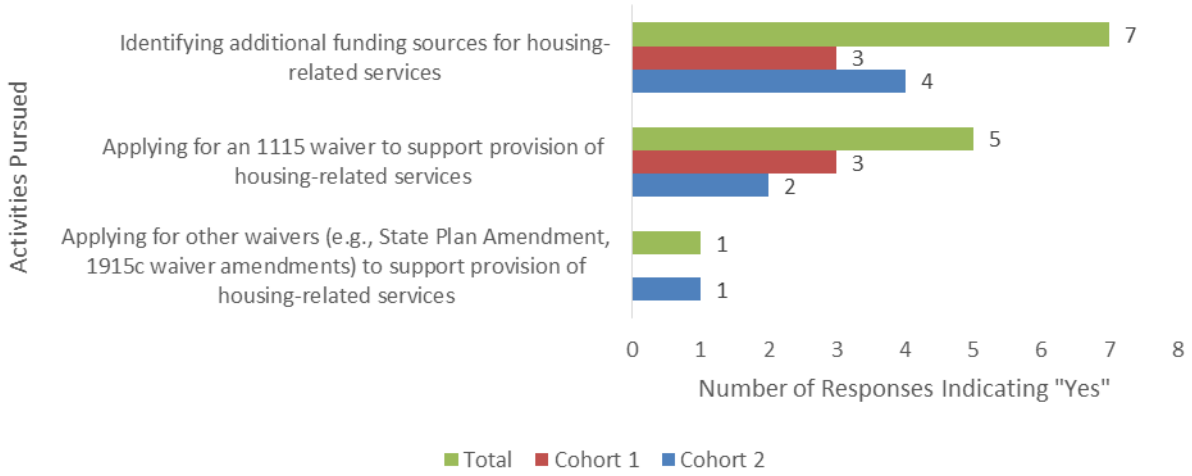
The IAP helped cross-agency state teams develop organized projects and coherent goals to work toward together. Connecting with CMS through the IAP endowed states' efforts with a sense of credibility and "clout" in being able to access resources and collaborate with other agencies.

> "The most valuable thing about this experience is that it created an expectation in our state that something was going to be done in this area. We have used that as a communications tool and have a lot more people understand what can be done, what we're trying to do. Getting high level decision-makers to understand that, and that we're expected to have outcomes—that's a big deal."
>
> ~ PARTNERSHIP TRACK PARTICIPANT

Some IAP participants applied for Medicaid waivers as a result of their participation in the IAP.

As shown in Exhibit 4.4, as a result of the participating in the IAP track three Cohort 1 state teams and four Cohort 2 state teams identified additional funding sources for housing-related services. Three Cohort 1 teams, and two Cohort 2 teams, applied for a Section 1115 demonstration waiver to support the provision of housing-related services, or pursued other state policy or program changes that link LTSS and housing, following their participation in the cohort. One state team applied for other waivers to support the provision of housing-related services.

Exhibit 4.4. Demonstration Waivers Pursued by Cohort 1 (n=8 respondents)[1] and Cohort 2 (n=6 respondents)[2] as a Result of Participating in the CI-LTSS HRSP Partnership Track



Note. Activities pursued as of August 2017 for Cohort 1 and March 2018 for Cohort 2. [1] Each respondent represented one state (n=8 states); [2]Each respondent represented one state (n=6 states).

Value-Based Payment for Home and Community-based Services Component

The Value-Based Payment for Home and Community-Based Services (VBP for HCBS) component of the CI-LTSS program area aimed to increase adoption of strategies that tie together quality, cost, and outcomes in support of community-based LTSS programs.

Planning a Value-Based Payment for Home and Community-Based Services Strategy[26] Track

The goal of the Planning a VBP for HCBS Strategy track, which ran from April through October 2016, was to provide planning support in developing a VBP approach for community-based LTSS.

VBP FOR HCBS COMPONENT, PLANNING A VBP FOR HCBS STRATEGY TRACK	
GOALS	• Provide planning support in developing a value-based payment approach for community-based LTSS
LENGTH OF SUPPORT	• April 2016–October 2016
PARTICIPATING STATES	
COMPOSITION OF STATE TEAMS	• State Medicaid Agency • State Developmental Disabilities Agency • State Aging Agency
MODES OF SUPPORT	• A series of six webinars (e.g., on incentivizing HCBS quality and outcomes, moving from policy towards implementation) • Groupsite online resource library

KEY FINDINGS

What knowledge did participants acquire from the Planning a VBP for HCBS Strategy track of the IAP?

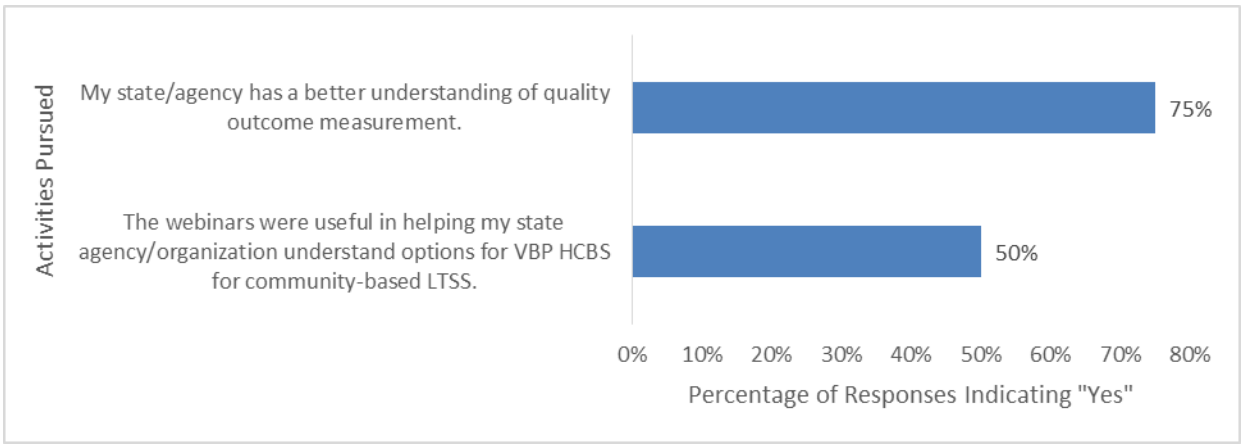
State teams gained a better understanding of quality outcome measurement and options for VBP for HCBS.

[26] The evaluation of this track was based solely on participant responses to a post-webinar series survey. Ongoing reforms were not assessed in the evaluation of the Planning a VBP for HCBS Strategy track.

The webinars offered state teams new or more in-depth information, and state teams gained a better understanding of quality outcome measurement as a result of participating in the Planning a VBP for HCBS Strategy track. Participants pointed specifically to quality measures for HCBS, such as survey data from the National Core Indicators[27] project, and information on introducing VBP to HCBS providers, as the most useful information presented. State participants also valued hearing from other states about their experiences with the development of quality strategies.

As Exhibit 4.5 illustrates, three quarters of post-webinar series survey respondents (representing five states) indicated that their participation in the Planning a VBP for HCBS Strategy track resulted in a better understanding of quality outcome measurement, and half of the respondents (representing three states) reported that the webinars helped their agency better understand the options for VBP for community-based LTSS.

Exhibit 4.5. Knowledge Gained as a Result of Participating in the Planning a VBP for HCBS Strategy Track (n=10 respondents)[1]



Note. [1]The 10 respondents represented eight states; reported percentages indicate percentage of responses to each question, not percentage of all respondents.

What Medicaid program activities did state teams undertake as a result of participating in the Planning a VBP for HCBS Strategy track of the IAP?

Some state teams were pursuing options for implementing VBP HCBS.

As Exhibit 4.6 illustrates, three post-webinar series survey respondents, representing 3 of the 10 participating states, reported pursuing options for implementing VBP for HCBS for community-based LTSS. Three respondents also reported using information provided in the webinars to support program changes or delivery system reform efforts.

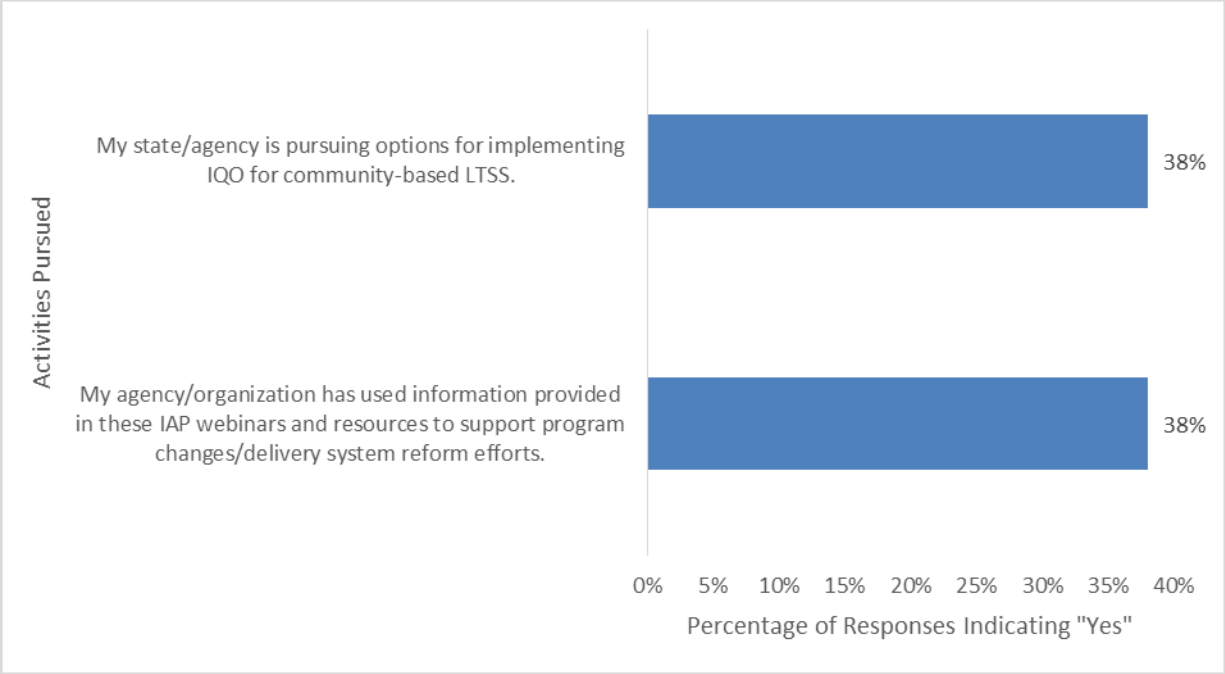
Participants reported that they intended to apply the information learned from the Planning a VBP for HCBS Strategy track webinar series in the following ways:

- Develop a VBP for HCBS work plan
- Support VBP in MCO contracts

[27] For more information on the National Core Indicators-Aging and Disabilities survey, see http://www.advancingstates.org/initiatives/national-core-indicators-aging-and-disabilities.

- Explore the use of the National Core Indicators-Aging and Disabilities survey as part of sustainability plans for the state's Money Follows the Person[28] program
- Obtain additional stakeholders' buy-in to VBP methodology

Exhibit 4.6. Activities Pursued by Planning a VBP for HCBS Strategy Track States Following IAP Participation (n=10 respondents)[1]



Note. [1] The 10 respondents represented eight states.

What happened as a result of participation in the VBP Planning track of the IAP?

Participation in the Planning a VBP for HCBS Strategy webinar series led state teams to participate in other CI-LTSS tracks.

Five post-webinar series survey respondents representing four states indicated that their state would be interested in participating in another VBP for HCBS track if offered. About half of the participants also said they were interested in other IAP program or functional areas. Of the nine states that participated in the Planning a VBP for HCBS Strategy track, representatives from one later participated in the Implementing a VBP for HCBS Strategy track, and representatives from two later participated in the Designing a VBP for HCBS Strategy track.

What barriers, if any, reduced the impact of participation in the Planning a VBP for HCBS Strategy track of the IAP?

[28] For more information on the Money Follows the Person program, see https://www.medicaid.gov/medicaid/long-term-services supports/money-follows-person/index.html.

State teams identified resource constraints and difficulty ensuring stakeholder agreement as barriers in implementing what they learned through the IAP.

Participants in the Planning a VBP for HCBS Strategy track anticipated that they would face challenges in implementing the lessons learned through the six webinars. Specific barriers state participants noted included resource constraints, especially those related to staffing, and difficulty ensuring that stakeholders agree with the selected measures.

Implementing a Value-Based Payment for Home and Community-Based Services Strategy Track

The goal of the Implementing a VBP for HCBS Strategy track, which ran from November 2016 through April 2017, was to provide support to state teams undertaking early stages of VBP for HCBS strategy implementation.

VBP FOR HCBS COMPONENT, IMPLEMENTING A VBP FOR HCBS STRATEGY TRACK	
GOALS	• Provide support to state teams undertaking early stages of VBP for HCBS strategy implementation
LENGTH OF SUPPORT	• November 2016–April 2017 (support extended to September 2017)
PARTICIPATING STATES	
COMPOSITION OF STATE TEAMS	• State Medicaid Agency • State Aging and Disability Services Agency • State Department of Social & Health Services
MODES OF SUPPORT	• Webinars with subject matter experts and peers (e.g., on peer-to-peer VBP discussion) • Coaching (e.g., on developing a sustainable VBP program, on designing a process for sharing information with the state's Medicaid MCOs) • PI SMEs • Email updates (also stored on Groupsite) • Groupsite online resource library (also distributed via email)

KEY FINDINGS

What knowledge did participants acquire from the Implementing a VBP for HCBS Strategy track of the IAP?

Participants learned about different models of VBP and approaches to incentives.

Participants learned valuable information from other states during a peer-to-peer webinar. One state team learned how other states structured performance incentive programs for MCOs. Another state team learned how to develop incentive strategies that leveraged state data to link quality to payment. However, participants lacked context to assess how other states' experiences applied in their own settings.

"While I walked away with a good understanding of the approaches and decisions states had made, I did not have a great sense for why they made certain decisions and the factors at play in the decision-making processes."

~ VBP HCBS IMPLEMENTATION STATE PARTICIPANT

IAP participation helped state teams articulate desired VBP outcomes and identify staff to collect quality measures.

The IAP helped two state teams articulate what outcomes they sought to measure in order to assess the quality of community-based LTSS, and to better understand the measurement process. One participant remarked that coaching support helped the state team "work through the process of developing a program that was going to move the needle … on quality." Another state participant said the IAP helped them "pave the way" for incorporating LTSS quality measures into state programs. The IAP also helped state teams identify appropriate staff to collect measures.

What Medicaid program activities did state teams undertake as a result of participating in the Implementing a VBP for HCBS Strategy track of the IAP?

State teams identified and selected LTSS performance measures.

State teams selected performance measures, developed scoring methodology, and defined MCO measure specifications. One state participant said that "the most valuable aspect of the IAP was helping [our team] streamline the performance measurement selection." Another state team developed a scoring methodology to determine quality incentive payments. A third state team identified specifications for measures they planned to tie to MLTSS[29] capitation payments, along with appropriate withholds.

What happened as a result of participation in the Implementing a VBP for HCBS Strategy track of the IAP?

One state team selected measures and designed a process for data sharing.

The extended, unstructured coaching support period from May to September 2017 enabled one state team to engage stakeholders and design a process for sharing information with the state's Medicaid MCO. The team implemented five measures that assess quality of life, person-centeredness, and the safety and maintenance of community-based living arrangements.

What barriers, if any, reduced the impact of participation in the Implementing a VBP for HCBS Strategy track of the IAP?

Respondents anticipated operational challenges in implementing the lessons learned through the Implementing a VBP for HCBS Strategy track.

[29] Managed LTSS refers to the delivery of long-term services and supports through capitated (fixed, pre-arranged payments) Medicaid managed care programs.

Implementing a VBP for HCBS Strategy track participants anticipated challenges when attempting to apply what they learned through the IAP. Participants noted operational challenges, rather than resource constraints, as potential barriers. For example, one participant anticipated challenges in using or implementing what they learned about quality measures, and difficulty interpreting MLTSS data.

> "It took getting past some operational implementation milestones before we could focus more resources on performance incentive structures."
>
> ~ VBP HCBS IMPLEMENTATION STATE PARTICIPANT

How did the Implementing a VBP for HCBS Strategy track of the IAP support any ongoing reforms?

IAP participation supported states' ongoing reform efforts.

Participants pointed to waiver renewals, pursuing ACO waivers, and MLTSS finance restructuring activities, all of which lay the groundwork for VBP, as examples of work that continued as a result of the strategic design support they received from the IAP.

Designing a Value-Based Payment for Home and Community-Based Services Strategy Track

The Designing a VBP for HCBS Strategy track, which ran from May 2018 through March 2019, had two key objectives: building state knowledge and capacity to design a VBP strategy for HCBS; and moving states toward implementation of a VBP for HCBS strategy. In this track, state teams worked toward increasing the adoption of strategies that tie together quality, cost, and outcomes in support of community-based LTSS.

VBP FOR HCBS COMPONENT, DESIGNING A VBP FOR HCBS STRATEGY TRACK	
GOALS	• Build state knowledge and capacity to design a VBP strategy for HCBS and move states toward implementation of a VBP strategy for HCBS
LENGTH OF SUPPORT	• May 2018 – March 2019 (support extended to August 2019)[1]
PARTICIPATING STATES	
COMPOSITION OF STATE TEAMS	• State Medicaid Agency • State Housing Agency • State Mental Health Agency • State Developmental Disabilities Agency • State Aging Agency
MODES OF SUPPORT	• Webinars with SMEs and peer learning (e.g., on quality measurement, payment models, Medicaid authorities and CMS requirements for VBP for HCBS) • Coaching (e.g., on improving data collection, identifying specific diagnosis codes for analyses, and turning data into meaningful and actionable information) • PI SMEs • Site visits • Email updates (also stored on Groupsite) • Groupsite online resource library (also distributed via email)

[1]Nine of the 10 states received an extension: four through July 2019, and five through August 2019.

KEY FINDINGS

What knowledge did participants acquire from the Designing a VBP for HCBS Strategy track of the IAP?

Participating state teams gained foundational knowledge to support early development of a VBP for HCBS strategy.

The Designing a VBP for HCBS Strategy track webinars provided useful basic and high-level information. State participants learned about national quality frameworks for HCBS, state adoption of specific quality measures, guiding principles for designing measures, star rating systems, and financial incentive options. The track offered "needed education" on the foundational elements of a VBP initiative, including the articulation of policy goals, identification and selection of quality measures, and assessment and collection of data. The VBP roadmap tool provided guidance on the steps that "CMS thinks are critical" in the development of VBP strategies. Participants received information from coaches about quality measures (e.g., resident, family, and staff satisfaction; culture change/quality of life; staffing/staff competency; clinical performance) that other states were considering. Coaches also helped participants develop a plan for stakeholder engagement.

"We had a lot of basic knowledge around VBP and it was more: how do we take what we know and we're working on and apply it to this new set of services?"

~ VBP HCBS DESIGN STATE PARTICIPANT

Coaches' expert feedback and outside perspective helped state teams think strategically.

State teams involved coaches in strategic discussions to learn how they could improve data collection, identify specific diagnosis codes for analyses, and turn data into meaningful and actionable information. State teams with more VBP experience or defined strategies to implement a VBP for HCBS strategy used coaches as a sounding board. One participant commented that "it has been more helpful to have a knowledgeable team to be able to bounce our ideas against and say 'hey, wait, you didn't think about this pitfall, or this one didn't align with your goal.'"

What Medicaid program activities did state teams undertake as a result of participating in the Designing a VBP for HCBS Strategy track of the IAP?

State participants organized peer learning forums.

Designing a VBP for HCBS Strategy track state participants attended an informal meeting during the annual National Association of States United for Aging and Disabilities HCBS conference in August 2018 to provide updates on IAP activities, discuss what they had learned, and exchange ideas. State teams requested a similarly structured peer-to-peer learning opportunity through the Designing a VBP for HCBS Strategy track. In December 2018, Designing a VBP for HCBS Strategy track coaches facilitated a "roundtable" peer-to-peer discussion that focused on MLTSS, with specific attention to the following topics of interest to states:

- Advice and challenges related to measurement for VBP for HCBS
- Training of direct care workers
- Nonfinancial incentives
- Incentivizing nursing home transitions

State teams engaged providers in strategic discussions about VBP for HCBS.

Teams from several states held meetings with providers to educate them and seek their feedback on proposed VBP for HCBS strategies. One state team repurposed Designing a VBP for HCBS Strategy track resources and materials (e.g., webinar content) to develop an informational presentation for provider groups. Some state teams relied on IAP coaches to facilitate discussions between state officials and providers during site visits.

State teams assessed their data and performed analyses to support VBP for HCBS.

State teams drew on the IAP's data analytic support to identify data gaps (e.g., in client satisfaction data) and improve data quality. State teams used data to establish benchmarks, perform financial simulations, design payment models with financial incentives, and understand opportunities for PI. One state team analyzed five years of utilization trends for specific services to inform the development of a measurement framework to implement financial incentives.

State teams leveraged the work accomplished as part of the IAP to advance payment reform efforts.

Technical assistance provided through CMS and by SMEs lent a sense of credibility to proposed VBP strategies. Participation in the Designing a VBP for HCBS Strategy track supported conversations with state

leadership about specific VBP strategies, (e.g., investing in data and analytics capabilities), and informed responses to legislative requests or reporting requirements pertaining to value-based care. IAP coaches, as national experts, brought an objective, outside perspective that is helpful for obtaining leadership buy-in. One state participant said of its leadership: "They are receptive ... it adds validity to the kinds of things that we are recommending."

What happened as a result of participation in the Designing a VBP for HCBS Strategy track of the IAP?

Participation raised awareness among state agency staff of VBP and HCBS activities.

State participants in the Designing a VBP for HCBS Strategy track unanimously "agreed" or "strongly agreed" that their participation increased knowledge about VBP among staff focused on HCBS-related activities.[30] In one state, IAP support led to an increased awareness among state officials of MCO payment reform activities, and had a "spillover effect" to other initiatives also focused on promoting community integration. Another state team created its own Medicaid Innovation Office that will focus on improving the quality, delivery, and value of care. The state team used information and resources from the IAP to inform the office's structure and activities.

What barriers, if any, reduced the impact of participation in the Designing a VBP for HCBS Strategy track of the IAP?

State participants were reticent to engage in open dialogue during knowledge-building webinars.

Webinar hosts encouraged open dialogue, but at times attendees were hesitant to discuss strategies or plans that were still under development. Participants who were in the early knowledge-building phase of VBP for HCBS were focused on absorbing and processing information, and reserved questions for one-on-one discussion with their coaches.

Varying state readiness for reform affected states' ability to apply IAP learning to state delivery system reforms.

State teams were at varying points in their readiness for VBP for HCBS, and in their experience with payment reform. Some participants found that the high-level information met their needs, while others sought more-in-depth information and greater insight to advance their work. One participant indicated that "it's a completely new area," so there was little information about specific VBP models that could be shared and replicated. The amount of time needed to build provider support and obtain buy-in for a VBP model may have slowed progress toward implementation. Data availability and the diversity of states' HCBS programs and policy environments were also influential factors.

[30] There were 11 total responses to the Summative Survey. Two partially completed surveys were excluded from reported results.

"The sessions were done well, and people were prepared, but they didn't exceed the state's current knowledge of HCBS quality measurement and VBP as those approaches are still in very early stages."

~ VBP HCBS DESIGN STATE PARTICIPANT

How did the Designing a VBP for HCBS Strategy track support any ongoing reforms?

State teams gained capacity in obtaining and generating robust and reliable data that continue to inform their HCBS programs.

One state team is generating quality measurement data at the provider level to better document and ultimately improve the quality of care provided through HCBS. Another state team developed a better process to ensure robust and reliable data capture which they are using to inform a redesign of their 1915c waiver.

Conclusion

Across all CI-LTSS tracks, state teams acquired new information and knowledge. They were able to develop or refine their goals and strategies for making delivery system reforms as a result of participating in the IAP. Participation resulted in state teams' gaining knowledge and information that was readily applicable to their payment and delivery system reform efforts with specific attention to integrating quality performance. Further, participation in tracks focused solely at Stage 1: learning, (i.e., HRSP Component, Tenancy track and VBP for HCBS Component, Planning a VBP for HCBS Strategy track) led to later participation in more-intensive CI-LTSS tracks (HRSP Component, Partnership and VBP for HCBS Component, Implementing a VBP for HCBS Strategy and Design) or other IAP areas (e.g., PMH, DA, and VBPFS). In higher-intensity tracks, participants were able to support ongoing reform efforts by receiving strategic design assistance with the development of Medicaid waiver renewals and applications. Through MLTSS finance restructuring activities participants were able to engage providers in development of new payment models, and assess and analyze data to inform activities.

SUPPORTING PHYSICAL AND MENTAL HEALTH INTEGRATION

CMS provided technical assistance to states in the Supporting Physical and Mental Health Integration (PMH) program area for developing, expanding, or improving efforts to integrate physical and mental health services. There were two tracks within the PMH program area:

- Physical and Mental Health Integration Group (PMH Group)
- Integration Strategy Workgroup (ISW)

State teams participating in the PMH Group track had access to individualized coaching, discussion groups with peers, webinars, and other additional resources. State teams participating in ISW had access to webinars and post-webinar calls with technical assistance providers, but did not receive individualized coaching. In both tracks, the IAP activities helped the state teams start or continue existing PMH delivery system reform projects.

Summary of Key Findings

PHYSICAL AND MENTAL HEALTH INTEGRATION GROUP

- PMH Group track state teams enhanced their understanding of: pay for performance and alternative payment methodologies, quality measures for high-needs populations, telemedicine for behavioral health, and mental health emergency room boarding.
- PMH Group track state teams established new partnerships and strengthened existing partnerships among Medicaid, other state agencies, and health system stakeholders, and incorporated PI techniques into their IAP project work plans.
- State teams made advances in quality measurement, screening, and payment reform to expand PMH access and integration.
- State teams needed more detail in order to apply promising practices from other states, and lacked cooperation from critical stakeholders.
- At the end of the PMH Group track, some state teams continued work on PMH initiatives, including: draft legislation, screening tools, and PMH integration at federally qualified health centers (FQHCs).

INTEGRATION STRATEGY WORKGROUP

- ISW state teams learned about models for integrating physical and mental health, and chose models appropriate to their states.
- One state team developed a health home state plan amendment.
- State teams established and improved cross-agency partnerships between Medicaid and behavioral health agencies.
- Diverse state goals sometimes limited group learning, and structural barriers slowed implementation.
- One state team implemented a five-year initiative to expand Screening, Brief Intervention, and Referral to Treatment.

Physical and Mental Health Integration Group Track

The PMH Group track, which ran from April 2016 to April 2017, aimed to improve behavioral and physical health outcomes and care experiences for Medicaid beneficiaries with mental health conditions by expanding or improving existing PMH integration efforts.

PHYSICAL AND MENTAL HEALTH INTEGRATION GROUP TRACK	
GOALS[1]	• Improve the behavioral and physical health outcomes and experience of care of individuals with a mental health condition(s) • Create opportunities for state teams to link payments with improved outcomes for Medicaid beneficiaries with co-morbid physical and mental health conditions • Expand or enhance existing state physical and mental health integration efforts to customize for specific populations • Spread physical-mental health integration efforts to new areas of the state or to new types of health professionals
LENGTH OF SUPPORT	• April 2016–April 2017
PARTICIPATING STATES	NEVADA, NEW HAMPSHIRE, NEW JERSEY, WASHINGTON, PUERTO RICO
COMPOSITION OF STATE TEAMS	• Medicaid agency • Department of Mental or Behavioral Health • Department of Public Health • Department of Children and Families
MODES OF SUPPORT	• Webinars (e.g., on quality measures, provider capacity) • Discussion groups • Coaching (e.g., on billing and coding, alternative payment methodologies, quality measures, telemedicine) • PI SMEs • Email updates (also stored on Groupsite) • Groupsite online resource library (also distributed via email)

[1] CMS revised these goals based on results of a gap analysis conducted with participating states which found states at a less advanced stage of readiness to implement physical-mental health integration strategies than had been anticipated.

KEY FINDINGS

What knowledge did participants acquire from the PMH Group track of the IAP?

PMH Group track participants enhanced their understanding of the following topics:

- Pay-for-performance and alternative payment methodologies
- Quality measures for high-needs populations
- Incorporating telemedicine into children's behavioral health settings
- Emergency room boarding for mental health

Four of five PMH Group track respondents (representing four states; two respondents were from different agencies within the same state) strongly agreed or agreed that in-state knowledge of PMH delivery reform options increased as a result of IAP participation. Three of five respondents strongly agreed or agreed that they were able to apply the newly gained information.

What Medicaid program activities did state teams undertake as a result of participating in the PMH Group track of the IAP?

PMH Group track participants refined their goals and work plans to incorporate PI techniques.

Examples of PI activities included:

- Developing specific, measurable, achievable, relevant, and time-bound (SMART) goals and driver diagrams
- Defining a timeline for implementation
- Drafting a work plan to strengthen a state's integrated care model using pay-for-performance incentives

PMH Group track participants built and strengthened partnerships among Medicaid, other state agencies, and health system partners.

Three state teams strengthened partnerships between their state Medicaid agency and other state agencies through participation in the PMH Group track. Their IAP teams comprised representatives from multiple authorities, including the Department of Public Health, the Department of Mental Health, and the Department of Children and Families. Team members who had not worked together before forged relationships to pursue PMH integration reforms.

These state teams' PMH goals also required that they work closely with external stakeholders. One state team, for example, hoped to expand the behavioral health services offered in federally qualified health centers (FQHCs). Participants from this state reported that their PMH coach helped facilitate conversations between the Medicaid agency and FQHCs. In another state, the PMH team engaged providers, MCOs, and a university to identify best practices to integrate delivery systems.

> "One of our goals was to build a better relationship with FQHCs to better integrate care. Since the PMH IAP, we have made much headway and are working on a couple of shared ideas to further integration efforts."
>
> ~ PMH GROUP STATE PARTICIPANT

What happened as a result of participation in the PMH Group track of the IAP?

State teams made advances in quality measurement, screening, and payment reform to expand PMH access and integration.

Examples of these advances include the following:

- Identified 10 quality measures to monitor, measure, and evaluate PMH outcomes
- Implemented a pilot program to screen people with serious mental illness for diabetes
- Authorized clinical providers (e.g., advanced practice registered nurses) at mental health clinics to provide physical health services
- Passed legislation that allows Medicaid to reimburse for telemedicine services at the same rate as for in-person services

> "[This opportunity] has helped us improve infrastructure, re-think how we're doing things, improve how we provide service delivery to citizens."
>
> ~ PMH GROUP STATE PARTICIPANT

What barriers, if any, reduced the impact of participation in the PMH Group track of the IAP?

State teams needed more detail about other states' delivery system reform efforts in order to apply lessons learned.

One state team learned about the general direction of other states' reform efforts, but they instead would have liked receiving "more of a 'how to' approach … a do-it yourself for delivery system reform."

State teams lacked cooperation from critical stakeholders internal and external to the Medicaid agency.

One state participant noted the barriers to making data-driven decisions when operating in a predominantly fee-for-service environment with fragmented behavioral health service data. The participant explained: "It is still a little patchwork. We have different divisions that all have a piece of a person receiving integrated services, and we each capture data, but we don't do a good job of putting it in one centralized location."

How did the PMH Group track of the IAP support any ongoing reforms?

At the end of the PMH Group track, some state teams continued to work on their PMH projects.

Some PMH Group track survey respondents reported sustaining delivery system reform efforts that began during PMH Group track participation. Three out of five respondents (representing four states; two respondents were from different agencies within the same state) agreed or strongly agreed that they have been able to sustain these efforts.

- In one state, the Medicaid agency, in collaboration with its FQHC partners, is participating in multiple grant opportunities that provide technical assistance around PMH integration in FQHCs.
- Two state teams leveraged what they had learned across IAP areas to improve integration of physical health, mental health, and SUD services.
- Two state teams participated in both the IAP SUD HILC track and the PMH Group track, and reported sharing information across areas. In one of the two states, there was overlap in members

who were on both teams, allowing them to dovetail their efforts after the programs ended and pursue PMH and SUD issues simultaneously. This state's Medicaid agency opened a SBIRT payment code that allows primary care physicians to bill Medicaid for mental health counseling services.

In addition, state teams continued working on the following initiatives after the conclusion of the PMH Group track:

- One state team drafted legislation on PMH payment guidelines based, in part, on guidance from the IAP coach on billing and coding regulations for PMH service integration.
- One state team developed a standardized holistic assessment tool, including screening for substance use and depression. The tool was informed by a gap analysis conducted across networks of primary care and behavioral health providers.
- One team developed and pilot-tested a screening assessment for diabetes among individuals who had a severe mental illness. The state subsequently added the Social Security Disability Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications to their 2017 Healthcare Effectiveness Data and Information Set measure set.

Integration Strategy Workgroup Track

The ISW track, which ran from April 2016 through February 2017, provided participating states with technical assistance on identifying quality measures to use for integrated physical and mental health care and understanding ways to build provider capacity.

INTEGRATION STRATEGY WORKGROUP TRACK	
GOALS	• Identify quality measures to use for integrated care • Understand ways to build provider capacity
LENGTH OF SUPPORT	• April 2016–February 2017
PARTICIPATING STATES	
COMPOSITION OF STATE TEAMS	• Medicaid agency • Department of Public Health • Department of Mental or Behavioral Health • Department of Human Services
MODES OF SUPPORT	• Webinars (e.g., on quality improvement measures, payment, provider capacity for physical-mental health integration) • Post-webinar calls with topic area experts • Email updates (also stored on Groupsite) • Groupsite online resource library (also distributed via email)

KEY FINDINGS

What knowledge did participants acquire from the ISW track of the IAP?

ISW participants learned about various models for integrating physical and mental health.

ISW participants made informed decisions about which physical-mental health integration model to pursue in their states based on the knowledge they had gained through ISW. Participants also discussed how to apply the knowledge they had gained about VBP and quality metrics to current reform initiatives such as ACO development or telehealth implementation.

Three of four ISW participants (representing three states; two respondents were from different agencies within the same state) agreed or strongly agreed that knowledge of PMH delivery system reform options increased as a result of their participation in the ISW.

What Medicaid program activities did state teams undertake as a result of participating in the ISW track of the IAP?

One state team developed a health home state plan amendment.

This ISW participant worked extensively on the development and submission of an integrated health home state plan amendment. Representatives of the state Medicaid agency collaborated with those of the state's managed care plans to improve care coordination for individuals served by the Medicaid program. This participant noted that the Medicaid agency staff conveyed their knowledge of and emphasized the importance of PMH integration with "sister agencies, [the] provider community, and other stakeholders" as part of the state plan amendment development.

What happened as a result of participation in the ISW track of the IAP?

State teams established and improved cross-agency partnerships.

Cross-agency participation in the ISW taught state health officials (e.g., behavioral health) more about Medicaid's role. Partner agencies in one state became more open to collaborating with the state Medicaid agency after participating in the ISW, and relationships across state agencies continued to strengthen after ISW technical assistance had ended. ISW participants shared resources provided by ISW coaches with colleagues across agencies.

What barriers, if any, reduced the impact of participation in the ISW track of the IAP?

Diverse state goals limited group learning.

The diversity of ISW participants' goals and interests made the selection of webinar topics challenging. While participants found ISW webinar content useful, they would have benefited from more specific information. The webinar follow-up discussions with the ISW technical assistance providers helped, in part, to address this need. ISW participants also would have found it useful to work with other states focused on the same target population (e.g., children).

Structural barriers impeded physical-mental health integration.

ISW participants cited the "natural silo of the behavioral health carve-out" and the slow process of regional implementation as barriers. One participant also noted that finding time to translate "useful information into action" was a barrier.

How did the ISW track of the IAP support any ongoing reforms?

One ISW state team implemented a five-year SBIRT grant from Substance Abuse and Mental Health Services Administration.

This grant supports the expansion of SBIRT in the state's FQHCs through strategies such as providing training to primary and behavioral health professionals and developing a referral system for individuals in need of substance use treatment.

> "For the SBIRT grant, [IAP] was really helpful in how we are implementing that five-year project. A lot of the [information] we got from IAP was used to adjust some of the original implementation plans that we had for that project to lay the groundwork for sustainability and integration."
>
> ~ ISW TRACK STATE PARTICIPANT

Half of the ISW survey respondents (representing three states) agreed and half disagreed that their state was able to apply knowledge gained through ISW track participation toward delivery system reform.

Conclusion

Participants in the PMH Group track increased their knowledge of various PMH integration topics and were able to build and strengthen partnerships among Medicaid, other state agencies, and health system partners. They expanded and improved integration of physical and mental health and SUD services. ISW track participants gained knowledge of various models for integrating physical and mental health, and in some cases were able to apply what they had learned to develop a state plan amendment, establish and improve cross-agency partnerships, and successfully pursue funding opportunities to support delivery system reforms.

DATA ANALYTICS

The Data Analytics (DA) functional area provided states with tools to improve data-driven decision-making. The DA functional area consisted of two tracks[31]:

- Medicare-Medicaid Data Integration (MMDI)
- Data Analytics Technical Support

In the MMDI track, state teams received individual support in accessing and integrating Medicare data with their state's Medicaid data for dually eligible beneficiaries. In the Data Analytics Technical Support track, state teams received individual support with data analysis and presentation.

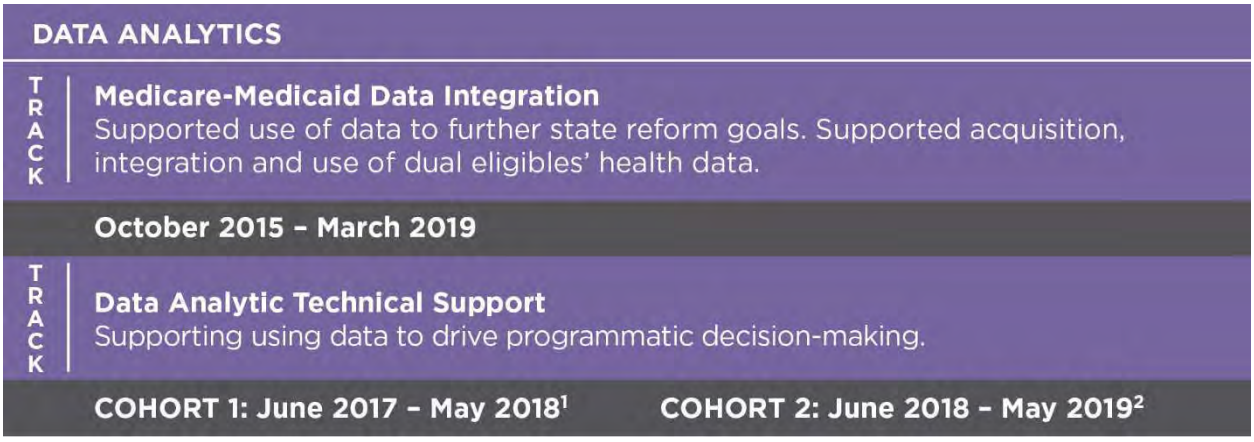
Summary of Key Findings

MEDICARE-MEDICAID DATA INTEGRATION

- State teams learned how to request Medicare data in a format needed for the purposes of care coordination or program integrity for the dually eligible population, and learned how to integrate Medicare and Medicaid data.
- State teams worked with IAP coaches to design use cases (i.e., a technical application of integrated data to address a policy question), completed applications for Medicare data, and began linking Medicare and Medicaid data.
- State teams were hindered in acquiring and using Medicare data by the CMS Medicare data application process, Medicare data security requirements, and state staffing changes.
- One state team acquired and integrated Medicare data in a replicable manner.

DATA ANALYTICS TECHNICAL SUPPORT

- State teams learned how to use the Medicaid data and data visualization techniques to create and refine dashboards.
- Teams used dashboards, infographics, and reports to educate stakeholders, and reviewed processes to improve data quality.
- State teams produced informational materials for multiple stakeholders.
- Changes in staffing or priorities and the time required to execute DUAs slowed state progress.
- New reporting enhanced Medicaid program understanding, and more-accurate data continue to support better informed decision-making.



[1] Two of the nine states received extensions through July 2018. In addition, two states received support for an optional task through September 2018. [2]Three of the eight states received extensions through July 2019.

[31] In some IAP areas, new cohorts and/or tracks were added after the evaluation period ended because the IAP continued through September 2020. The Data Analytics Technical Support track Cohorts 3 and 4 are not included in this report.

Medicare-Medicaid Data Integration Track

The MMDI track, which ran from October 2015 through March 2019, had the goal of helping state teams better coordinate care for their dually eligible populations by acquiring Medicare data and integrating them with their Medicaid data. Teams from five states participated in this track. One state team withdrew after three years following changes to their Medicaid program, including the loss of a key leader. The intent of acquiring Medicare data and integrating them with Medicaid data was to have information about all clinical services billed either to Medicare or to Medicaid, and thereby to have a more complete clinical story about dually eligible beneficiaries. This information can only be used for program integrity or care coordination purposes. State teams had access to a range of resources to assist with meeting their data integration and use goals, including: webinars, custom use cases (a structured technical approach to addressing a policy question that can be answered with the integrated data), technical tools such as data transfer protocols, methodologies such as beneficiary matching, and tailored coaching support.

Medicare-Medicaid Data Integration Track	
GOALS	• Acquire Medicare data and integrate them with Medicaid data in order to improve care coordination or program integrity for dually eligible beneficiaries • Use integrated Medicare and Medicaid data to support programs that provide care for the dually eligible population
LENGTH OF SUPPORT	• October 2015–March 2019
PARTICIPATING STATES	
COMPOSITION OF STATE TEAMS	• Medicaid agency
MODES OF SUPPORT	• Webinars (e.g., on data mapping, using integrated data) • Use cases (both generic and tailored to each state) • Coaching (e.g., on detailed analysis of data platforms; recommendations about data integration protocols, guidelines, and taxonomies; using integrated data to address policy objectives) • Site visits

KEY FINDINGS

What knowledge did participants acquire from the MMDI track of the IAP?

State teams learned how to request Medicare data in a format needed for care coordination.

State teams started the MMDI track with different levels of knowledge about Medicare data. The state teams that had previously used mature Medicare data for financial analytics learned that these data have a lag time. In contrast, the Medicare data that supports care coordination is almost current.

State teams also learned the process of applying for Medicare data for use in care coordination, including how to complete the State Data Resource Center form detailing how they would use each data element.

State teams learned how to access and integrate Medicare and Medicaid data.

Teams that received reports from SMEs on their dually eligible population learned a great deal about this population. State teams realized that they were missing diagnoses recorded only in Medicare claims but not in Medicaid claims. One state participant learned about the level and amount of mental illness in the community-dwelling dually eligible population: "[There were] extensive amounts of depression and other sorts of mental health issues which hadn't really been brought into consideration a great deal before."

State teams also learned the importance of engaging both technical staff and policy staff early in the process of data integration. Technical staff were necessary because they understood the structure of their existing data management system(s), knew which factors must be considered when choosing approaches to integrating data, and could write required code. Policy staff understood the state's reform goals and could frame questions that yielded actionable answers.

> "The two key components are data integration and then the use of that data. You need to both have a technical person and also understand your goals and what you're planning to do with the data, what questions you're answering."
>
> ~ MMDI STATE PARTICIPANT

State teams gained a great deal of knowledge about integrating Medicare and Medicaid data, but were less successful in applying that knowledge to fully integrate the data. Three of four respondents to an evaluation survey agreed or strongly agreed that in-state knowledge increased as a result of IAP participation. Three respondents also agreed that they have been able to apply knowledge gained through IAP participation, though none strongly agreed. None of the respondents disagreed with either statement.

What Medicaid program activities did state teams undertake as a result of participating in the MMDI track of the IAP?

Each state team selected a use case, which is performing a technical application of integrated data to address a policy question.

The coaches performed the use case selected by each state team, and then demonstrated the approach to the teams. The goal was for the state teams to be able to continuously refresh the use cases with new data. State teams chose from generic or tailored use cases. One team selected a generic use case—a demographic and clinical profile of its dually eligible population—because its relevance to their needs was "about as obvious as the nose on your face." Most teams selected a unique use case, such as monitoring managed care contracts, or attributing dually eligible enrollees entering a home health program to the appropriate primary care provider.

The use cases served a secondary, but important, function of demonstrating to stakeholders the value of integrated data. As one state participant explained, they were unable to convince state leaders to expend resources on Medicare data,

> "They [MMDI coaches] were very thorough on their end and they met our technical needs. We had questions with coding and such; they ran sensitivity analyses to do deeper dives into coding issues. And if there was anything that we felt we couldn't provide from a data standpoint then they were able to see what kind of effect that could have and how we could move forward and work around those obstacles."
>
> ~ MMDI STATE PARTICIPANT

so it "shifted a lot of our work towards the use case because we thought it would build interest in integrating the data." Another participant described its use case as a "clever way for us to learn," resulting in an "actual, tangible, meaningful product."

All state teams that finished the structured period (*one did not*) completed the application to receive the Medicare data they needed.

The process of accessing Medicare data was more challenging than anticipated. However, most state teams were able to overcome barriers and complete an application for their Medicare data.

State teams used technical tools provided by the coaches to begin linking Medicare and Medicaid data.

All state teams discussed data architecture, approaches to integrating the data, and analytic needs with their coaches. State teams then used technical tools provided by the coaches to help with processes such as mapping Medicare data elements to the state's Medicaid data or linking an enrollee across all data sources.

What happened as a result of participation in the MMDI track of the IAP?

All state teams received a completed use case that provided actionable and potentially replicable information about their dually eligible population at a point in time.

One state team's use case involved an algorithm that determined which primary care provider each enrollee saw most frequently, in order to identify that specific provider as responsible for the enrollee in a managed care plan. At least one state team used the use case as a business case to persuade leadership to acquire Medicare data. In addition, one state team acquired and integrated Medicare data.

What barriers, if any, reduced the impact of participation in the MMDI track of the IAP?

The application for Medicare data was challenging for state teams to complete.

The application required precise information about every potential use of each Medicare data element the state requested. Some state teams struggled with anticipating potential uses. For example, if a team initially anticipated using enrollees' birth dates to understand the population's needs by age group, and then later decided to also match birth dates to enrollment data, the team would have to submit a revised application.

The coaches provided guidance to state teams as they applied for Medicare data. The coaches' guidance helped most teams phrase their requests successfully. However, one team lacked policy experience to complete the Medicare data application.

Medicare data require storage and security processes and resources.

The Medicare data application required material resources such as server storage, as well as significant state resources in staff and vendor time. One state team, after recognizing the security implications of hosting Medicare data, embarked on an exhaustive review of all Medicaid security protocols. That state team planned to hold the Medicare data they receive monthly in a locked safe until the review is completed and the Medicare data security protocols are approved.

Medicaid priorities and staffing changes affected state teams' ability to focus on MMDI.

During the three and a half years of MMDI technical assistance, some state teams experienced revisions to Medicaid policy or changes in leadership, which impeded their ability to maintain a commitment to integrating

their data. Teams from two states changed Medicaid payment policies, resulting in revised delivery system reform goals.

State teams had different degrees of success acquiring and using Medicare data to evaluate their state Medicaid programs and policies.

Teams from three of the five participating states received the Medicare data that they requested. However, only one had all the tools in place and staff trained to use the data. One state team's access to the data was delayed by a state-mandated data security review. Another state team was hampered in obtaining up-to-date Medicare data by complex data sharing restrictions.

How did the MMDI track of the IAP support any ongoing reforms?

State Medicaid agencies implemented changes and anticipated future changes; one state team acquired and integrated Medicare data.

One state team now uses integrated Medicare and Medicaid claims and encounter data in its quality management system. The team revised its quality measures to include the dually eligible population, and will be able to compare results over time.

Most teams were not far enough in the process of integrating Medicare data with their Medicaid data to implement policy or payment changes during the IAP technical assistance period. As they continue working towards fully integrating the data, state teams will use the results of their use cases, which produced data integrated at a specific point in time, to better understand and coordinate care for their dually eligible populations.

State teams need integrated Medicare and Medicaid data to obtain an accurate and complete picture of the dually eligible population's clinical conditions, service use, and providers. Once they have integrated data, the teams plan to conduct analyses including:

- Understanding which services dually eligible beneficiaries receive from primary care providers versus specialists
- Assessing continuity of care among dually eligible beneficiaries by identifying follow-up visits
- Calculating long-term care service use by assessing the length of stay at facilities and transitions between facilities
- Determining the level of need for care coordination or disease management programs
- Integrating the dually eligible population data with other data, such as housing and substance abuse data, in order to identify additional social services used by the dually eligible population
- Developing and monitoring PI plans for MCOs
- Responding to internal and external requests for information to support policy decisions

Data Analytic Technical Support Track

The first cohort (Cohort 1) of states in the Data Analytics Technical Support track began in June 2017 and continued through May 2018. Cohort 1 consisted of nine states. A second cohort of eight states ran from June 2018 through May 2019 and included two states that were supplementing work done in Cohort 1. Teams from both cohorts sought to improve their use of Medicaid data by working with teams including DA coaches, programmers, policy experts, and analysts.

State teams in both cohorts used data visualization techniques to more effectively present data on their Medicaid populations to various audiences, including their legislatures, Medicaid and other state executives, and the public. State teams also refined their data analytic skills, such as learning to code quality measures, or how to use specific components of their state's Medicaid data.

Cohort 1 states could apply for optional technical assistance to link their Medicaid data with other state data. Two state teams received this support and integrated vital statistics data with Medicaid data.

Data Analytics Technical Support Track	
GOALS	• Improve the data analytic capacity of states by providing support in developing a data analytic strategy, using data to drive programmatic decision-making • Improve statistical programming and data modeling skills, integrate Medicaid data with other state data sets, or develop transfer protocols for sharing data with stakeholders
LENGTH OF SUPPORT – COHORT 1	• Cohort 1: June 2017–May 2018[1]
PARTICIPATING STATES – COHORT 1	
LENGTH OF SUPPORT – COHORT 2	• Cohort 2: June 2018–May 2019[2]
PARTICIPATING STATES – COHORT 2	
COMPOSITION OF STATE TEAMS	• Medicaid agency
MODES OF SUPPORT	• Coaching (e.g., on data visualization techniques, dashboard design and development, integrating state agency data)

Note. [1]Two of the nine states received extensions through July 2018. In addition, two states received support for an optional task through September 2018. [2]Three of the eight states received extensions through July 2019.

KEY FINDINGS

What knowledge did participants acquire from the Data Analytics Technical Support track of the IAP?

State teams gained skills to improve data visualization techniques and data requirements as part of designing reports and developing dashboards.

State teams learned how to present data consistently, such as showing data by month or by quarter across reports, to maximize impact. In addition, teams learned to efficiently compile important information in a small set of charts, rather than presenting multiple tables. Finally, participants studied data presentation examples from other states to learn which language is meaningful and "digestible" to the intended audience.

State teams learned how to select and use data visualization software to create and refine dashboards for multiple audiences.

Teams new to dashboard development first learned to identify their needs and select the most appropriate software for their agency and staff. One state team learned to inspect a template dashboard in order to "reverse engineer" it, discovering the underlying data structure, in order to create other dashboards. State teams shared strategies for handling encounter data and assigning claims to service categories in order to create utilization reports. Finally, Medicaid agency staff, beyond the IAP team, received training on using dashboards.

Most participants learned to understand and effectively use their unique Medicaid data.

State teams learned ways to more effectively use their state-specific Medicaid datasets. For example, one state team learned that they should require their Medicaid care management vendors to produce reports on the number of claims submitted, accepted, and rejected. Another team learned how to handle laboratory data, which have a specific format.

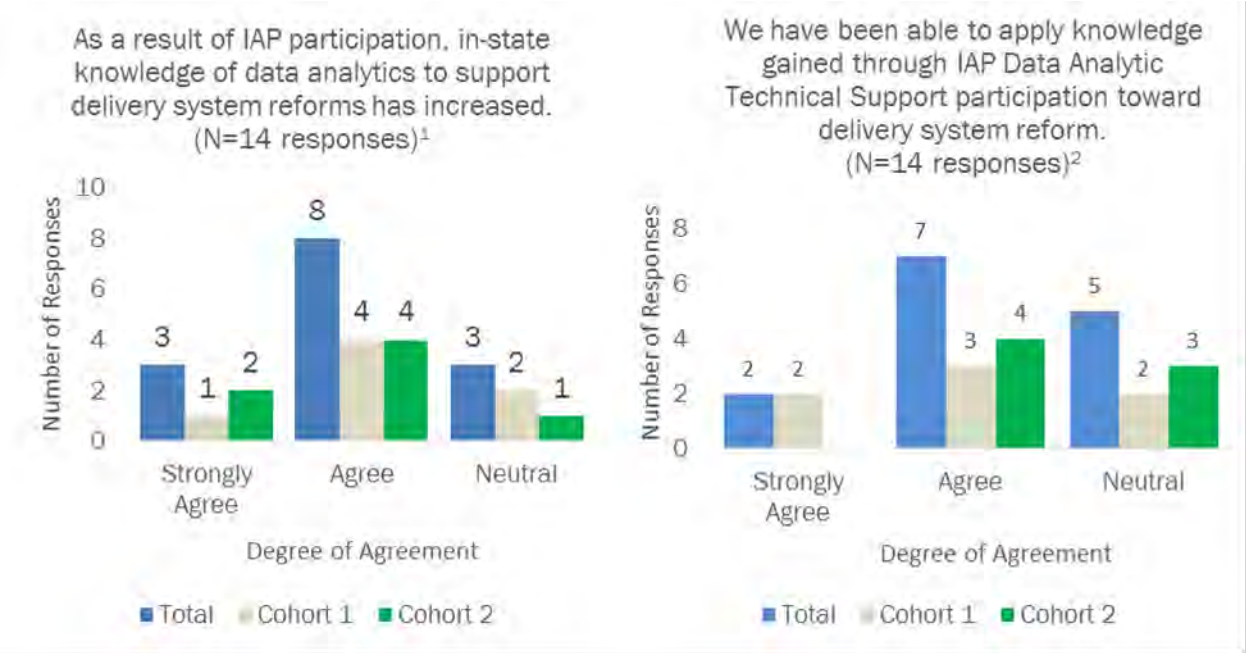
A state team with poor-quality encounter data learned how to group the data by type of data quality issue in order to determine how to address the deficiencies. The groupings revealed that the Medicaid actuarial staff and contractors applied different data quality checks, and that some checks did not reflect legislated changes.

Another state team with minimal analytic experience learned the fundamentals of population health, including how to use claims data to identify highly prevalent conditions, estimate per member per month costs, and consider risk adjustment. A state team that had previously relied on Excel to analyze Medicaid data were introduced to an open source (free) analytic software, and started to learn how to use it, following a curriculum developed by the coach.

> "The coaching model works well where there are lots of steps along the way, and lots of products that build on each other. Coaching is really effective for evaluating those things over the course of the year, and providing feedback on them. It allows the state [team] to learn more and more over the course of the year."
>
> ~ DATA ANALYTICS COACH

As shown in Exhibit 4.7, the majority of state teams gained knowledge through their participation in the IAP's technical assistance. Slightly fewer were able to apply the knowledge gained to further their delivery system reform goals. Neither of the two state teams that participated in both cohorts was able to apply what they had learned at the end of Cohort 1; one of these teams changed its response from "neutral" to "agree" at the end of Cohort 2.

Exhibit 4.7. Knowledge Gained and Applied by Participants in the IAP Data Analytic Technical Support Track



Note. [1, 2]The 14 respondents represented 12 states. Note that none of the respondents disagreed or strongly disagreed with these statements.

What Medicaid program activities did state teams undertake as a result of participating in the Data Analytics Technical Support track of the IAP?

State teams created or improved dashboards, infographics, and other reports to educate and inform stakeholders.

State teams at all levels of prior experience created, or improved existing, dashboards, infographics, and other reports. In addition to technical staff (e.g., economists, biostatisticians, and programmers), Medicaid management staff reviewed materials such as dashboard prototypes. State teams tailored their data visualizations to the needs and preferences of specific audiences. Some audiences preferred printable materials to interactive dashboards, while others appreciated the ability to manipulate reports, drilling down to compare providers or time periods. State teams developed dashboards iteratively, incorporating suggestions from future users into their designs.

Participants reviewed processes to improve data quality.

State teams improved the way data are reported to them, data cleaning processes, and data integration approaches. A team from one state reviewed data quality errors in its encounter data and determined who should address them. Another team ensured that they were consistently receiving the laboratory data necessary to calculate quality measures. A third team created a central repository of all the data warehouse reports produced by its multiple vendors. The team now has a "clear understanding of what our vendors and systems could do."

What happened as a result of participation in the Data Analytics Technical Support track of the IAP?

State teams produced new and improved data analytic tools for multiple stakeholders.

State teams gained expertise in understanding the needs of a specific audience, selecting the most salient data, and presenting it in a format the audience could easily comprehend. State teams that were not ready to produce dashboards at the end of the cohort, because the data were not ready, expected to have the capacity in the near future.

- State teams improved dashboards for internal use, such as more-efficient, intuitive dashboards on financial status for Medicaid agency leaders and on claims status for operations managers.
- Many state teams created dashboards and reports for their legislators to describe the Medicaid system, population served, costs, and utilization.
- State teams also created dashboards or infographics for the public.
- A team from one state posted a data request form on its Medicaid website for stakeholders, including the public, to use when submitting questions (e.g., about prevalence of conditions covered by Medicaid, about Medicaid expenditures) to Medicaid analysts, biostatisticians, and economists.

> Explaining "how Medicaid is impacting [our state] in infographic format speaks volumes."
>
> ~ DATA ANALYTICS TECHNICAL SUPPORT STATE PARTICIPANT

What barriers, if any, reduced the impact of participation in the Data Analytics Technical Support track of the IAP?

Changes in staffing or priorities disrupted work on the IAP.

Staff changes at any level in the Medicaid agency delayed progress on IAP projects. Changes at the management level influenced the priority of the IAP relative to other demands. In addition, requests from state legislators received priority over IAP project work. In one case, a natural disaster devastated the local tourism-driven economy, resulting in staff taking a required unpaid day off every two weeks.

Sharing data is complex and often requires time-consuming DUAs.

Many Cohort 1 state teams faced delays producing DUAs.[32] The Cohort 2 EOI form required state teams to acknowledge that they understood the DUA requirement and to identify the staff person responsible for a DUA. Many Cohort 2 state teams chose goals that did not require a DUA. Avoiding a DUA, however, introduced its own challenges: "the hardest thing was to come up with specific projects that wouldn't involve identifiable data."

[32] The DUAs were between the Medicaid agency and: 1) the targeted support provider, 2) their vendors (e.g., managed care vendors), and 3) in two instances, the agency that manages the state vital statistics data.

Leadership resistance sometimes inhibited use of new tools or techniques.

Some Medicaid agency executives and state legislators resisted using dashboards, preferring static materials they could print. Others did not understand that a dashboard's purpose was to provide high-level information rather than to address detailed questions. State teams that learned data visualization but not dashboard development, and teams that built a dashboard to answer a single question, did not develop skills as quickly as states that built more-flexible dashboards.

> "Executives were asking for tables, not dashboards. But [IAP] was a good exercise in driving adoption."
>
> ~ DATA ANALYTICS TECHNICAL SUPPORT STATE PARTICIPANT

How did the Data Analytics Technical Support track of the IAP support any ongoing reforms?

New reporting enhanced Medicaid program understanding.

New reports about Medicaid program coverage and costs, presented via interactive dashboards and one-page infographics, enhanced public understanding of the Medicaid program. Participating state teams created reports and dashboards that will remain visible to executive leaders, legislators, and the public. These tools enhance transparency about the Medicaid program, and provide details about Medicaid beneficiaries, costs, and use of health care.

More accurate data support more reliable analysis.

State teams that improved specific data elements now have more-reliable reports. For example, one team improved their encounter data to better understand capitated services and costs. A team from another state is positioned to include laboratory data in its calculation of quality measures.

Conclusion

Overall, participation in the DA IAP area furthered state teams' abilities to use data to achieve their reform goals. MMDI track participants received the results of a use case that demonstrated how integrated data could be used to address a policy question. Each use case provided actionable information about a state's dual eligible population at a point in time. Although only one state team fully integrated the Medicare data with its Medicaid data, all participants learned about the types and formats of Medicare data, the potential uses of each type, the process of applying for Medicare data, and how to use technical tools.

Participants in the Data Analytics Technical Support track addressed specific data needs and developed new or improved ways to present information about the Medicaid program to multiple audiences. State teams developed skills in data visualization, including data cleaning and data management, as well as a better understanding their audiences' needs and terminology.

VALUE-BASED PAYMENT AND FINANCIAL SIMULATIONS

For many states, payment reform is a critical component of Medicaid delivery system reform. The IAP's Value-Based Payment and Financial Simulations (VBPFS) area provided technical assistance for states designing, developing, or implementing VBP approaches. The IAP also provided interested states with support to conduct financial simulations and forecasts that analyze the financial impact of payment and delivery strategies. The VBPFS area included three tracks[33]:

- Value-Based Payment and Financial Simulations Technical Support (VBPFS)
- Maternal and Infant Health Initiative Value-Based Payment Technical Support (MIHI VBP)
- Children's Oral Health Initiative Value-Based Payment Technical Support (OHI VBP)

Summary of Key Findings

VALUE-BASED PAYMENT AND FINANCIAL SIMULATIONS TECHNICAL SUPPORT

- State teams increased their knowledge about successful approaches to design and implement Medicaid VBP programs and the financial implications of various VBP approaches.
- State teams made strategic decisions about VBP initiatives based on information imparted by IAP coaches.
- Teams from a few states made immediate changes as a result of VBPFS participation, including securing commitments from providers or managed care organizations for new payment arrangements that included VBP components.
- Staff turnover and lack of leadership buy-in created barriers to progress. In addition, delays in securing DUAs and lack of staff capacity limited the utility of financial simulations support.
- State teams used IAP materials to engage key stakeholders and advance planning for VBP initiatives.

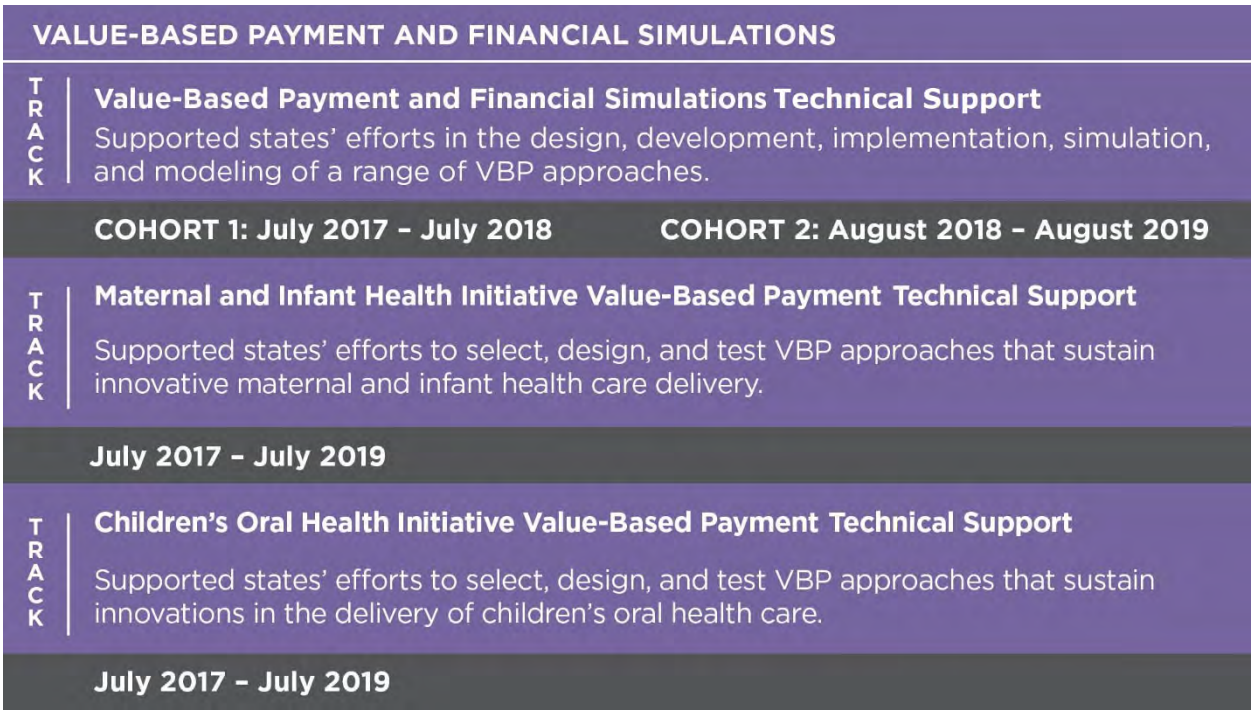
MATERNAL AND INFANT HEALTH INITIATIVE VALUE-BASED PAYMENT TECHNICAL SUPPORT

- State teams learned about protocols for screening women for SUD during the prenatal and postpartum periods, linking data, and using quality and performance monitoring tools.
- State teams developed strategies for educating providers about SUD screening and used PI tools to mark progress toward their project goals.
- Teams from some states designed VBP models to support innovative maternal and infant health care delivery. All state teams strengthened partnerships to advance maternal and infant health VBP initiatives.
- Staff turnover was a major challenge for state teams.
- State teams applied MIHI VBP track information and tools to new and ongoing delivery system reform efforts.

CHILDREN'S ORAL HEALTH INITIATIVE VALUE-BASED PAYMENT TECHNICAL SUPPORT

- State teams learned about design and implementation considerations for VBP approaches, how to use data and risk stratification tools to identify high-risk populations, and how to conduct cost analyses.
- State teams gathered and analyzed data to better understand the costs associated with providing children's oral health services, and met with partners integral to the eventual implementation of specific VBP models.
- State teams designed VBP models to support children's oral health care.
- Participants needed more time for implementation and engagement with care delivery partners.
- A team from one state began testing a VBP model with care delivery partners.

[33] In some IAP areas, new cohorts and/or tracks were added after the evaluation period ended because the IAP continued through September 2020. The Value-Based Payment and Financial Simulations track Cohort 3 is not included in this report.



Value-Based Payment and Financial Simulations Technical Support Track

This evaluation covers two cohorts that received support in the VBPFS track. Cohort 1 began July 2017 and continued through July 2018. Cohort 2 followed from August 2018 through August 2019. Both cohorts supported states as they developed new payment models, or enhanced and expanded existing state Medicaid payment reform efforts. State teams also received support to conduct financial simulations that analyzed the financial impact of their payment and delivery strategies. In addition, state teams in Cohort 2 could receive TA related to A) developing provider tools and trainings, and B) developing stakeholder engagement.

VALUE-BASED PAYMENT AND FINANCIAL SIMULATIONS TECHNICAL SUPPORT TRACK	
GOALS	• Provide strategic design to states' payment models • Develop and implement Medicaid VBP approaches • Conduct financial simulations and forecasts that analyze the financial impact of changes of payment and delivery strategies
LENGTH OF SUPPORT – COHORT 1	• Cohort 1: July 2017–July 2018
PARTICIPATING STATES – COHORT 1[1]	
LENGTH OF SUPPORT – COHORT 2	• Cohort 2: August 2018–August 2019
PARTICIPATING STATES – COHORT 2	
COMPOSITION OF STATE TEAMS	• Medicaid agency
MODES OF SUPPORT	• Peer-to-peer learning (e.g., on VBP for behavioral health and physical health integration, Medicaid managed care, long-term services and supports) • Coaching (e.g., on implementing VBP in managed care contracts, VBP options for specific sub-populations of Medicaid beneficiaries) • Financial simulation SMEs • Email updates (also stored on Groupsite) • Groupsite online resource library (also distributed via email)

Note.[1] Illinois withdrew from participation before the end of VBPFS track Cohort 1.

KEY FINDINGS

What knowledge did participants acquire from the VBPFS track of the IAP?

State teams obtained knowledge about successful approaches to designing and implementing Medicaid VBP programs.

State teams gained knowledge about design and implementation considerations for various Medicaid VBP approaches from the resources produced by coaches. Some state teams learned about contractual language to include VBP in managed care contracts. Teams in Cohort 2 also learned about tools, materials, and strategies for engaging providers in new VBP approaches. Specific examples include:

- Strategies to support the implementation of VBP focused on a comprehensive delivery model integrating HCBS and LTSS
- Details about how other states structured downside risk[34] in their Medicaid programs and incorporated VBP into contracts with Medicaid MCOs
- Financial implications and regulatory requirements for Medicaid ACOs
- State Medicaid quality programs aligned with CMS's Quality Payment Program and Merit-Based Incentive Payment System Program

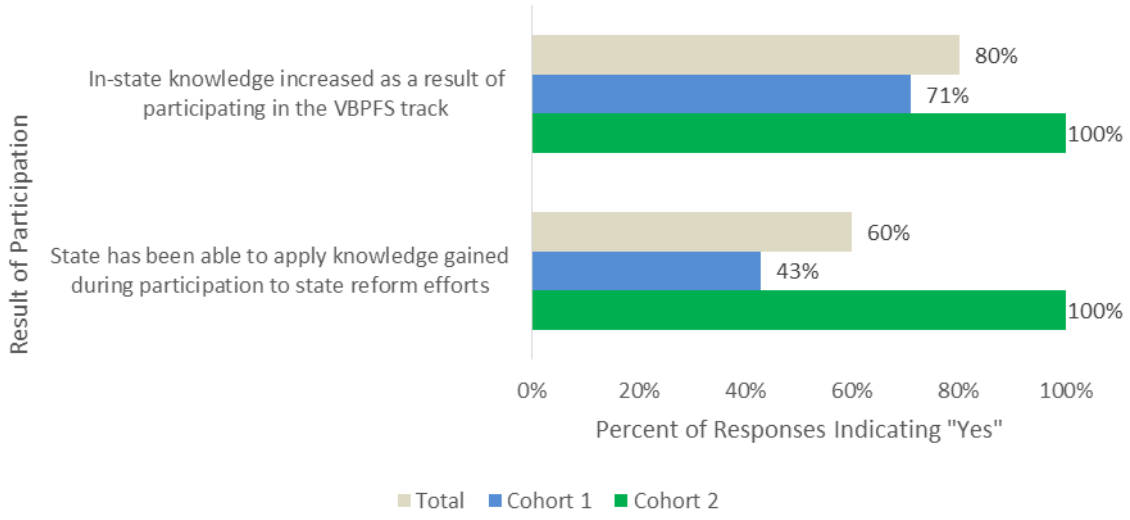
State teams learned about the financial implications of various VBP approaches.

State teams learned about the financial implications of VBP models from the analyses conducted by the financial simulations SMEs. For example, one state participant learned about the implications of including social factors in their risk adjustment methodology. "Having [an] external review of analytics methods and [the] framework for social risk adjustment verified was helpful." Another team learned about the impact of various downside risk arrangements on their Medicaid program. Some state teams learned more broadly about the financial considerations associated with various VBP approaches. Often these teams weren't far enough along in the design of their VBP approaches to benefit from a state-specific modeling tool, but they learned about key factors to consider in future modeling efforts.

State teams increased their knowledge about VBP approaches as a result of participating in the VBPFS track.

In-state knowledge of VBP increased as a result of participating in the VBPFS track, and state teams were able to apply that knowledge (see Exhibit 4.8).

Exhibit 4.8. Results of Participation in the VBPFS Track (n=20 respondents).



[34] Downside risk is the financial risk associated with potential losses. Under downside risk models, providers must refund a payer if the actual care costs exceed financial benchmarks. https://www.medicaleconomics.com/health-law-and-policy/strategies-manage-risk-value-based-payment-environment. Accessed 4/30/20.

Note. [1]The 20 respondents represented 13 states.

What Medicaid program activities did state teams undertake as a result of participating in the VBPFS track of the IAP?

State teams made strategic decisions about VBP initiatives based on information imparted by IAP coaches.

State teams used white papers, literature reviews, and environmental scans produced by their IAP coaches to help them design their VBP programs and stakeholder engagement strategies. For example, one team identified priority areas for potential VBP interventions from options presented by coaches. Another team developed contract language incorporating VBP principles relating to performance measures in advance of a forthcoming MCO procurement. A participant from yet another state noted that "[there was] direct impact on [the state's] contract approach with hospitals for [a] VBP program."

What happened as a result of participation in the VBPFS track of the IAP?

A few state teams achieved short-term outcomes as a result of VBPFS participation.

A few state teams reported concrete, short-term outcomes from participating in the VBPFS track. For example, one team created a new office within their Medicaid agency to centralize work on VBP policy. Another team began to secure provider commitments to participate in a Medicaid ACO model. A third team instituted new requirements for VBP in their Medicaid ACO contract that started in 2020. In addition, a few state teams incorporated VBP specifications into their managed care contracts in advance of planned procurements.

What barriers, if any, reduced the impact of participation in the VBPFS track of the IAP?

Staff turnover, limited resources, and lack of leadership buy-in created barriers to progress.

A number of state teams experienced staff turnover, which slowed progress. Staff attrition often meant that coaching teams needed to start over with new staff, or that remaining staff were tasked with additional work. State teams without dedicated financial resources for delivery system reforms (e.g., states not participating in CMS's State Innovation Models or Delivery System Reform Incentive Payment programs) sometimes struggled to maintain momentum. Teams from some states experienced changes in Medicaid leadership or changes to higher-level state leadership during the VBPFS support period. This sometimes resulted in a shift in priorities and focus for the state Medicaid program, which in turn could delay reform efforts.

> "Looking back, hindsight is 20/20 and I wished we had involved more people [in the IAP team] especially our upper management, because we had so much turnover we really didn't have that upper management person on the calls, like I would have liked. If I were to do it again I would make sure that there was someone above me on the call. They have the power that I don't have to make things happen faster."
>
> ~ VBPFS STATE PARTICIPANT

Financial simulations support took longer than anticipated due to state delays in establishing DUAs.

Receiving financial simulation support was a time-intensive process, and most state teams did not receive these tools until the latter part of the support period. Most often, delays were caused by the length of time it took for states to set up DUAs to allow SMEs access to state Medicaid data. While the coaching team streamlined the

process in Cohort 2, there were still significant delays. Unanimously, coaches suggested that 18 months of technical assistance, rather than 12 months, would better ensure successful completion of financial simulations.

Lack of internal capacity limited state teams' ability to capitalize on financial simulations assistance.

Financial simulations are complex. State teams without related expertise required time and coaching to fully understand the possibilities for generating and applying financial simulations. One of the financial simulation SMEs noted was that it was often a challenge to respond to participants' requests. The initial requests were quite general, and the SMEs had to first discern what specific information the team was seeking before they could provide assistance. The modeling tools and reports produced by the financial simulations SMEs were more sophisticated than some state teams were ready to interpret. Despite this, state teams still found them valuable.

> "They have built something pretty sophisticated for us, but I think it's a bit further ahead of where we are. I hope it will be useful in the future, but I struggled to connect the dots to see how we were going to use it."
>
> ~VBPFS STATE PARTICIPANT

How did the VBPFS track of the IAP support any ongoing reforms?

State teams used IAP materials to engage key stakeholders.

State teams used the materials produced by coaches to engage key internal stakeholders or explain the nuances of various VBP approaches to others in their state Medicaid programs.

Participating in the VBPFS track helped advance states' planning for VBP initiatives.

For most state teams, the transition from fee-for-service to VBP is part of a longer-term strategy. A number of state teams planned to adopt VBP approaches in additional areas of their Medicaid programs. For example, as one state participant described, "I think what we learn in this program about transitioning away from fee-for-service to VBP is going to be replicated throughout the state's Medicaid program. I don't think we've seen the ripples yet, but I do think it will impact other programs. We're just the first guinea pigs out of the gate."

> "[Lessons learned from the IAP] have not only informed our current [managed care contract procurement] but also inform the concepts as we move toward including the expansion population back into managed care and contemplate models for LTSS and other aspects of Medicaid. One of the state's big challenges has been managing vendors; some of the insights that IAP taught us are important and applicable to many vendor settings."
>
> ~ VBPFS STATE PARTICIPANT

Maternal and Infant Health Initiative Value-Based Payment Technical Support Track

The MIHI VBP track supported states' efforts to develop VBP approaches that sustain innovations in the delivery of maternal and child health care. The track began in July 2017 and continued through July 2019.

State teams participating in MIHI VBP partnered with care delivery providers to design, implement, and test a VBP approach to support improvements in maternal and infant health care.

MATERNAL AND INFANT HEALTH INITIATIVE VALUE-BASED PAYMENT TECHNICAL SUPPORT TRACK	
GOALS	• Support states' efforts to select, design, and test VBP approaches that sustain innovative maternal and infant health care delivery
LENGTH OF SUPPORT	• July 2017–July 2019
PARTICIPATING STATES[1]	
COMPOSITION OF STATE TEAMS	• Medicaid agency • Care delivery partners including a nonprofit organization working with pediatric and family practices, a public health agency, a coordinated care organization, and a primary care association
MODES OF SUPPORT	• Peer-to-peer learning calls (e.g., on linking data to support VBP approaches, screening and care coordination for pregnant and parenting women with SUD) • Coaching (e.g., on provider education about a new billing code) • PI SMEs • Site visits • Email updates (also stored on Groupsite) • Groupsite online resource library (also distributed via email)

Note. [1] Oregon withdrew from the MIHI VBP track before technical assistance began.

KEY FINDINGS

What knowledge did participants acquire from the MIHI VBP track of the IAP?

State teams learned about protocols for identifying and screening women for risk factors during the prenatal and postpartum period.

One state team learned about screening tools and protocols to help identify women with a high probability of OUD. Another team learned about other states' approaches for screening women for postpartum depression. They were able to apply lessons learned to develop a maternal depression screening toolkit for pediatricians.

State teams learned to use data to link information and populations.

State teams learned how to link maternal and infant data. One team shared the relevant MIHI VBP track materials with colleagues in partner organizations and agencies to help with a state opioid use prevention initiative. State teams also learned from peer states about successful strategies for linking Medicaid claims data to other data sources.

States learned how to use quality and performance monitoring tools.

State teams learned new ways to implement quality improvement processes. State teams also learned about metrics and performance indicators and how to use an actuarial spreadsheet, designed by the SMEs, to assess costs.

What Medicaid program activities did state teams undertake as a result of participating in the MIHI VBP track of the IAP?

State teams used PI tools to mark progress towards their maternal and infant health VBP goals.

State teams developed and revised driver diagrams throughout the MIHI VBP track. The driver diagrams included customized goals and measures to help state teams assess progress and "give [states] a handle on what's happening." Teams worked with coaches to continually revisit this tool and update goals as their projects evolved over the course of the MIHI VBP track. One state participant noted it is "front and center in terms of tools we're using." Another participant felt that "the driver diagram is a good foundation to jump start from," and added that they continued to use this tool after the conclusion of the MIHI VBP track to help move them into the next phase of their VBP work.

> "It's a value add because you work together to build a team of two disparate offices, come out with outcomes that are measurable, and get paid with professional technical assistance."
>
> ~ MIHI VBP TRACK PARTICIPANT

State teams developed strategies for educating providers.

A care delivery partner on one state MIHI VBP track team developed a toolkit on postpartum depression screening for pediatric providers that included information on VBP. The team used resources gleaned from participation in the IAP to inform the development of the VBP section of the toolkit. Another state team educated providers about a billing code available for conducting OUD screening.

What happened as a result of participation in the MIHI VBP track of the IAP?

Some state teams designed VBP models to support maternal and infant health.

One state team opened a new billing code for OUD screening. The team can now track OUD in claims data and provide reimbursement to providers. The team assessed provider awareness of the code and leveraged partnerships developed during the MIHI VBP track to continue to promote use of the code among providers.

State teams developed and strengthened new partnerships to advance MIHI VBP initiatives.

State teams shared information with colleagues and leveraged resources across divisions within their Medicaid agency as well as with sister agencies that focus on behavioral health or maternal and child health issues to advance VBP work. The coaching support helped bring individuals from different state teams together through regular project meetings. In one state, collaboration on the MIHI VBP track led to a stronger relationship between the Medicaid and public health agencies. Representatives from the two agencies noted that "now there is a really good relationship between the two, and there have been a couple more projects that we have partnered on." Two state teams noted that fostering and strengthening relationships has been the best part of the MIHI VBP track, and that the relationships are critical for moving future state maternal and infant health VBP efforts forward.

"I think it was cool to hear what other states were doing because we are kind of operating [with] the same resources, but we also all have different contexts. It was interesting to hear what other strategies were."

~ MIHI VBP STATE PARTICIPANT

What barriers, if any, reduced the impact of participation in the MIHI VBP track of the IAP?

Staff turnover was a major challenge for state teams.

State teams experienced staff turnover in Medicaid agencies that impacted MIHI VBP track team composition. Teams found it difficult to have team members transitioning on and off the team, and progress stalled when people with decision-making power or relevant expertise were not at the table. State teams that lacked a champion for their work often had to shift direction due to administration or leadership changes and shifting priorities and resources. One coach experienced challenges making progress when there was turnover because "it takes times to develop the trust and rapport to have honest conversations." Competing demands also took away from states' MIHI VBP track work and led to project delays.

How did the MIHI VBP track of the IAP support any ongoing reforms?

State teams applied MIHI VBP information and tools to new and ongoing delivery system reform efforts.

Two state teams used the information and results achieved from participation in the MIHI VBP track to apply to another federal model focused on addressing fragmentation in care for pregnant and postpartum Medicaid beneficiaries with OUD. One team began developing a universal notification of pregnancy form and a pay-for-performance approach to incentivize earlier prenatal care. State teams continued to use the tools (e.g., driver diagrams, project blueprint) from the MIHI VBP track to move toward the next phase of testing and implementing VBP approaches.

Children's Oral Health Initiative Value-Based Payment Technical Support Track

The OHI VBP track supported states' efforts to develop VBP approaches that sustain innovations in the delivery of children's oral health care. The track began in July 2017 and continued through July 2019. State Medicaid agencies participating in the OHI VBP track partnered with care delivery providers to design, implement, and test a VBP approach to support improvements in children's oral health.

CHILDREN'S ORAL HEALTH INITIATIVE VALUE-BASED PAYMENT TECHNICAL SUPPORT TRACK	
GOALS	• Support states' efforts to develop VBP approaches to care delivery reforms that foster improvements in children's oral health.
LENGTH OF SUPPORT	• July 2017–July 2019
PARTICIPATING STATES	
COMPOSITION OF STATE TEAMS	• Medicaid agencies • Care delivery partners, including an MCO, a Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program, and a children's hospital
MODES OF SUPPORT	• Webinars (e.g., on leveraging dental claims data, incorporating oral health risk assessments into care delivery models) • Peer-to-peer learning calls • Coaching (e.g. environmental scans, policy option memos) • PI SMEs • Email updates (also stored on Groupsite) • Groupsite online resource library (also distributed via email)

KEY FINDINGS

What knowledge did participants acquire from the OHI VBP track of the IAP?

State teams learned about oral health VBP activities from other states and from SMEs, including key design and implementation considerations for oral health VBP approaches.

State teams learned from other states and from SMEs during bimonthly peer-to-peer learning calls. For example, state officials from a non-participating, experienced state presented information about their use of dental claims data to support improved oral health outcomes for children and the development of pediatric dental homes. State teams also received training from PI SMEs on iterative testing of VBP approaches.

State teams learned to use data and risk stratification tools to identify high-risk populations.

State teams learned how to access and combine information from different state data sources to identify high-risk populations of interest. A team from one state used risk assessments to identify children at high risk of dental caries; another team used data to examine disparities.

State teams learned to conduct cost analyses.

State teams gathered information on the costs of the care delivery models they were developing, and learned to distinguish costs that can be reimbursed by available funding sources from those that were not reimbursable. One state team used a cost spreadsheet designed by the coaches to produce a comprehensive picture of the costs of providing children's oral health services, including staff and overhead costs.

What Medicaid program activities did state teams undertake as a result of participating in the OHI VBP track of the IAP?

State teams gathered and analyzed data to better understand the costs associated with providing children's oral health services.

State teams worked with their partners to obtain data about the costs of providing preventive and restorative children's oral health services in settings including dentists' offices, WIC clinics, and hospitals. Teams also collected data on children's oral health outcomes. These data inputs were critical to designing a VBP model.

State teams met with partners integral to the eventual implementation of specific oral health VBP models.

OHI VBP track coaches helped state Medicaid officials conduct meetings with key partners, including Medicaid managed care plans and hospitals, to discuss proposed changes in payment. Some states teams faced initial resistance from key partners whose reimbursements for children's oral health services would be affected by a VBP. Teams appreciated having external assistance to bring partners together.

What happened as a result of participating in the OHI VBP track of the IAP?

State teams designed VBP models to support children's oral health.

While no state team progressed to full implementation of a VBP during the IAP support period, all teams designed critical elements of their models. One team created a model testing plan using Plan-Do-Study-Act cycles to document results of a pilot oral health VBP implementation. One state's Medicaid MCO added reimbursement for children's preventive oral health care, including exams, fluoride varnish, and case management. A team from another state began collecting performance metrics from providers, in advance of adding financial incentives. A coach commented, "if entities are on the ground and willing to implement [the payment model], that'll be a success."

What barriers, if any, reduced the impact of participation in the OHI VBP track of the IAP?

State teams needed more time to implement their OHI VBP models.

Although the OHI VBP track envisioned designing, piloting, and implementing VBP models for children's oral health, all participating state teams needed more time in the design phase than was anticipated. Thus, states did not progress to full implementation of the VBP models they designed. One state team was also hampered by budget and legislative constraints that took time to resolve.

Including care delivery partners in oral health VBP design added complexity to the process.

State teams were understandably cautious about sharing preliminary oral health VBP model details with care delivery partners, whose reimbursement would be affected. While gaining buy-in from these partners is critical to success, participants initially underestimated the time needed to do so. In addition, external factors (e.g., an MCO re-procurement process, a lawsuit involving a care delivery partner, staff vacancies at a care delivery partner) affected state teams' ability to consistently engage care delivery partners.

How did the OHI VBP track of the IAP support any ongoing reforms?

One state team began testing its VBP model with care delivery partners.

One state team began testing a small (0.5%) withhold to their children's oral health providers, to be paid if specific performance metrics are met. A cost analysis spreadsheet that the state developed through the IAP has

been a useful communication tool with clinical delivery partners. The team will continue to analyze data to show whether the VBP they developed is sustainable.

> "I can share the basic structure [of the cost analysis spreadsheet] with other locations, and they can plug in information like basic salaries. I can take all the other data we collect and feed it into that and show someone 'these are all the things that you need.' That will have a life extending [beyond] the IAP."
>
> ~ OHI VBP STATE PARTICIPANT

Conclusion

All state teams made progress toward oral health VBP goals. State teams learned about various possible approaches to VBP from their coaching teams and the deliverables coaches produced. Some selected a VBP approach best suited to their unique state environments. Some teams used IAP support to begin implementing VBP pilots. Stakeholder engagement—from Medicaid leaders and affected providers—was a key step in moving toward implementation. A lack of internal engagement and state staff turnover were common challenges.

Chapter 5: Overall IAP Conclusions

CMS provided non-financial technical assistance to state Medicaid programs and their partners through the IAP. Key content and technical areas were identified as priorities by CMS, state Medicaid agencies, and other stakeholders. The IAP experimented with how best to offer the support that states were seeking by trying out various technical assistance delivery modes, lengths of support, make-ups of coaching teams, and groupings of state agencies across the IAP areas and tracks. CMS continuously solicited feedback from IAP program participants, coaches, and the evaluation team, and adapted its technical assistance in response to that feedback.

The majority of the IAP's tracks supported state-designed projects to reform Medicaid delivery or payment systems. To ensure that team members had the expertise, authority, and resources to further Medicaid reforms, CMS selected states for participation in each IAP track based on information gathered through an expression of interest form and a telephone discussion. Within each IAP track, state teams brought different levels of prior knowledge, experience, and technical skills. This variation led to challenges in delivering both peer-to-peer and coach-led support that engaged all participants as teachers and learners. Despite these challenges, IAP state participants expressed strong appreciation for coaching and for each coach's dedication to the state team and the state's IAP project success. State teams often needed assistance with analyzing data to clearly identify a project focus. When needed, coaches helped state teams modify their projects to make their goals feasible.

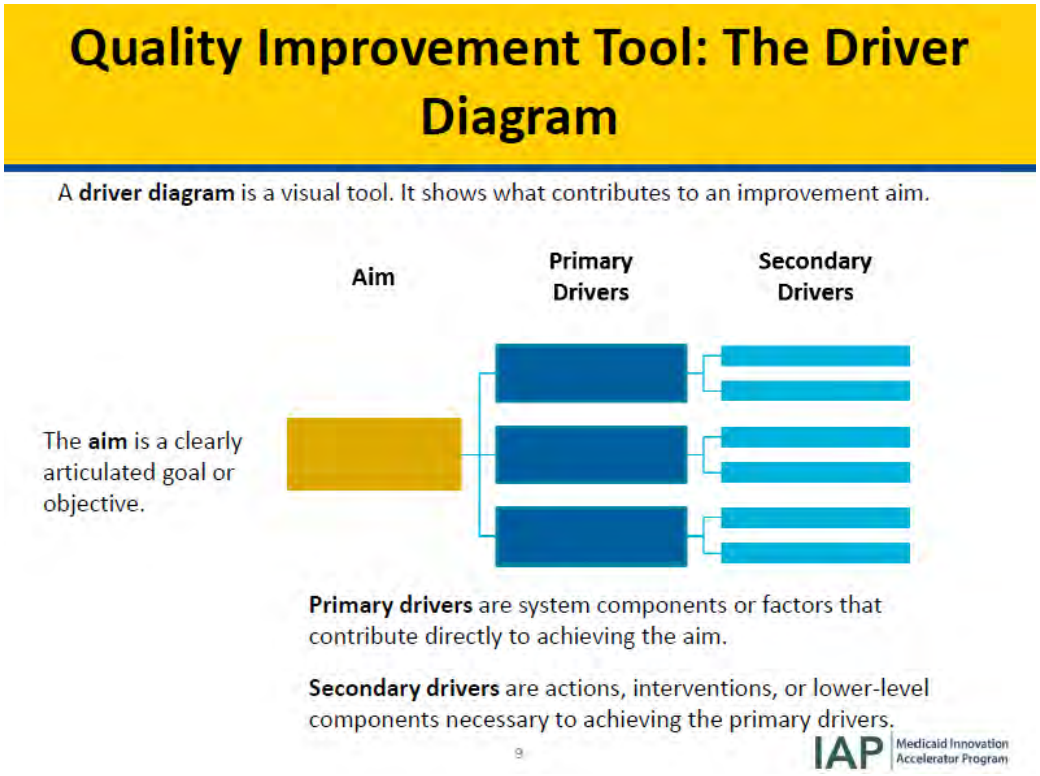
The IAP helped state teams make progress toward their delivery system reform goals. IAP coaching and tools offered unique resources to state Medicaid agencies that were not otherwise readily available. The IAP helped build state officials' knowledge base and skills related to delivery system reform efforts. State teams made small but concrete changes to their Medicaid programs consistent with the implementation stage at which they engaged with the IAP. The IAP also provided a platform for state teams to build relationships within and across state agencies that could foster future reforms as state contexts continually evolve.

Appendix A: Description of IAP Performance Improvement Activities

The Medicaid Innovation Accelerator Program (IAP)'s Performance Improvement functional area was designed by the Center for Medicare & Medicaid Innovation (CMMI)'s Learning and Diffusion Group. Initially, the Centers for Medicare & Medicaid Services (CMS) staff provided performance improvement (PI) support to participants in the Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs (BCN) area, the Reducing Substance Use Disorders (SUD) High Intensity Learning Collaborative (HILC) track, and the Supporting Physical and Mental Health (PMH) Integration Group (PMH Group) track. Beginning in May 2017, CMMI engaged a PI contractor who worked with additional IAP tracks: Promoting Community Integration through Long-Term Services and Supports (CI-LTSS) Medicaid-Housing Agency Partnerships (Partnership) track, CI-LTSS Designing a Value-Based Payment for Home and Community-Based Services (Designing a VBP for HCBS Strategy) track, Value-Based Payment and Financial Simulations (VBPFS) Maternal and Infant Health Initiative Technical Support (MIHI VBP) track, and VBPFS Children's Oral Health Initiative Technical Support (OHI VBP) track.

The IAP assigned each state team that received PI support a dedicated PI SME who worked in collaboration with the state team and their coach to create a driver diagram (see Exhibit A1) that documented the state's delivery system reform objectives, activities, interventions, and drivers. These driver diagrams helped participants establish project goals, and guided the development and implementation of states' IAP initiatives.

Exhibit A1. Driver Diagram Performance Improvement Tool



Source: CMS (2018). Using quality improvement to determine whether your Medicaid delivery system reform is effective [PowerPoint slides]. Retrieved from https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/quality-improvement-webinar.pdf. Accessed April 26, 2020.

The PI contractor described the three steps involved in PI support:

- Create a driver diagram to specify an aim and identify the drivers needed to achieve the aim. The driver diagram required the team to think through all elements (e.g., stakeholders, activities) needed to be successful.
- Help the state team select metrics for its identified drivers. These process measures were used to assess progress toward the state's aim.
- Teach state participants how to conduct iterative testing of state delivery system reform initiatives. The PI SME and the state team reviewed metrics and decided whether drivers need to be fine-tuned to reach the state's goals.

The CI-LTSS State Medicaid-Housing Agency Partnerships track Cohort 2 participants received training on the driver diagram during the Medicaid Housing Partnership in-person kick-off meeting in August 2017; participants in other tracks received this training as a webinar. With one exception, ongoing PI support was provided virtually via webinars or teleconferences (because most of the PI SMEs were located in the District of Columbia, they were able to conduct an in-person visit with the District of Columbia's OHI VBP team).

Two PI webinars created by CMS staff and PI contractor are posted on the IAP website:

- Using Quality Improvement to Determine Whether Your Medicaid Delivery System Reform is Effective[35]
- Diving Deeper into Driver Diagrams & Delivery System Reform Success Using Quality Improvement Techniques[36]

[35] Webinar slides available at https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/quality-improvement-webinar.pdf

[36] Webinar slides available at https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/driver-diagrams-delivery-system-reform-webinar.pdf

Appendix B: IAP Resources

The Centers for Medicare & Medicaid Services (CMS) maintains a web page on Medicaid.gov that compiles materials generated by and for the Medicaid Innovation Accelerator Program (IAP). Within each IAP program and functional area, materials may include: webinar slides and recordings, toolkits, technical resources, sample data use agreements, and fact sheets. CMS has also posted fact sheets of short summaries describing participating Medicaid agencies' IAP work.

Exhibit B1 catalogs the materials available in each area and provides a link to the main page where these resources may be accessed. To help readers who may be particularly interested in specific participating Medicaid agencies' IAP work, Exhibit B2 provides some example excerpts from the short summaries in track fact sheets, as well as links to the fact sheets, available as of December 1, 2019.

Exhibit B1. Examples of IAP Materials

IAP Program or Functional Area and Hyperlink	Materials Available as of December 1, 2019
Reducing Substance Use Disorders https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/program-areas/reducing-substance-use-disorders/index.html	Webinar slides Webinar recordings Technical resources
Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/program-areas/beneficiaries-with-complex-needs/index.html	Webinar slides Webinar recordings Technical resources Fact sheets
Supporting Physical and Mental Health Integration https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/program-areas/physical-and-mental-health-integration/index.html	Webinar slides Webinar recordings Fact sheets
Promoting Community Integration through Long-Term Services and Supports https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/program-areas/community-integration-ltss/index.html	Webinar slides Webinar recording Fact sheets Toolkit
Data Analytics https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-functional-areas/data-analytics/index.html	Webinar slides Webinar recording Technical specifications and tools Technical resources Use cases
Value-Based Payment and Financial Simulations https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-functional-areas/value-based-payment/index.html	Webinar slides Webinar recordings Technical resources Fact sheets Environmental scan

Exhibit B2. Examples of IAP Track Fact Sheets with State Participant Project Summaries

Area Track	Summary and Link to Fact Sheet
Reducing Substance Use Disorders	
High-Intensity Learning Collaborative	The IAP supported seven Medicaid agencies in designing, planning and implementing strategies to improve their substance use disorder (SUD) delivery systems through a High-Intensity Learning Collaborative (HILC). Using a cadre of substance use experts, the IAP offered each state team technical assistance to introduce policy, program, and payment reforms. Examples of state projects are: • The IAP provided technical assistance to *Louisiana* by identifying relevant national best-practice approaches, selecting quality measures, and engaging local health systems to improve health outcomes for mothers at risk of SUD and infants at risk of neonatal abstinence syndrome. • The IAP assisted *Pennsylvania* in exploring naloxone prescribing patterns and connecting the state team with leaders in data collection and reporting of opioid-related deaths. • *Texas* received IAP technical support to calculate a return on investment for their SUD system investments; match data across different payers and data systems; survey and engage their managed care organization (MCO) partners; and investigate adding peer support specialists to the Medicaid benefit package. Fact sheet available at: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/learn-hilc-iap.pdf
Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs	
	The IAP supported five Medicaid agencies in designing, planning, and implementing strategies to improve care coordination for Medicaid beneficiaries with complex care needs (BCN). The IAP provided each state team with a dedicated coach and access to experts and other support to introduce policy, program, and payment reforms. Examples of state projects are: • The IAP coach provided information to the *District of Columbia* about health home program funding opportunities and alternative payment mechanisms, which supported the development and implementation of the District's second health home program to serve individuals with chronic conditions. • IAP provided *New Jersey* with guidance and resources on establishing data use agreements, which helped the state team use cross-agency data sources to identify service gaps. • The IAP helped *Oregon* identify individuals dually eligible for Medicare and Medicaid and created one consolidated dataset to evaluate the Coordinated Care Organization program's impact on BCN populations. • The IAP helped *Texas* enhance incorporation of social determinants into their data analytics. Fact sheet available at: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/program-areas/iap-bcn-factsheet.pdf
Supporting Physical and Mental Health Integration	

Area Track	Summary and Link to Fact Sheet
Physical and Mental Health Integration Group	The IAP collaborated with five Medicaid agencies to expand and/or improve existing Physical and Mental Health (PMH) integration efforts. Examples of state projects are: • The IAP assisted *Nevada* in identifying approaches to integrate care for individuals with serious mental illness in managed care. • The IAP provided *New Hampshire* with technical support on alternative payment models related to PMH integration. • The IAP helped *Puerto Rico* develop a strategy to identify how aspects of its regional pilot study could promote PMH integration island-wide. • The IAP assessed *Washington's* strategies to support clinical models for PMH integration and identify best practices for integrated care. Fact sheet available at: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/program-areas/pmh-overview-factsheet.pdf
Promoting Community Integration through Long-Term Services and Supports (LTSS)	
State Medicaid-Housing Agency Partnerships	From 2016 through 2018, the IAP supported 16 Medicaid agencies in developing: (1) public and private partnerships between their Medicaid agencies and housing systems; and (2) detailed action plans to promote other community living opportunities for Medicaid beneficiaries. The IAP's hands-on technical support helped state Medicaid agencies build sustainable collaborations with housing and other service agency partners. Examples of state projects are: • The IAP assisted *California* in consolidating its multiple housing and service initiatives into a single plan for improved coordination. • The IAP examined *Connecticut's* data use agreements to expand data matching activities across Medicaid, corrections, and homelessness systems. • The IAP helped *Hawaii* align multiple housing and health initiatives, redesign the delivery system for supportive housing services, and address affordable housing for people experiencing chronic homelessness. • The IAP provided *Nebraska* technical assistance on finding new avenues for affordable housing and support services and developing a coordinated action plan between Medicaid and housing agencies. Fact sheets available at: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/program-areas/medicaid-iap-housing-partnership-factsheet.pdf And: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/program-areas/medicaid-iap-ciltss-housing-partnership-factsheet.pdf

Area Track	Summary and Link to Fact Sheet
Implementing a Value-Based Payment for Home and Community-Based Services Strategy	The IAP provided one-on-one technical assistance to four state teams in designing and implementing a home and community-based services VBP strategy. States received support in areas such as selecting quality measures, developing a stakeholder engagement approach, identifying payment options and drafting guidance for accountable entities. Examples of state projects are: • The IAP performed a gap analysis of *Massachusetts'* existing HCBS measures across various programs and collected additional measures for a measurement framework. • The IAP supported *New Jersey* in developing a strategy to incentivize the successful transition of Medicaid beneficiaries from an institution to an appropriate community-based setting. • The IAP helped *Virginia* design and implement quality measurement roll-out schedule for its new managed LTSS program. • The IAP identified options for a VBP in *Washington* and developed a proposed financial model to incentivize quality and outcomes for HCBS beneficiaries. Fact sheet available at: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/program-areas/vbp-hcbs-strategy-implementation-092016.pdf
Data Analytics	
Data Analytics Technical Support Cohort 1	The IAP provided a wide range of data analytics technical assistance to 10 Medicaid programs (eight states and two territories). The support helped these programs plan various reforms and lay the foundation for using data analytics more effectively in future implementation efforts. Examples of state projects are: • The IAP assisted *Alabama* in redesigning its Medicaid Agency Annual Report to better explain its Medicaid program and population. In particular, the IAP team provided detailed feedback on report design and best practices of data visualization. • The IAP provided *North Dakota* demonstrations to help the state teams enhance data management and visualization for data dashboards. • The IAP presented *West Virginia* with best practices to improve the quality of its encounter data, and technical support to integrate Medicaid eligibility data with mortality vital statistics data. Fact sheet available at: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/iap-da-tech-support-042017.pdf

Area Track	Summary and Link to Fact Sheet
Value-Based Payment and Financial Simulations	
Value-Based Payment and Financial Simulations Technical Support Cohort 1	The IAP worked with teams from nine states and the District of Columbia to provide hands-on technical assistance to help advance their VBP approaches. The IAP assisted state teams in designing, developing, and/or implementing VBP approaches and conducting financial simulations and forecasts analyzing the impact of these VBP strategies. Examples of state projects are: • The IAP developed three VBP option papers that will help the *District of Columbia* advance its VBP approach in LTSS. • The IAP provided *Idaho* with information on existing shared savings payment models and shared various methodological decisions and considerations required for designing a shared savings program. • The IAP presented *Illinois* information on how to develop adequate systems for monitoring and oversight for integrated health homes. • The IAP conducted an environmental scan for *Minnesota* outlining various methodologies used by other states and payers to adjust payments for social determinants of health factors. Fact sheet available at: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/states-iap-work.pdf

Appendix C: Evaluation Framework and Methods

INTRODUCTION

The goal of the Medicaid Innovation Accelerator Program (IAP) was to offer state teams resources to support ongoing Medicaid reform initiatives. The goal of the evaluation was to provide an independent assessment of the IAP intervention. The evaluation was conducted simultaneously with the sequenced roll-out of technical assistance across IAP program and functional areas.[37] This approach enabled the evaluation team to provide the Centers for Medicare & Medicaid Services (CMS) with rapid-cycle feedback to inform real-time modifications to IAP technical assistance tracks.

This appendix presents the research questions, evaluation framework, data sources and data collection strategy, and analytic approach used to conduct the evaluation of state teams' experiences with the IAP as reported in this report.

RESEARCH QUESTIONS AND EVALUATION FRAMEWORK

Research Questions

The final report focuses on state participants' responses to the IAP and the results of participation by addressing the questions:

- Did the IAP offer the technical assistance that state teams were seeking?
- What knowledge did participants acquire from the IAP?
- What Medicaid program activities did state teams undertake as a result of participating in the IAP?
- What happened as a result of participation in the IAP?
- What barriers, if any, reduced the impact of participation in the IAP?
- How did the IAP support any ongoing reforms?

Evaluation Framework

We structured the IAP evaluation based on the Kirkpatrick model[38] for evaluating training and technical assistance. We categorized our evaluation questions by the four domains of the Kirkpatrick model: Reaction, Learning, Response, and Results. We applied the evaluation framework to each of the IAP's four program areas and two functional areas that were included in our evaluation.

[37] With the exception of the Reducing Substance Use Disorders (SUD) area, which launched prior to the evaluation contract award.

[38] See, for example, Kirkpatrick D. Techniques for evaluating training, *Training & Development Journal.* 1979; 33(6):78-92; and Kirkpatrick J. The hidden power of Kirkpatrick's four levels. *Training & Development Journal.* 2007; 61(8):34.

Exhibit C1. Methodological Approach Using the Kirkpatrick Framework

Model Domain	Detailed Research Questions	Data Sources	Qualitative Analyses	Descriptive Data
Reaction	Did the IAP offer the technical assistance that state teams were seeking?	In-person and telephone key stakeholder interviews; in-person and virtual participant focus groups; post-event surveys; summative survey	Summary of state participant feedback on usability of technical assistance offered and its alignment with delivery system reform goals	Number and percentage of states reporting alignment with delivery system reform goals Average participant rating of the usefulness of technical assistance modes
Learning	What knowledge did participants acquire from the IAP?	In-person and telephone key stakeholder interviews; in-person and virtual participant focus groups; post-event surveys; summative survey	Summary of state participant feedback on new knowledge acquired from specific technical assistance activities and their perceived ability to act on this knowledge	Number and percentage of states reporting increased knowledge
Response	What Medicaid program activities did participants undertake as a result of participating in the IAP?	In-person and telephone key stakeholder interviews; in-person and virtual participant focus groups; post-event surveys; summative survey	Summary of state participant-reported activities and initiatives stemming from participation in technical assistance	Number and percentage of states pursuing delivery system reform activities as a result of participating in the IAP

Model Domain	Detailed Research Questions	Data Sources	Qualitative Analyses	Descriptive Data
Results	What happened as a result of participation in the IAP?	In-person and telephone key informant interviews; virtual participant focus groups; summative survey; review of administrative state materials	Summary of state participant-reported delivery system reform progress and early outcomes	Number and percentage of state participants interested in other IAP opportunities as a result of participating in the IAP Number and percentage of state participants reporting that IAP participation helped them make progress on delivery system reform goals
	What barriers, if any, reduced the impact of participation in the IAP?	In-person and telephone key informant interviews; in-person and virtual participant focus groups; summative survey	Summary of state participant-reported barriers to accomplishing delivery system reform activities	N/A
	How did the IAP support any ongoing reforms?	In-person and telephone key informant interviews; in-person and virtual participant focus groups; summative survey	Summary of state participant-reported reform efforts that were stimulated or strengthened	Number and percentage of states reporting sustained delivery system reform efforts

DATA SOURCES AND DATA COLLECTION STRATEGY

Our evaluation used a qualitative research approach, supplemented with descriptive statistics obtained through web-based surveys. We selected this approach based on CMS's goals to understand state participants' experiences with and response to IAP technical assistance, and the need for real-time feedback to the IAP's implementers.

Sample

The IAP's target population was state stakeholders (i.e., Medicaid agencies and their partners) who received technical assistance and access to resources under one or more of the IAP program or functional areas inclusive of:

- Reducing Substance Use Disorders (SUD)
- Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs, (BCN)
- Promoting Community Integration through Long-Term Services and Supports (CI-LTSS)
- Supporting Physical and Mental Health Integration (PMH)
- Data Analytics (DA)
- Value-Based Payment and Financial Simulations (VBPFS)

CMS staff introduced the evaluation team to IAP participants via email to facilitate state contact and encourage state team participation in interviews and focus groups. CMS staff emails included a description of the evaluation and a request for voluntary participation. The evaluation team sent an outreach message approximately one week after the CMS staff email was sent, requesting a time to interview the participants.

The sample of interviewees also included relevant CMS staff and technical assistance providers, including the technical assistance coaches. We did not use comparison groups for this evaluation, given the timing of the rollout of program and functional areas and the difficulty in controlling for all contextual factors that may confound true program effects. The IAP tested various support modes, rather than applying a consistent model across program or functional areas. As a result, rather than testing program effectiveness relative to non-participants, this evaluation focuses on descriptive findings.

Data Collection

To address the evaluation research questions, we analyzed data collected from primary and secondary sources, as relevant for each IAP program and functional area.

We held routine calls with CMS lead staff throughout program implementation to remain informed given the evolving nature of the IAP program and functional areas.

Secondary Data

We collected secondary data from CMS to minimize the burden on IAP state participants. Secondary data sources we used included:

- ***Program overview documents***. CMS staff developed program overview documents and informational webinar slides to describe each IAP program and functional area to potential applicants.
- ***Expression of Interest forms.*** All state teams interested in participating in an IAP program or functional area submitted a short application, known as an expression of interest (EOI) form.
- ***Webinar and in-person meeting materials***. These included agendas, slide decks, and any handouts provided to IAP participants through webinar or in-person learning events.
- ***Webinar statistics, including attendance, responses to polling questions, and evaluation results.*** The technical assistance providers tracked webinar registration and attendance information, analyzed responses to polling questions and webinar evaluations, and forwarded the results to the evaluation team.
- ***Materials generated for or by the IAP.*** These included materials that participants used in a program or functional area (e.g., the crosswalk developed for the CI-LTSS Supporting Housing Tenancy track participants; reports drafted by the DA Medicare-Medicaid Data Integration (MMDI) technical assistance provider), as well as tools created for the National Dissemination Strategy (e.g., the MAT Clinical Pathway and Rate Design Tool developed in the SUD area).

Primary Data

To address the research questions, the evaluation team drafted a standard set of generic qualitative protocols for each type of respondent (see Appendix D). CMS reviewed and approved these protocols. We modified the generic protocols for each program and functional area based on the timing of the data collection (i.e., initial interview versus follow-up interview) and the modes of technical assistance offered in each area (for interviews, focus groups and surveys).

We conducted one-on-one interviews and focus group discussions with state participants and coaches. We also conducted state participant web-based surveys. Our sampling strategy for all interviews, focus groups, and web-based surveys of participants was one of convenience, using snowball sampling. The evaluation team invited everyone in a state who had been affiliated with the IAP to participate. We obtained email addresses from CMCS and asked that at least one person per team participate; we allowed invitees to forward the invitation to others on their team. All coaches and subject matter experts were invited to participate in coach interviews and focus groups.

Following is a list of primary data sources used to address the evaluation research questions. Each data source is described in more detail below.

- Interviews with state participants
- Interviews with coaches
- Focus groups with state participants
- Focus groups with coaches
- In-person meeting participant surveys
- Summative state participant surveys
- Post-webinar series attendee surveys
- Event observations

Interviews

In most cases, interviews were conducted by telephone. Exceptions are noted below. For all interviews, whether in person or by telephone, we asked permission to audio record, and obtained consent; all interviewees agreed to audio recording. Recordings were not transcribed, but were referenced to check content and coding of interview notes.

Interviews with state participants. We conducted a total of 195 60- to 90-minute interviews with IAP participants across all IAP areas. The interviews were conducted at various points determined in collaboration with CMS staff, and chosen to minimize burden on state participants relative to their ongoing IAP activities. The number of interviews per IAP area varied with the length of the IAP program or functional area engagement. The interviews gathered information on states' goals for IAP participation, their reaction to the technical assistance received to that point, and whether the IAP technical assistance met their needs.

Interviews with coaches. The evaluation team conducted a total of 104 interviews with coaches who provided technical assistance to state participants. One hundred-two were conducted as 60-minute telephone interviews, and two were conducted in person and lasted between 30 and 60 minutes. The evaluation team conducted the two interviews in-person because their location was convenient to the evaluation team. The interviews were designed to obtain coaches' perspectives on the effectiveness of the IAP overall, and the appropriateness of the modes, level, and duration of technical assistance provided to state teams.

Focus Groups

The evaluation team conducted seven focus group discussions with state participants and 21 focus groups with coaches. Focus groups allowed exploration of common themes, activities, and goals. We conducted three in-person state participant focus groups (i.e., Medicaid representatives; housing representatives; behavioral health and social sciences representatives) in conjunction with an in-person CI-LTSS Medicaid-Housing Agency

Partnerships meeting. We convened all other focus groups virtually using a Web interface that allowed participants to view discussion questions.

All members of the state team and all coaches were invited to participate in respective focus groups. The Abt Team sent out a Doodle Poll to find the date and time when the majority of participants could attend. A seasoned focus group moderator led each focus group with assistance from a junior staff note-taker. All focus group moderators and note-takers participated in training to familiarize them with focus group procedures.

For all focus groups, whether in person or by telephone, we asked permission to audio record, and obtained consent; all interviewees agreed to audio recording. Recordings were not transcribed, but were referenced to check content and coding of interview notes.

Surveys

In-person meeting participant surveys. At the end of the CI-LTSS Medicaid-Housing Agency Partnership Cohort 1 meetings in May and October 2016 and the Cohort 2 meeting in August 2017, we administered a pencil and paper participant survey.[39] The 15-minute surveys requested participant feedback on the logistics and content of the in-person meetings. BCN also offered an in-person workshop, which the evaluation team observed, but no evaluation activities were conducted. Finally, SUD offered an in-person meeting that occurred prior to the evaluation contract being awarded.

Summative surveys. We conducted a comprehensive survey with participants following the conclusion of all IAP tracks that included coaching. As with our approach for state participant interviewees, we sent these summative surveys to all state IAP participants for whom we had an email address (generally the state IAP lead and one or two other staff members), three to six months after the end of structured support. Surveys were sent via a web-based platform (e.g., SurveyMonkey, FluidSurvey, or Survey Gizmo). We asked at least one person per team to complete and return the survey, and used snowball sampling, allowing them to forward the link to additional team members. The summative survey asked participants about their experience with IAP technical assistance, Medicaid program changes related to the support received, and the ongoing impact of the technical assistance on delivery system reforms. Results reported in each chapter note how many respondents and how many states are represented in the findings.

Post-webinar series surveys. For IAP tracks that limited support to a webinar series (i.e., SUD Targeted Learning Opportunities, CI-LTSS Supporting Housing Tenancy track, and CI-LTSS VBP Home and Community-Based Services Planning), we administered web-based surveys at the conclusion of each webinar series. As with our approach for state participant interviewees, we sent these post-webinar series surveys to everyone who participated in each state's IAP team for whom we had an email address, via a web-based platform (e.g., SurveyMonkey, FluidSurvey, or Survey Gizmo). We asked at least one person per team to complete and return the survey, and used snowball sampling by allowing them to forward the link to other team members. The 5- to 10-minute surveys were designed to obtain respondents' thoughts on how well each webinar series met its program area-specific goals.

[39] After the May 2016 meeting, we followed up the in-person paper and pencil version of the survey with a web-based version. However, given the low response rate, we decided (in collaboration with CMS staff) not to repeat the web-based version, following subsequent meetings.

Event Observations

The evaluation team was a silent participant at in-person and virtual (e.g., webinars) IAP group events. We used an observational matrix to record data on state participant engagement (e.g., number of questions asked, comments made); technical issues (audio or visual); and time allotted for questions. In addition, the technical assistance contractors shared post-webinar satisfaction survey results with the evaluation team.

ANALYTIC APPROACH

Secondary Data

The evaluation team reviewed the materials obtained during the course of IAP implementation. We gathered information by IAP area and track for synthesis into reports.

Primary Data

Interview and Focus Group Data

We analyzed interview and focus group data using the NVivo software package. The coding scheme aligned with the topics addressed during the interviews and focus groups, and was tailored to each IAP program and functional area. Specific comments recorded during the interviews and focus groups could be coded by more than one theme, but all comments were coded by the most relevant, specific theme. The data management lead, and one or more team members who conducted the interviews or focus groups, reviewed the coded content to identify inconsistencies, redundancies, or imprecisions. The coding scheme was revised as needed to support consistent coding and incorporate emerging themes.

Abt evaluation staff experienced in the use of NVivo trained additional analysts to implement the coding scheme for all interview and focus group notes. Coders analyzed the data by aggregating at the theme level and by type of participant. Analyses were largely limited to within-area comparisons, because the interviews and focus groups were designed to illuminate experiences unique to each program or functional area. However, some cross-program area themes were identified by analyzing specific standardized questions within each of the evaluation domains. We also documented changes in responses over time.

Survey Data

Abt conducted analyses of data collected from three sets of surveys. Team members analyzed all survey data using Excel or Stata software. The analyses were limited to descriptive statistics (e.g., frequencies and cross-tabs). We present survey findings in the final report as graphic exhibits only when representatives from ten or more states responded to the survey.

Event Observations

We incorporated information recorded on the observational matrices into our qualitative analyses, supplementing the key findings that emerged from analysis of interview and focus group data.

Appendix D: Generic Data Collection Protocols

Participant Data Collection Protocols

PARTICIPANT TELEPHONE INTERVIEW GUIDE

Thank you for taking the time to speak with us today. I'm **[NAME]** from Abt Associates. As you may be aware, our organization was hired by the Centers for Medicare & Medicaid Services to evaluate the Medicaid Innovation Accelerator Program (IAP) targeted support program. Before we begin the discussion, I will tell you a bit more about the evaluation.

The goal of the evaluation is to understand the effectiveness of the IAP model in supporting ongoing reform in state Medicaid programs. Your perspective is critical to our understanding of what is working [worked] well about the **[program/functional area and track, if necessary]** model utilized. The input you provide will influence how targeted technical support is provided in the future to promote further Medicaid innovation.

You should have received a consent document that describes how we will use the information collected as part of the study. If you have the document in front of you, please feel free follow along as I read it. At the end, I will ask if you agree to participate and have the discussion recorded.

NOTE: INTERVIEWER SHOULD NOW READ CONSENT DOCUMENT TO PARTICIPANTS

Identifying information

1. Please tell me your first name(s), the department you represent, and your role on the IAP team.
2. **[If applicable]** Do you work with other state agencies or non-state organizations in the **[program/functional area or track, if appropriate]**? If so, which ones? What roles do these partners play?

Motivation

[ASK ONLY AT FIRST INTERVIEW WITH PARTICIPANTS. DO NOT ASK AT FOLLOW UP INTERVIEWS.]

3. Why did your state apply to participate in the IAP? What about the model did you find most appealing?
4. How did you decide what type and level of technical support you wanted or needed?
5. What were you hoping to gain from participating in the IAP? Have your expectations changed? If yes, please explain how they have changed.
6. The IAP was designed based on the assumptions that various levers are effective in promoting health system reform. When you applied for the IAP, did you want to receive support in any of the following areas to address your state's **[program area or track]** goals?
    a. Data analytics
    b. Financial modeling
    c. Quality measurement
    d. Performance improvement

Application and Onboarding Experience

[ASK ONLY AT FIRST INTERVIEW WITH PARTICIPANTS. DO NOT ASK AT FOLLOW UP INTERVIEWS.]

Next, I would like to talk about your experiences with the [program/functional area or track].

7. CMS hosted an information session webinar for anyone interested in applying for the **[program/functional area or track]** on **[date]**. Did you attend this webinar? If so, was it helpful to you in crafting your application? Would you recommend any changes?
8. Please describe your experience with the **application process.** That is, filling out the expression of interest (EOI) form. What worked well? What could have been improved?
    a. In your EOI, you selected the following items as areas that you would like assistance with **[INTERVIEWER: PREFILL BEFORE THE CALL]**. How did you decide which items to check?
    b. Did you participate in an **office hour call** with CMS? Did you find this call helpful in clarifying the **[program/functional area or track]** program? Please explain.
9. CMS hosted a kick-off webinar for all participants in the **[program/functional area or track]** on **[date]**. Did you attend this webinar? If so, was it helpful to you? Would you recommend any changes?
10. Did you participate in an **onboarding call** with CMS? If yes, was this call helpful? Would you recommend any changes?
11. [**High intensity tracks only**] What are/were your [**program/functional area or track**] goals?
    a. To what extent have these goals changed since you started? Did participating in the **[program/functional area or track]** advance your goals?
    b. If yes, how?
    c. If not, why not?
12. **[Light touch tracks only]** What did you expect from the **[program area track]** "light touch" support approach? What were your goals?
    a. Did the **[program area track]** meet those expectations?
    b. If no, please explain.

Technical Support Experience – Specific Modes of Support

I would now like to focus on your experiences [thus far] with specific aspects of the IAP program.

[CHOOSE ONLY QUESTIONS THAT APPLY TO THE PROGRAM/FUNCTIONAL AREA OR TRACK.]

13. **[As appropriate]** What is working [worked] well about the **webinar series**? Would you recommend any changes to improve the webinar series?
    a. Were any particular webinars more helpful than others? Why?
    b. Did they provide new or more detailed information for your state?
    c. What staff members attend [attended] these webinars?
    d. Do you feel that there was sufficient time for Q&A or state-to-state interaction during the webinars?

14. **[High intensity tracks only]** What is working [worked] well about the **targeted support coaching model**? Would you recommend any changes for improvement in the coaching/facilitator model?

    a. How often do [did] you meet with your coach/facilitator (e.g., regularly, ad hoc)? Do [did] you have enough contact with the support team?

    b. What types of support does [did] the coach/facilitator offer?

PROBES: For example, finding resources, introducing subject matter experts (SMEs), writing the application, site visit.

    c. Was the targeted support tailored to your needs? Please describe.

    d. Was the targeted support that you received timely?

    e. Was the coach/facilitator responsive to your needs?

    f. Did the coach/facilitator conduct a **site visit**? If yes, please describe your experience. What worked well? Would you recommend any changes for improvement?

        i. Were you provided with information in advance of the site visit to allow you to prepare (e.g., ensure the right people were available; gather necessary materials; prepare questions/areas where help would be most useful)?

        ii. Did the amount of time between the initial conversation with the targeted support contractor and the site visit impact the effectiveness of the site visit on your reform efforts? If yes, please explain.

15. **[As appropriate]** What worked well with the **in-person meeting(s)**? Would you recommend any changes for improving the in-person meetings?

    a. Was the duration of the meeting adequate?

    b. Were the logistics appropriate (i.e., where it was held; format; content)?

    c. Did you have the opportunity during the meeting to meet with any of the following, and did you find these meetings helpful?

        i. Your own state team
        ii. Your coach
        iii. Participants from other states
        iv. Subject matter experts
        v. CMS

16. **[High intensity tracks that received PI support only]** Each state is offered PI support that can include developing driver diagrams, selecting metrics, and conducting iterative testing. Please describe your experience with this support.

    a. Is a designated Performance Improvement (PI) SME working with your state on the development of a driver diagram?

    b. Was developing the driver diagram collaborative process between you, your coach/facilitator, and the PI SME [**if appropriate**]? Did one (either the coach/facilitator, PI SME, or you) take the lead?

    c. Was there collaboration among state officials participating in the **[program/functional area or track]** to complete the [driver diagram]?

d. Did you find the exercise useful in refining your **[program/functional area or track]** strategy? Why or why not?

e. Did the PI SME help you select metrics for your secondary and primary drivers? [Interviewer: These were intended as process measures and not outcome measures (e.g., increase in the number of veteran housing units).] If yes, please describe this process and its effectiveness.

f. [Interviewer: this activity likely happens later in the track, so depending on the timing of the interview, it may not have yet taken place. Our understanding is that this step may have occurred during quarterly meetings when metrics were reviewed and decisions on whether or not to fine-tune drivers to reach your goals were made.] Did the PI SME help you to understand how to conduct iterative testing?

g. Is the PI support aligned with your needs?

h. Is the PI support timely?

i. Do you anticipate any changes in how you work with the PI SMEs for the remainder of the program?

j. Would you recommend any changes to the PI support model to CMS?

17. **[High intensity tracks only, as applicable]** Each state was required to complete an **[action plan, work plan, use case, etc.]**. Please describe your experience developing these materials.

    a. Was developing this [these] program management tool(s) a collaborative process between you and your coach/facilitator? Did one (either the coach/facilitator or you) take the lead?

    b. Was there collaboration among state officials participating in the [**program/functional area or track**] to complete the [**action plan, work plan, use case, etc.**]?

    c. Did you find the exercise useful in refining your **[program/functional area or track**] strategy? Why or why not?

18. [**All tracks**] Does your state receive biweekly emails from CMS?

    a. Do you find these emails useful?

    b. How have you used the information or resources presented in these emails?

    c. Do you have any recommended changes to improve the email format?

19. [**High intensity tracks only**] Have you used the IAP website, Groupsite?

    a. If yes, do you find the resources on this site valuable?

    b. Would you recommend any changes to improve the website?

20. **[High intensity tracks only]** Have you received support in any of the following areas?

    a. Data Analytics?

        i. If yes, please describe the support that you received.

        ii. Was the support that you received helpful? If yes, please explain.

        iii. Would you recommend any changes to improve the data analytic support you received?

b. Financial Modeling?

   i. If yes, please describe the support that you received.

   ii. Was the support that you received helpful? If yes, please explain.

   iii. Would you recommend any changes to improve the financial modeling support you received?

c. Quality measurement?

   i. If yes, please describe the support that you received.

   ii. Was the support that you received helpful? If yes, please explain.

   iii. Would you recommend any changes to improve the quality measurement support you received?

d. Performance improvement?

[Interviewer: Refer to the response to question 16a as to whether or not the state is working with a PI SME, and ask this question accordingly.] You said that [**state**] does work with a PI SME.

   i. Do you have anything further to add than what you described earlier?

   ii. Was the support that you received helpful? If yes, please explain.

   iii. Would you recommend any changes to improve the performance improvement support you received?

Technical Support Experience – Overall Impressions

I would now like to focus on your experiences [thus far] with the IAP as a whole.

21. The **[program/functional area or track]** is scheduled to continue through [ended] **[month/year]**. Do you think the length of the program is [was] adequate to meet your needs?

    a. If no, what would be a more appropriate amount of time?

22. Is [was] the frequency and timing of the targeted support (e.g., webinars, coaching, in-person meetings/site visits) appropriate?

23. Has the amount or intensity of targeted support been appropriate to meet your needs? If yes, please explain. If no, can you recommend changes to improve it?

24. Overall, was the targeted support provided aligned with your goals? If no, please describe what information was either missing or not relevant.

Learning, Response, and Results

[DO NOT ASK AT INITIAL (EARLY) INTERVIEWS. ASK ONLY AT FOLLOW-UP INTERVIEWS WITH PARTICIPANTS.]

25. Have you applied any of the information or resources to your reform efforts that you gained from participating in the **[program/functional area or track]**?

a. If yes, what specific activities or changes to your Medicaid program have you made in response to the targeted support that you received? Are additional activities or changes planned?

b. If no, do you plan to use it in the future? Please explain.

26. How has the technical support that you received through the **[program/functional area or track]** impacted your ability to make progress toward your reform goals?

27. Have you faced any barriers that slowed your ability to apply **[program/functional area or track]** learning to your reform efforts?

Conclusion and Next Steps

28. What aspect of the [**program/functional area or track**] did you find the most valuable?

29. Do you have any suggestions for CMS about possible modifications to the program?

30. Is there anything that we haven't discussed that you think we should know about your experience with the IAP targeted support initiative?

Thank you for your time. We appreciate your ongoing participation in the IAP program support evaluation.

PARTICIPANT IN-PERSON OR VIRTUAL FOCUS GROUP DISCUSSION GUIDE

Moderator/Note Taker Focus Materials Checklist

- Flip chart [in-person] or Power Point [virtual]
- Recording equipment
- Discussion guide
- Markers [In-person only]
- Participant name tents [In-person only]
- Interviewer clock
- Laptop for note-taking with plug
- Copies of statement of informed consent [In-person only]
- Attached to the Outlook meeting invite [Virtual only]:
    - WebEx link
    - Informed consent document
    - PowerPoint flip chart/slides
- List of confirmed attendees (via Outlook meeting invite)

In-Person Room Set-up Checklist

- Tables in a circle or hollow square
- Enough chairs for all participants
- Note taker has room for laptop and access to power plug
- Recorder where it can be easily turned on and can record all voices in room
- Flip chart(s) near facilitator [or use a PowerPoint presentation]
- Name card at each place
- Markers on table so people can write name cards
- Copies of statements of informed consent

Introduction

Slide 1 of the Flip Chart (in-person) or PowerPoint (virtual), ***Title Page***

Welcome and Purpose of the Focus Group (5 minutes)

Hello, I'm [***NAME]*** from Abt Associates. I will be moderating our discussion today.

Today, I am working with **[Introduce co-moderator and note taker, if appropriate]**.

Thank you for taking the time to join this focus group on the targeted support provided to the **[program/functional area/track]** IAP group. We are members of the Medicaid Innovation Accelerator Program (IAP) evaluation team from Abt Associates and are tasked with evaluating the targeted support provided to the **[program/functional area/track]** states under the IAP. We are here specifically to learn more about your experiences as part of the **[program/functional area/track**] group and to hear more about the support you have received thus far. The goals of the evaluation are to:

- Evaluate process of providing support – design, mode, and timing of support.
- Assess the efficacy and the level of state acceptance of support.
- Provide real-time cycle feedback to CMS.
- Evaluate impact of the support on state's behavior and whether the support has helped to further reforms.

You have been invited to this focus group because your state is participating in the IAP initiative related to **[program or functional area]**. We are interested in hearing about your experiences with this program since it began.

Review of informed consent

[In-Person only: As participants enter the room provide them with a copy of the statement of informed consent (SIC). Ask them to read the SIC prior to the start of the focus group meeting.]

[Virtual only] *Go to slide 2 of the PowerPoint (virtual), "**Informed Consent**"*

You should have received a consent document that describes how we will use the information collected as part of the study. It is also on the shared screen via the WebEx application. Please feel free follow along as I read it. At the end, I will ask if you agree to participate and have the discussion recorded.

- Your participation is voluntary.
- This focus group will last approximately one hour.
- The discussion will be audio recorded so that we can be sure to capture everything that is said. Transcripts will be made of the recordings; although the transcripts will not include participants' names nor will they be shared with CMS.
- The discussion will be confidential. Your comments, and those of others in the group, will be used in reports to the government, in summary form. Your name will not appear in any reports to the government and, no statements you make will be attributed to you, your state, or organization.
- The recordings and transcripts will not be shared with anyone outside the evaluation research team.
- You can refuse to take part in this focus group without any effect on your professional relationship with CMS or your organization/employer.
- You can also refuse to answer any particular question during the discussion, without affecting your continued participation in the group or your relationship with CMS.

We do not foresee any possible risks from participating in this focus group other than the possibility that a participant might share what was heard in the room. We ask that nothing discussed here be shared with others.

Does anyone have any questions about the statement of informed consent, the goals of the evaluation, the purpose of the focus group or your participation in the focus group?

Is there anyone who does not consent to participate in the group?

Great, let's get started.

I'd like to go over a few ground rules to ensure that the group goes smoothly:

- Let's keep the conversation informal. Don't hesitate to ask me or each other questions. Please be honest in your feedback. It's fine to disagree – there are no right or wrong answers.
- In every group there are people who talk a lot and others who don't. My job is to make sure we hear from everyone. So I may call on you specifically if I haven't heard your voice in a while. I also may need to cut off conversation to make sure we cover all the topics; please don't take offense.
- We appreciate your full attention and engagement during the call.
- **[In-person only]** Please put your phones on vibrate and put them away. If you need to step out to take a call, do so, but please do not check emails during this focus group.

Does anyone have any questions before we get started?

*Go to slide 3 of the Flip Chart (in-person) or PowerPoint (virtual), "**Introductions**"*

[In-person only] I'd like to ask you to introduce yourselves by stating your name, state, affiliated agency and position at the agency, and your role on this project.

[Virtual only] When I call your name, would you please introduce yourself by telling us your name, which state you are from, which organization/agency you are part of, and what role you play(ed) on your state IAP team? [Facilitator: Since we are not able to "go around the table" as the discussion is taking place virtually, make sure the number of vocal introductions matches the number of people that are registered on WebEx.]

Experience

*Go to slide 4 of the Flip Chart (in-person) or PowerPoint (virtual), "**Program Experience**"*

During this next segment of our discussion, we would like to speak more specifically about your experiences with the technical support provided under this IAP **[program/functional area/track]** group. We may cover similar topics to what you discussed with our team during your interview in order to better understand the collective experience amongst the states.

1. I would like to hear about specific aspects of the IAP program. Which types of technical support were most useful to your state during the **[program/functional area/track]**, and why?
    a. Ongoing targeted assistance from a coach
        i. What worked well about this model?
        ii. What could have been better?
        iii. How did it meet/not meet your needs?
    b. IAP Activities (e.g., Action Plan, Driver Diagrams)
        i. What worked well about this model?
        ii. What could have been better?
        iii. How did you use the Action Plan in your reform efforts, if at all?
    c. Peer-to-Peer Discussion/Webinars
        i. What worked well about this model?
        ii. What could have been better?
        iii. Did you reach out to other states during the course of the IAP?
    d. Communication from CMS and the support contractor such as biweekly emails and Groupsite
        i. What worked well about these methods of communication and information sharing?
        ii. What, if anything, could be improved?
        iii. How did you use this information?
    e. In-Person Meetings?
        i. What worked well about the meetings?
        ii. What, if anything, could be improved?
    f. Are there any other resources or components of the IAP program we haven't discussed?

*Go to slide 5 of the Flip Chart (in-person) or PowerPoint (virtual), "**Program Experience (continued)**"*

2. Was your state ready (at a good point) to participate in this **[program/functional area/track]**?
3. To what extent have your targeted support requirements changed since you started the **[program/functional area/track]** project?

4. Compared to your expectations going into the project, how would you describe the support experience thus far in terms of:
    a. Amount of time allocated by the Center for Medicaid and CHIP Services (CMCS) and its contractors to targeted support activities?
    b. Resources allocated by them for targeted support?
    c. Time commitment required by you and your colleagues for the [program/functional area/track] initiative?
    d. Value to your state?
        i. What was the most valuable aspect of the IAP program in terms of helping your state reach your goals? Please explain.
        ii. What was the least valuable aspect of the IAP program? Please explain.

Intermediate Outcomes

*Go to slide 6 of the Flip Chart (in-person) or PowerPoint (virtual), "**Intermediate Outcomes**"*

5. Has the IAP affected the way you *approach r*eform in your state?

For example, have you taken a different approach to planning activities? Started a new collaboration with a state agency/department with which you had not worked previously on **[issue]?** Changed implementation strategies?

6. Are your state's reform activities related to **[program/functional area/track]** where you expected to be at this stage, having participated in the IAP? Why or why not.
7. Have you implemented reform as a result of the IAP (e.g., regulatory reform, developing a Medicaid state plan amendment)? If not, do you expect to do so?

*Go to slide 7 of the Flip Chart (in-person) or PowerPoint (virtual), "**Discussion Questions**"*

8. If you provided feedback to CMS, were they responsive?
9. Does your state need additional support to further reform efforts related to **[program/functional area/track]** implementation? If yes, specifically, what type of support would be most helpful?
10. What barriers, if any intervened to reduce the impact of the target support and other resources?
11. Looking ahead, what are the biggest challenges you are facing that the [program/functional area/track] support could address, but has not yet covered?
    a. How would you like to get that information? (Which IAP mode?)

Next Steps and Conclusion

*Go to slide 8 of the Flip Chart (in-person) or PowerPoint (virtual), "**Closing Thoughts**"*

Before we close, I want to give everyone the opportunity to add any final thoughts or comments.

12. If you were appointed to an advisory board on IAP, what would you recommend to CMS to improve the program? What kind of assistance should CMS offer in the future?
13. Will your state seek targeted support in other areas through the IAP? If so, which areas?

14. Is there anything that we haven't discussed that you think we should know about your experience with the IAP targeted support initiative?

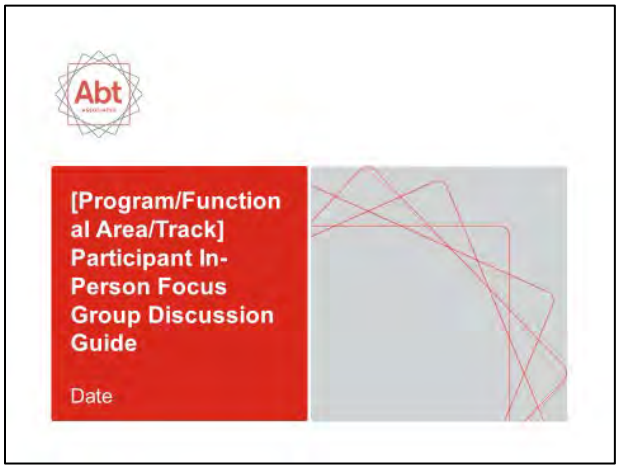
15. Go to slide Go to page 9 of the Flip Chart (in-person) or PowerPoint (virtual), "**Thank You"**

Thank you again for this lively discussion today. The information you provided will help the evaluation team give constructive feedback to CMS and is much appreciated. It will help CMS as it considers opportunities for enhancements to both their current and future programs.

If you have any questions about this focus group meeting, or the evaluation overall, please contact Vetisha McClair/Steve Blackwell, CMS COR, or Kathy Witgert, Abt PD.

PARTICIPANT FOCUS GROUP SLIDES

Slide 1:



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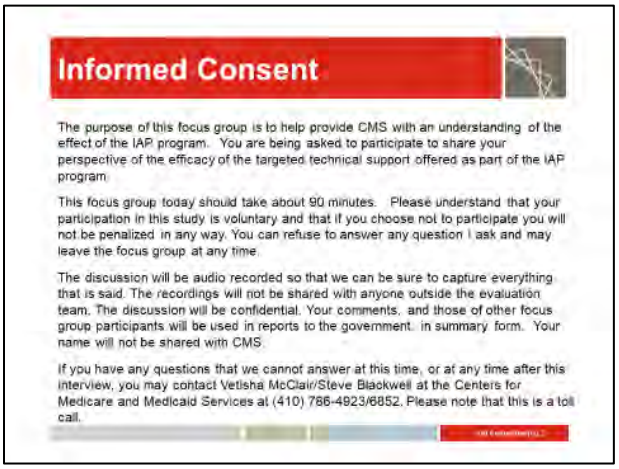

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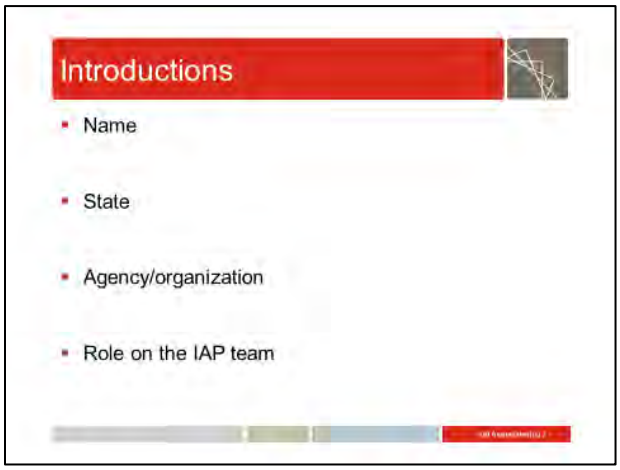

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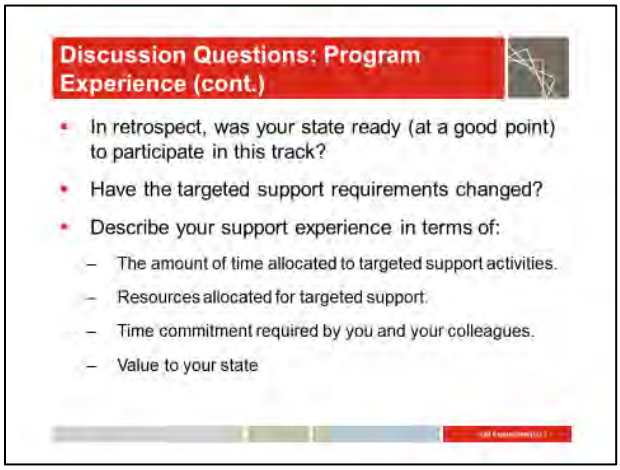

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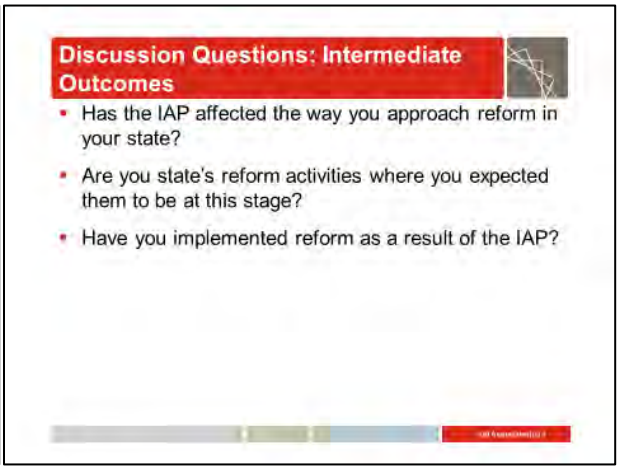

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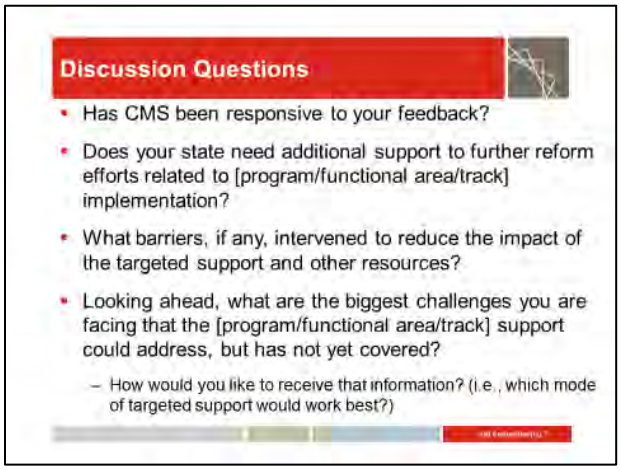

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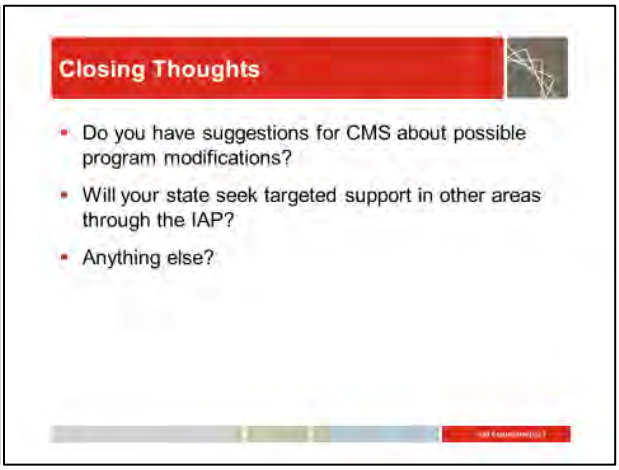

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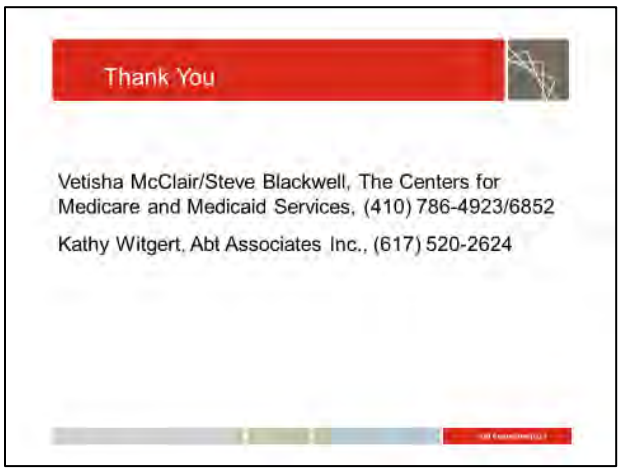


Coach Data Collection Protocols

COACH TELEPHONE INTERVIEW GUIDE

Thank you for taking the time to speak with us today. I'm [NAME] from Abt Associates. As you may be aware, our organization was hired by the Centers for Medicare & Medicaid Services (CMS) to evaluate the Medicaid Innovation Accelerator Program (IAP) targeted support program. Before we begin the discussion, I will tell you a bit more about the evaluation.

The goal of the evaluation is to understand the effectiveness of the IAP model in supporting ongoing reform in state Medicaid programs. Your perspective is critical to our understanding of what is working [worked] well about the **[program/functional area and track, if necessary]** model utilized. The input you provide will influence how targeted technical support is provided in the future to promote further Medicaid innovation.

You should have received a consent document that describes how we will use the information collected as part of the study. If you have the document in front of you, please feel free follow along as I read it. At the end, I will ask if you agree to participate and have the discussion recorded.

NOTE: INTERVIEWER SHOULD NOW READ CONSENT DOCUMENT TO PARTICIPANTS

Role

Thanks again for making the time to speak with us today. First I'd like to understand the nature of your coaching role and how you interact with **[state(s)]**.
[Interviewer: If interviewing only one respondent and you know that there is only one coach/facilitator per state, read questions 2, 3 and 5. If interviewing more than one respondent, read questions 1, 2 and 3 to each respondent, then proceed with questions 4 and 5 as a group.]

1. Please tell me your name(s) and your organization affiliation.

[Interviewer: If respondent is a coach for more than one state, have them respond to the following questions for each state individually, as appropriate.]

2. Please describe your role **[and state(s), if not known]** as you understand it.
    a. Were the expectations for this role clear?

PROBE: Did CMS provide any guidance about the agency's expectations of your coaching role? Would you say your role is clearly defined?

3. Has your role changed over time? If so, how has it changed?
4. Do you work as a technical support team in **[state(s)]**? That is, are there other coaches, experts, or technical support providers?
    a. If yes, please describe the composition of the team.
    b. Are the roles for support coaches clearly defined for you and for **[state(s)]**?
    c. Are all these individuals employed by **[targeted support contractor]** or by other organizations?
    d. How do you coordinate communication with the state(s)?
5. Could you describe the process of being paired with your state(s)?

Coaching Methods

[Interviewer: Ask questions 6 and 7 only if track received performance improvement support, else skip to question 8.]

6. Each state is offered PI support that can include developing driver diagrams, selecting metrics, and conducting iterative testing. Please describe your experience working with **[state(s)]** in supporting these activities. [If more than one state, ask them to describe their experience with each state separately.]

    a. Is a Performance Improvement (PI) subject matter expert (SME) working with the state team on the development of a driver diagram?

        i. If yes, are you also involved in the development of this tool?

    b. Did you visit **[state(s)]** in-person to support the completion of the driver diagram? Please tell me more about this visit. How useful did you find the in-person visit relative to virtual collaboration?

    c. Was developing the driver diagram a collaborative process between you, the **[state(s)]**, and the PI SME **[if appropriate]** or did one (you, the state, or the PI contractor or SME) take the lead?

    d. Was there collaboration among state officials participating in the **[program/functional area or track]** to complete the diagram?

    e. Do you think the driver diagram was an effective project management tool for the **[program/functional area or track]**? Why or why not?

    f. Did the PI SME help [state] select metrics for their secondary and primary drivers? [These were intended as process measures and not outcome measures (e.g., increase in the number of veteran housing units).] If yes, please describe this process and its effectiveness.

    g. [Interviewer, this activity likely happens later in the track, so depending on the timing of the interview, it may not have yet taken place. Our understanding is that this step may have occurred during quarterly meetings when metrics were reviewed and decisions on whether or not to fine-tune drivers to reach your goals were made.] Did the PI SME help [**state**] understand how to conduct iterative testing?

    h. Is the PI support aligned with **[state's]** needs?

    i. Is the PI support timely?

    j. Do you anticipate any changes in how you work with the PI SMEs for the remainder of the support period?

    k. Would you recommend any changes to the PI support model to CMS?

7. What feedback, if any, have you received from **[state(s)]** about the PI component of their IAP work?

8. **[High intensity tracks only, as applicable]** Each state was required to complete an **[action plan, work plan, use case, etc.]**. Please describe your experience helping **[state(s)]** develop these materials.

a. Was developing this (these) program management tool(s) a collaborative process between you and your **[state(s)]**? Did one (either you or the state) take the lead?

b. Was there collaboration among state officials participating in the **[program/functional area or track]** to complete the **[action plan, work plan, use case, etc.]**?

c. Did you find the exercise useful in helping **[state(s)]** refine their **[program/functional area or track]** strategy? Why or why not?

9. Are there other ways you and **[state(s)]** are identifying issues and priorities to address through the **[program/functional area and track]**?

10. Please describe the process you use **[used]** to identify issues and priorities you and your state(s) would address through coaching? How were priorities set?

[Interviewer: If the coach has more than one state ask question 11, else skip to question 12.]

11. Do [did] your coaching methods differ by state? If so, how? If so, what led you take a different approach with each state?

12. How do [did] you primarily communicate with **[state(s)]** (e.g., email, phone, in-person)?

a. Is [was] this the state's preference?
b. Is [was] this your preference?
c. Do you think this has been [was] an effective form of communication?

13. How regularly do [did] you communicate with states? Do [did] you have a set schedule or do [did] you meet on an ad hoc basis?

a. Is [was] contact frequent enough? Too frequent?
b. How much time do you estimate you spend [spent] working with **[state(s]** per week (or per month)?
c. Is [was] this enough from your perspective?
d. Has **[state(s)]** indicated they would like more (or less) engagement?

14. Did you conduct a **site visit** to meet with your assigned state? If yes, please describe the experience. What worked well? Would you recommend any changes for improvement?

a. Did the state ensure the right people were available; gather necessary materials; prepare questions/areas where help would be most useful?

b. Did the amount of time between the initial conversation with the state and the site visit impact the effectiveness of the site visit on your reform efforts? If yes, please explain.

15. What kinds of specific tasks have you been [were you] asked to perform by **[state(s)]**?

a. Were you [have you been] able to fulfill **[state(s)']** requests? Why or Why not?

16. Do **[**did] you enter information about state communications/questions in a technical support log?

a. (If yes) How do [did] you enter the information?

PROBE: Are [were] you provided with instructions?

PROBE: Where do [did] you draw the line between what is tracked in the log versus what is not tracked?

17. Have you received any feedback about the coaching model? If so, from whom? Did you make any changes to the coaching you provided as a result of the feedback?

Support for Coaches

18. Does [did] CMS provide any training for coaches? Can you tell me more about this?
    a. Is there standardization in coaching methods and topics across states or are you encouraged to customize your efforts to meet the specific needs of **[state(s)]**?
19. What support do [did] you receive in your role as a coach, if any (e.g., tools or materials, training, peer-to-peer support/interaction with other coaches)?

PROBE: Who provides this support? Is this support ongoing or was it one time?

a. Was the support that you received adequate for you to do your job well?
b. What additional resources or support (if any) would have been helpful?

20. Could you please describe any challenges in your experience as a coach for **[program/functional area or track]**?

IAP Program and Coaching Model

21. Can you provide any feedback on the **[program/functional area or track]** kick-off call that took place on **[date]**?
    a. Was the kick-off webinar valuable to you as a coach? Would you say it was valuable for participating states?
    b. Did CMS engage coaches in coordinating the kick-off webinar? If yes, how did they engage coaches?
    c. Have expectations for states evolved since the kick-off webinar? If yes, how has **[state(s)]** responded?
22. Are there opportunities to improve introductory calls/meetings?
23. Can you provide any feedback on the **[program/functional area or track]** learning events such as webinars and in-person meetings?
    a. Were the learning events valuable to you as a coach? Would you say they were valuable for participating states?
    b. Did CMS engage coaches in coordinating the learning events? If yes, how did they engage coaches?
24. Are there opportunities to improve the learning events?

[Functional areas skip question 24.]

25. What feedback, if any, have you received from **[state(s)]** about Groupsite?

PROBE: Are states using it? How?

26. What is your understanding of the **[program/functional area or track]** goals? State(s) goals?
27. Do you believe the length of the **[program/functional area or track]** coaching/facilitator support is

[was] sufficient to complete the program goals? States' goals? Why/why not?

   a. If no, what might be a more appropriate length of time?

28. Do you believe the type of support provided through the coaching model is [was] adequate to meet the **[program/functional area or track]** needs of **[state(s)]**? Why/why not?
29. What has worked well with the **[program/functional area or track]** coaching model?
30. What do you expect to see as a result of [what has resulted from] the state's participation in **[program/functional area or track]**?

    a. Are you able to provide examples of specific *activities or changes* the state is making **[has made]** as a result of **[program/functional area or track]** participation?

31. How do you define success for your state? How would CMS define success?
32. Do you have any recommendations for how technical support for **[program/functional area or track]** states could be improved?
33. What advice would you give to future IAP program **[functional]** area coaches?
34. Is there anything else about your coaching experience you would like to share or anything that we have not discussed?

COACH VIRTUAL FOCUS GROUP DISCUSSION GUIDE

Moderator/Note taker Focus Materials Checklist

- Flip chart [or PowerPoint presentation]
- Verify recording equipment
- Discussion guide
- Markers [In-person only]
- Participant name tents **[In-person only]**
- Interviewer clock
- Laptop for note-taking with plug
- Copies of statement of informed consent **[In-person only]**
- Attached to the Outlook meeting invite **[Virtual only]**:
  - WebEx link
  - Informed consent document
  - PowerPoint flip chart/slides
- List of confirmed attendees (via Outlook meeting invite)

[In-Person] Room Set-up Checklist

- Tables in a circle or hollow square
- Enough chairs for all participants
- Note taker has room for laptop and access to power plug
- Recorder where it can be easily turned on and can record all voices in room
- Flip chart(s) near facilitator **[or use a PowerPoint presentation]**
- Name card at each place
- Markers on table so people can write name cards
- Copies of statements of informed consent

Welcome and Purpose of the Focus Group (5 minutes)

*Open to page 1 of the Flip Chart (or slide 1 of PowerPoint), "**Title Page**"*

Welcome. Thank you for taking the time to join this focus group on the targeted support provided to the **[program/functional area/track]** IAP group. As you recall, we are members of the Medicaid Innovation Accelerator Program (IAP) evaluation team from Abt Associates. We are here specifically to learn more about your experiences as coaches and subject matter experts to the **[program/functional area/track]** and to hear more about the support that states have received thus far. As a reminder, the goals of the evaluation are to:

- Evaluate process of providing support – design, mode and timing of support.
- Assess the efficacy and the level of state acceptance of support.

- Provide real time cycle feedback to the Centers for Medicare & Medicaid Services (CMS).
- Evaluate impact of the support on state's behavior and whether the support has helped to further reforms.

Review of informed consent

Go to page 2 of the Flip Chart (or slide 2 of PowerPoint), "Informed Consent"

[In-person: As participants enter the room provide them with a copy of the statement of informed consent (SIC). Ask them to read the SIC prior to the start of the focus group meeting.]

[In-person] I hope that you all had a chance to look over the SIC - does everyone have a copy? I will also read it aloud. At the end, I will ask if you to sign the SIC if you agree to participate and have the discussion recorded.

[Virtual] You should have received a consent document that describes how we will use the information collected as part of the study. It is also on the shared screen via the WebEx application. Please feel free follow along as I read it. At the end, I will ask if you agree to participate and have the discussion recorded.

- **[After reading the informed consent]** Does anyone have any questions about the SIC, the goals of the evaluation, the purpose of the focus group or your participation in the focus group?
- Please sign and pass the signed statements to me.
- Okay, let's get started.
- **[Note taker name]** Please start the recording now.

Ground Rules

- Let's keep the conversation informal. Don't hesitate to ask me or each other questions. Please be honest in your feedback. It's fine to disagree – there are no right or wrong answers.
- In every group there are people who talk a lot and others who don't. My job is to make sure we hear from everyone. So I may call on you specifically if I haven't heard your voice in a while. I also may need to cut off conversation to make sure we cover all the topics; please don't take offense.
- Please put your phones on vibrate and put them away. If you need to step out to take a call, do so, but please do not check emails during this 60-minute focus group.
- We appreciate your full attention and engagement during the call.

Introductions (10 minutes)

You have all been invited to this group discussion because you have been providing targeted support to states participating in the **[Program/functional area/track]**.

*Go to page 3 of the Flip Chart (or slide 3 of PowerPoint), "**Introductions**"*

[In-person] I'd like to ask you to introduce yourselves by stating your name, the organization with which you are affiliated, the state or states for which you provide support, and your role on the IAP team. **[If coaches and subject matter experts are present, ask their role on IAP.]**

[Virtual] When I call your name, please introduce yourself by telling us your name, organization, and with which state(s) you have been working. [If coaches and subject matter experts are present, ask their role on IAP.] [Facilitator: Since you are not able to "go around the table" as the discussion is taking place virtually, make sure the number of vocal introductions matches the number of people that are registered on WebEx.]

Program Experience (30 minutes)

First we'd like to hear about your thoughts regarding the design and implementation of the [program/functional area] track.

*Go to page 4 of the Flip Chart (or slide 4 of PowerPoint), "**Clarity of Roles**"*

1. Thinking about the design and implementation of the [program/functional area] priority area, how well did you understand your role, the role of CMS, and the role of other technical support providers? How were the roles defined?
    a. Do you feel the IAP is supporting you in your role? If not, how could the support/communication be improved?
    b. Based on your experience working with participants, was your background/expertise matched appropriately with participants' needs?
        i. What worked well? Why?
        ii. What changes or modifications would you recommend to the matching process?

*Go to Page 5 of the Flip Chart (or slide 5 of PowerPoint), **"Goals and Participant Expectations"***

2. From your perspective as coaches, what are the program goals for **[program/functional area/track]** participants?
3. Do you feel that the participant expectations were clearly defined during the program kick-off?
    a. How have the expectations evolved over time?
    b. What would have helped make program expectations more clear?

*Go to page 6 of the Flip Chart (or slide 6 of PowerPoint), **"Tailoring Support for Participants"***

4. What approaches did you use to tailor coaching and facilitation or targeted support to meet participant needs?
    a. Did the type of support that you provided evolve over time? How?
    b. Can you share an example of tailored support that worked well?
    c. Can you share a challenge you faced in providing tailored support?
5. Did coaches interact with subject matter experts? If so, how?

*Go to page 7 of the Flip Chart (or slide 7 of PowerPoint), **"Program Timeline"***

6. Thinking about the overall progress that you have made with states since the program began, has the pacing of your interactions with participants and overall timeline been adequate?
    a. What has worked well? What could be improved?
7. Should the program have been longer or shorter? What would be the ideal length?
8. Do you have any feedback on the time of year the **[program/functional area/track]** was rolled out?
9. [If appropriate for the track, ask:] Did the extended period afford adequate time and support to help the state(s) further reform efforts?
    a. How have you used/are you planning to use the extended the timeline?

*Go to page 8 of the Flip Chart (or slide 8 of PowerPoint), **"Other Modes of Targeted Support"***

Beyond your role as coaches, we'd like to hear your thoughts regarding other modes of targeted support provided in the **[program/functional area/track]**.

[Focus Group Facilitator: ask each coach to respond to each bullet on the slide]:

For each of the IAP components on this slide, please consider worked well and why? What changes or modifications you would recommend?

10. [Ask item 10 only if applicable to the program/functional area] Each state was required to complete an **[activity, e.g., action plan, driver diagram]**; would you please describe your experience in working with your state(s) as they developed and updated their **[activity]**?
    a. Do you think the **[activity]** was an effective project management tool for the **[program/functional area/track]**? Why or why not?
11. [Ask item 11 only if applicable to the program/functional area.] The **[program/functional area/track]** states were invited to a peer learning opportunity **[name opportunity]**. Do you think this was a valuable and productive opportunity to share information? Why or why not?
    a. What other observations do you have about these discussions?
12. [Ask item 12 only if applicable to the program/functional area.] Did you participate in any [program/functional area/track]-related webinars including National Dissemination Strategy webinars?
    a. Would you please provide feedback about the webinars?

PROBE: Did they provide valuable information for you that have or will help with your reform efforts?

b. Which webinar was particularly useful?

2. Did you find the communication with your state(s) through emails and Groupsite to be helpful?
3. [Ask item 14 only if applicable to the program/functional area] States were invited to attend **[one or two]** in-person meeting(s); what is your reaction to those meetings?

13. PROBE: What aspects were most valuable?

    a. Do you think the in-person meeting(s) was (were) an effective way for states to share ideas and network across states? Why or why not?

    b. Was the length and format of the meeting(s) appropriate? Why or why not? Can you offer any suggestions for improving the in-person meeting(s)?

4. Is there any other component of the program that I missed?
5. What do you think was the most valuable aspect of the IAP?

Discussion Questions (15 minutes)

*Go to page 9 of the Flip Chart (or slide 9 of PowerPoint), "**Discussion Questions/Overall Thoughts**"*

6. Were the selected [**program/functional area**] states ready (at a good point) to take advantage of the targeted support provided in this track?

    a What about [**program/functional area**] participants?

    b What were some of the barriers to active participation?

7. Did participants bring team members with the right skills and level of commitment to work with the coaches?
8. Were state teams able to prioritize IAP activities take full advantage of the targeted support?
9. Has IAP affected the way participating states approach reform? Have they implemented reform as a result of the IAP?
10. What barriers, if any, intervened to reduce the impact of the targeted support and other resources?

Closing (5 minutes)

*Go to page 10 of the Flip Chart (or slide Go to slide 10 of the PowerPoint), "**Closing Thoughts**"*

Before we close, I want to give everyone the opportunity to add any final thoughts or comments.

11. If you were appointed to an advisory board on the IAP, what would you recommend to CMS to improve the program? What kind of assistance should CMS offer in the future?
12. If the opportunity arises, will your state(s) seek targeted support in other areas through the IAP in the future?
13. Do you have anything else to add?

Go to page 11 of the Flip Chart (or slide Go to slide 11 of the PowerPoint), "Thank You"

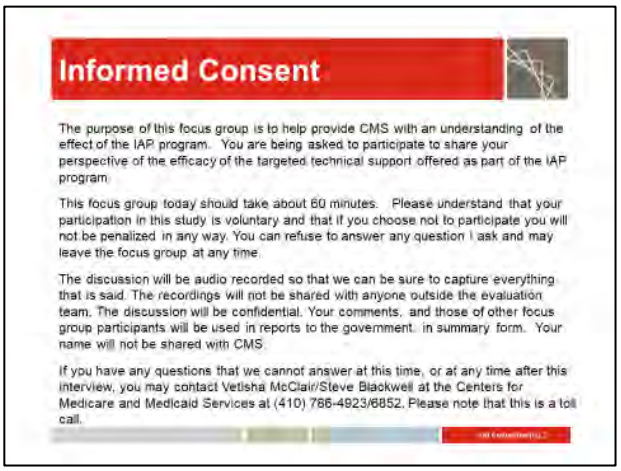
Thank you again for this lively discussion today. The information you provided will help the evaluation team give constructive feedback to CMS and is much appreciated. It will help CMS as it considers opportunities for enhancements to both their current and future programs.

If you have any questions about this focus group meeting, or the evaluation overall, please contact: Vetisha McClair/Steve Blackwell, CMS COR or Kathy Witgert, Abt PD.

COACH FOCUS GROUP SLIDES

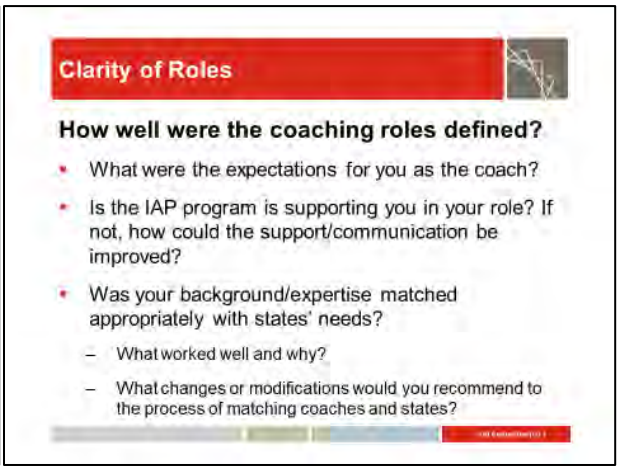
Slide 1:

Slide 2:



Slide 3:

Slide 4:



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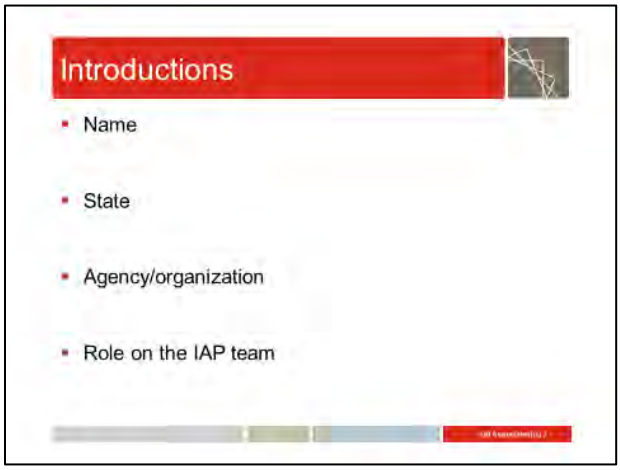

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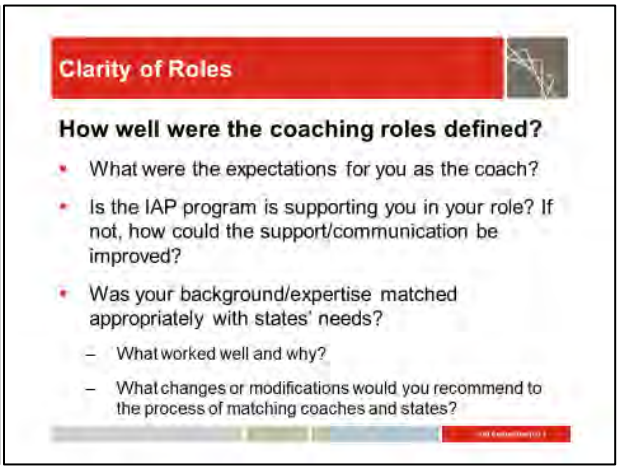

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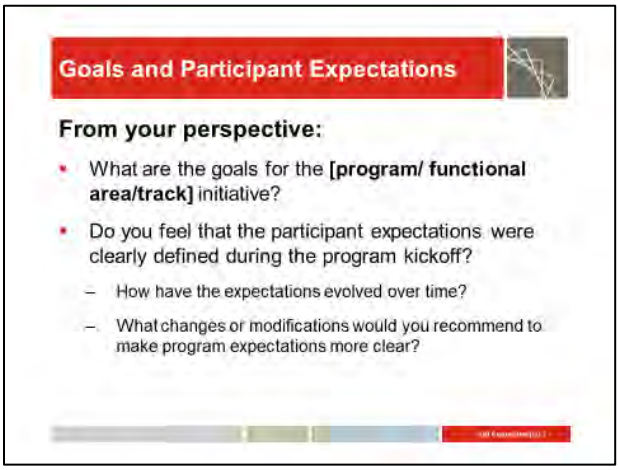

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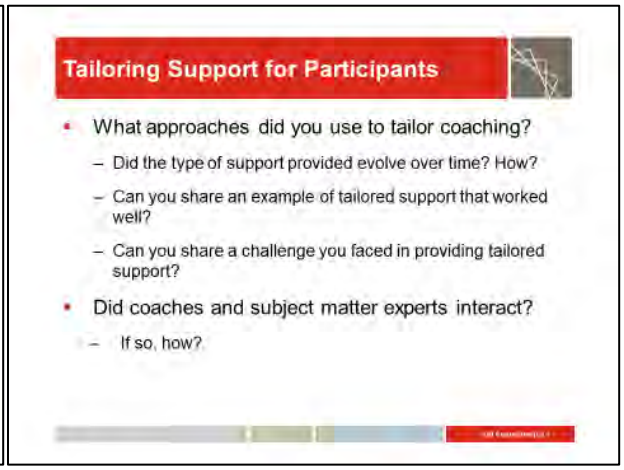

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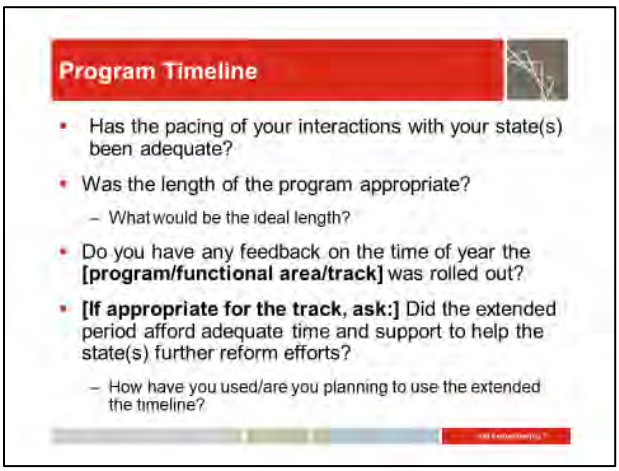

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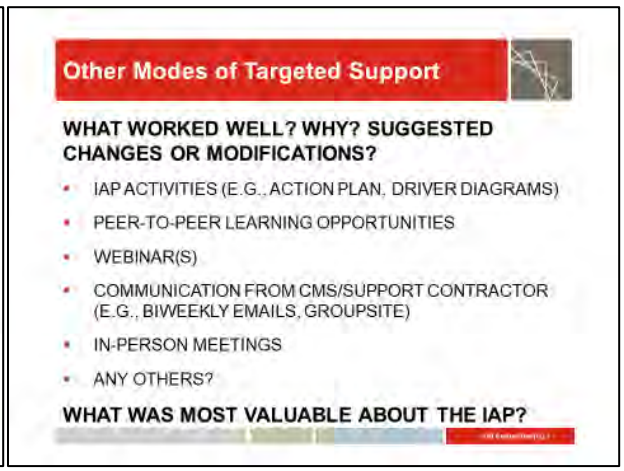

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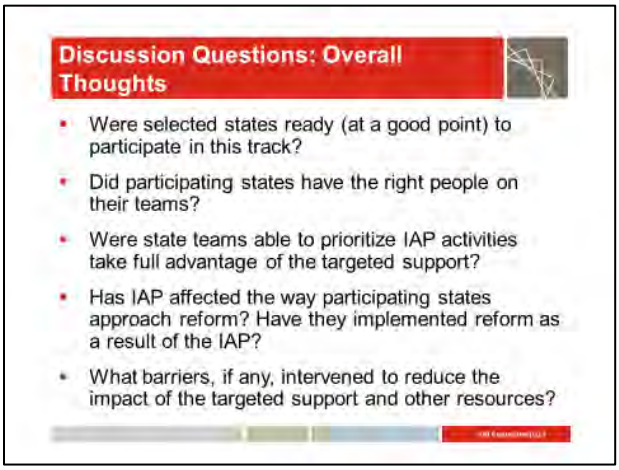

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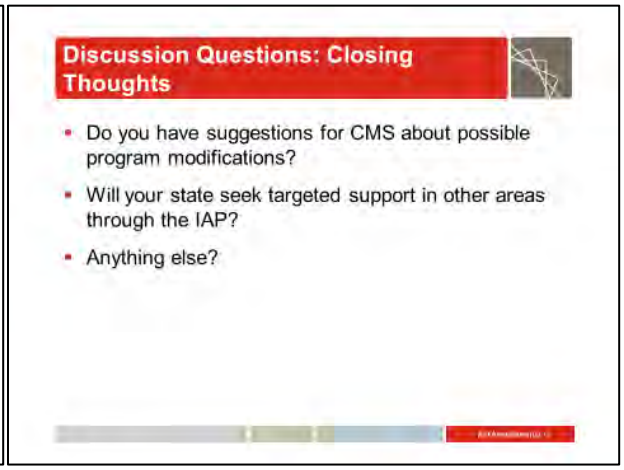

Slide 13:


Thank You
Vetisha McClair/Steve Blackwell, The Centers for Medicare and Medicaid Services, (410) 786-4923/6852
Kathy Witgert, Abt Associates Inc., (617) 520-2624

Event Observation Matrix

EVENT OBSERVATION MATRIX

This matrix can be used for in-person meetings and virtual presentations. It should be filled out during or immediately following an event. It is not a substitute for taking notes during the event; rather, it is a synthesis of the event experience. If you are using the matrix for an in-person event, please fill out the matrix for each presentation, individually. Note that there is a section at the end of the matrix that is meant to capture additional information if the presentation is offered by state participants.

Domain	Question/Item	Observations
N/A	Name(s) of observer(s)	
Context	Meeting title, location, dates	For in-person events only.
Context	Presentation title, date	
Context	Start time/ end time	
Context	Presenters names and affiliations	
Context	Intended Audience	Note whether the event is limited to IAP participants or open to a wider audience (e.g. National Dissemination Webinar).
Context	Were the objectives identified at the start of the presentation?	Y/N
Context	If yes, list the objectives	
Context	Did the presentation align with the objectives?	Y/N
Context	What were the Key Messages (i.e., takeaways) conveyed during the presentation? Note. This may or may not align with the stated objectives.	
Context	How was the content presented/knowledge shared?	
	Were examples provided, tools presented, strategies showing how concepts are actionable?	
	What worked well?	

Domain	Question/Item	Observations
	What could be improved?	
Context	Was the presentation well-organized?	Y/N
Reaction	Were you able to hear (and see if in-person meeting) the presenter?	Y/N "See" applies to in-person events only.
Reaction	Were the presenters easy to understand?	Y/N
Reaction	How did participants interact with the presenter(s)?	
	Did participants ask questions or respond to questions/share information?	Summarize participant questions/sharing including the state(s).
Reaction	Did participants interact with one another?	This is more relevant to in-person presentations, but in some instances may also be relevant to webinars.
Reaction	Was there adequate time for questions and answers?	Y/N
	Were adequate responses provided?	Y/N
Reaction	Did the participants interact with one another before or after the presentation?	For in-person events, only. If possible, please indicate if the interaction was around the topic of the presentation, the event, or other state program issues.
Reaction	Did the participants interact with the presenter before or after the presentation?	For in-person events, only. If possible, please indicate if the interaction was around the topic of the presentation, the event, or other state program issues.
Response	Did the presenters ask for suggestions for future topics/types of targeted assistance?	Y/N
	If yes, did the participants make any suggestions for future topics of targeted assistance?	Y/N
	If yes, what were the suggestions?	
Response	Did the presenter ask for suggestions for improving future events?	Y/N

Domain	Question/Item	Observations
	If yes, did participants make any suggestions for improving future events?	Y/N
	If yes, what were the suggestions?	
N/A	What other observations did you note that have not already been covered?	
N/A	Do you, the evaluator, have any ideas or recommendations for CMCS for improvement?	

For IAP participant presentations, please summarize the following from your observations:		
Reaction	**Program goals**	Summarize and indicate if they have changed over time.
Response	**Key strategies**	Summarize and indicate if they have changed over time.
Learning	**Key lessons learned**	Note any lessons learned or knowledge gained through IAP participation.
Learning	**Potential areas for additional support**	
Results	**Key successes**	Note specific activities or changes to programs.

In-Person Meeting Evaluation Form

IN-PERSON MEETING EVALUATION

[Tailor the meeting sessions (left column) as appropriate.

Add or delete days according to the length of the meeting]

*Please complete the matrix below by indicating a rating of **1 to 5 (1 = poor, 3 = average, 5 = excellent)** for each measure.*

	Clarity of objectives	Level of detail	Relevance of content	Usefulness of content	Meeting Logistics/ Technical Issues	Overall quality
Day 1 [insert day and date]						
Opening Session						
States' Status Reports						
Panel Presentation [if more than one, insert additional lines for each]						
Small Group Roundtable Discussions: Challenges & Successful Strategies (Group:_____)						
State Team Break Outs (State:_____)						
Closing Remarks						
Comments:						
Day 2 [insert day and date]						
Opening Session						
Panel Presentation [if more than one, insert additional lines for each]						
Small Group Roundtable Discussions: Challenges & Successful Strategies (Group:_____)						
State Team Break Outs (State:_____)						
Closing Remarks						
Comments:						

What did you find most valuable about the meeting?

_____

_____

_____

_____

What did you find least valuable about the meeting? Is there anything you would recommend for future IAP in-person meetings?

_____

_____

_____

_____

Are there any issues or strategies that you think are important that did not receive attention or sufficient attention at the meeting?

_____

_____

_____

_____

What specific, actionable knowledge did you acquire from this meeting? How do you intend to apply information you received to improve programs/policies in your state?

_____

_____

_____

_____

_____

Additional comments:

_____

_____

Please indicate your affiliation:

State official	___	Technical Support provider	___
Federal partner	___	Other partner	___
Guest speaker	___	Other	___

Surveys

POST-WEBINAR SERIES SURVEY

[Cover letter sent as the email request]

Dear **[program/functional area/track]** webinar series participant:

We are seeking your feedback regarding your participation in the Medicaid Innovation Accelerator Program's (IAP) **[program/functional area/track]** webinar series. As part of the Centers for Medicare & Medicaid Services' (CMS's) commitment to continually improve the delivery of program support and resources that serve the needs of Medicaid agencies, the evaluation team would like to hear your thoughts on how well the webinar series met its goals described below.

[Program/functional area/track] Goals:

- [Add for program/functional area/track. Use as many bullets as needed.]•

Please take a moment to complete our brief evaluation regarding your experience with the [**program/functional area/track**] webinar series. The polling will close in 14 days, on XX/XX/20XX. This evaluation should only take 5 minutes to complete**.**

[Insert evaluation link]

Kind regards,

The IAP Evaluation Team

Identifying information

1. Please identify your affiliation: **[Drop down menu of options as relevant: state Medicaid agency; state housing agency; state behavioral health agency; state mental health agency; state developmental disabilities agency; state aging agency; other state agency; other.]**
2. Which of the following [**program/functional area/track**] webinars did you attend? Please select all that apply. [*This will be programmed so that individuals click next to each space to mark their attendance. They will not click anything for the webinars they did not attend*.]
3. Please rate the following statements: [*A scale will appear for each response indicating strongly agree, agree, neutral, disagree, strongly disagree*.]
    a. My overall experience with the **[program/functional area/track]** webinar series was positive.
    b. Thinking back over the variety of **[program/functional area/track]** topics covered throughout the webinar series (noted above), I was satisfied with the range of issues discussed.
    c. I would continue to engage if more webinars were offered on topics of interest to my state.
    d. The webinars offered me new information or more in-depth information.
    e. The webinar slides were easy to follow.
    f. The webinar slides enhanced the speakers' delivery.
4. The webinar I found most useful to my agency/organization was: **[Drop down menu of options: list of all webinars.]**
    a. **Open response:** Please let us know what made this webinar the most useful in the series to your state.
5. The webinar I found least useful to my agency/organization was: **[Drop down menu of options: list of all webinars.]**
    a. **Open response:** Please let us know what made this webinar the least useful in the series to your state.
6. Please rate the following statements: [*A scale will appear for each response indicating strongly agree, agree, neutral, disagree, strongly disagree.]*
    a. This webinar series addressed specific areas in which technical support was needed to further my state/program's reform efforts.
    b. The webinars have been useful to helping my state agency/organization in understanding how Medicaid can support **[program/functional area/track]**.
    c. As a result of participating in the **[program/functional area/track]** series, my state/agency is pursuing other options for Medicaid supports for **[program/functional area/track]**.
    d. As a result of participating in the **[program/functional area/track]** series, my state/agency is interested in participating in other IAP program areas. Select all that

apply. **[Drop down menu of options as appropriate: Reducing Substance Use Disorders (SUD), Improving Care for Medicaid Beneficiaries with Complex Needs and High Costs (BCN), Promoting Community Integration through Long-Term Services and support (CI-LTSS) Medicaid Housing-Related Services and Partnerships, CI-LTSS Incentivizing Quality and Outcomes (IQO), Supporting Physical and Mental Health Integration (PMH), Data Analytic (DA), Value-Based Purchasing and Financial Simulations (VBPFS)].**

e. If IAP offered another **[program/functional area/track]** that offered more intensive support, would your state be interested?

f. My agency/organization has used information provided in these IAP webinars and resources to support program changes/delivery system reform efforts.

   i. [*If yes is selected, a free response box will appear*]. Please briefly describe the program changes or delivery system reform efforts to which IAP webinars and resources were helpful.

7. **Open Response:** Please provide a description of what additional information or topics you would have liked to have been addressed through the **[program/functional area/track]** series. [*Free response box*.]

Thank you very much for taking the time to provide us with this important feedback.

SUMMATIVE SURVEY

Thank you for taking the time to complete the **[program/functional area]** Medicaid Innovation Accelerator Program (IAP) survey as part of the Centers for Medicare & Medicaid Services (CMS) IAP evaluation. The purpose of the evaluation is to help provide CMS with an understanding of the efficacy of the IAP program model in supporting Medicaid system reform. Through this survey, we are interested in learning about the status of your **[program/functional area]** payment and/or delivery reform efforts following IAP participation.

Please understand that your participation in this study is voluntary and that if you choose not to participate you will not be penalized in any way. You can skip any item in the survey and may stop the survey at any time. **By completing and submitting this survey you agreeing to participate in the study/survey**.

If you have any questions at any time during or after completing this survey, you may contact Vetisha McClair/Steve Blackwell at the CMS at (410) 786-4923/6852. Please note that this is a toll call.

We anticipate that the survey will take no longer than 20 minutes to complete. You can complete the survey at your convenience, but be sure to "save" if you exit with the intent of returning to complete the survey at later time.

[Note that in most cases, we will not administer the summative survey to the lighter touch tracks. If support for the light touch track was a webinar series, administer the post-webinar series survey rather than the summative survey. Remove questions about any modes of support that do not apply to a specific IAP program/functional area or track.]

1. Please indicate the state that you represent.

[List all states participating in the relevant program/functional area]

2. Please indicate the agency that you represent.

[List agencies relevant to the program/functional area]

3. Participating in the **[program/functional area or track]** was effective in helping move our state toward our delivery system goals?

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly Disagree

4. The content and focus of the support provided in the **[program/functional area or track]** was aligned with our state's current delivery system reform efforts.

   - ☐ Strongly Agree
   - ☐ Agree
   - ☐ Neither agree nor disagree
   - ☐ Disagree
   - ☐ Strongly Disagree

5. We received sufficient advance information from the Centers for Medicaid and Medicare Services (CMS) about **[program/functional area or track]** to make a well-informed decision regarding participation.

   - ☐ Strongly Agree
   - ☐ Agree
   - ☐ Neither agree nor disagree
   - ☐ Disagree
   - ☐ Strongly Disagree

6. Participating in the **[program/functional area or track]** increased in-state knowledge of delivery system reform options.

   - ☐ Strongly Agree
   - ☐ Agree
   - ☐ Neither agree nor disagree
   - ☐ Disagree **[Skip to Item 9]**
   - ☐ Strongly Disagree **[Skip to Item 9]**

7. We have been able to apply knowledge gained through IAP **[program/functional area or track]** participation toward delivery system reform.

   - ☐ Strongly Agree
   - ☐ Agree
   - ☐ Neither agree nor disagree
   - ☐ Disagree
   - ☐ Strongly Disagree

8. Please provide examples of increased knowledge of delivery system reform options.

[Short open text response]

9. Please describe any barriers to applying this knowledge to delivery system reform.

[Short open text response]

10. Please describe how IAP could be improved to increase your knowledge acquisition about delivery system reform efforts.

[Short open text response]

11. Did the IAP technical support allow you to create/refine/build capacity in any of the following functional area topics (please check all that apply)?

    - ☐ Data Analytics
    - ☐ Quality Measurement
    - ☐ Value-Based Purchasing and Financial Simulation
    - ☐ Performance Indicators

12. We have been able to sustain delivery system reform efforts begun during IAP **[program/functional area or track]** participation.

    - ☐ Strongly Agree
    - ☐ Agree
    - ☐ Neither agree nor disagree
    - ☐ Disagree *[Item 12b will appear, and then the program will skip to Item 15]*
    - ☐ Strongly Disagree *[Item 12b will appear, and then the program will skip to Item 15]*

        a. How did your team ensure delivery system reform efforts begun during IAP [**program/functional area or track]** were sustained?

        b. Please describe any barriers to sustaining delivery system reform.

[Short open text response]

13. Please describe specific activities or changes your state has undertaken as a result of participating in the **[program/functional area or track].**

[Short open text response]

14. Please describe any outcomes that stem from the activities or changes your state has undertaken as a result of participating in the [**program/functional area or track**].

15. During the course of the **[program/functional area or track]** program, our feedback was obtained and incorporated into subsequent events (e.g., webinars, coaching) to better meet our requests and needs.

    - ☐ Strongly Agree
    - ☐ Agree
    - ☐ Neither Agree nor Disagree
    - ☐ Disagree
    - ☐ Strongly Disagree

16. Please rate the following types of support provided to IAP **[program/functional area or track],** participants from 1- least useful to 5-most useful for your state team. ***[Tailor left column to reflect relevant modes of support.]***

	1-Least Useful	2	3	4	5- Most Useful	Did not participate in this form of support
Webinars that featured outside experts as speakers						
Post-webinar discussions						
Peer-to-peer webinars that included primarily IAP group participants as speakers						
Coaching						
Site visits						
In-person meetings						
Discussion groups						
Project exercises (e.g., action plan, work plans, driver diagrams, use case, other homework)						
CMCS check-in calls						
CMCS email updates						
Targeted support summary memos						
Informal virtual convenings						
Groupsite virtual resource library						
Other support (please specify)						

17. We found the **[action plan, driver diagram, use case, homework]** exercise helpful in focusing and refining our delivery system reform goals.

    ☐ Strongly Agree
    ☐ Agree
    ☐ Neither Agree nor Disagree
    ☐ Disagree
    ☐ Strongly Disagree

18. We were able to apply the information learned from the webinar series to our state's **[program/functional area or track]** reform efforts (e.g., to make program or policy changes).

    ☐ Strongly Agree
    ☐ Agree
    ☐ Neither agree nor disagree
    ☐ Disagree *[Skip to item 20]*
    ☐ Strongly Disagree *[Skip to item 20]*

[If response to Item 18 is Strongly Agree or Agree, Item 19 will appear. If response to Item 18 is Disagree or Strongly Disagree, the program will skip to Item 20.]

19. Please describe what was most valuable about this webinar series to your state's **[program/functional area or track]** reform efforts.

[Short open text response]

20. Can you recommend any changes to the webinar series that would have made it more valuable to your state's **[program/functional area or track]** reform efforts?

[Short open text response]

21. Was coaching support a component of IAP participation in your state?

    - ☐ Yes
    - ☐ No *[The program will skip to Item 29]*

22. The amount of coaching provided was sufficient to help advance our **[program/functional area or track]** delivery system reform efforts.

    - ☐ Strongly Agree
    - ☐ Agree
    - ☐ Neither agree nor disagree
    - ☐ Disagree
    - ☐ Strongly Disagree

23. Over the course of the program, the coaching approach was tailored to our state's specific needs and the status of our reform efforts.

    - ☐ Strongly Agree
    - ☐ Agree
    - ☐ Neither agree nor disagree
    - ☐ Disagree
    - ☐ Strongly Disagree

24. The coaching support helped our state further our delivery system reform efforts.

    - ☐ Strongly Agree
    - ☐ Agree
    - ☐ Neither agree nor disagree
    - ☐ Disagree *[Skip to Item 27]*
    - ☐ Strongly Disagree *[Skip to Item 27]*

[If response to Item 24 is Strongly Agree or Agree, Items 25 and 26 will appear. If response to Item 24 is Disagree or Strongly Disagree, the program will skip to Item 27.]

25. Please describe how coaching supported reform efforts.

[Short open text response]

26. What was the most valuable aspect of the coaching support offered to your state's **[program/functional area or track]** reform efforts?

[Short open text response]

27. Can you describe one thing that could be improved about the coaching support offered to your state's **[program/functional area or track]** reform efforts.

[Short open text response]

28. Did you continue contact with your coach after [date of the end of the structured period]?

29. Were one or more in-person meetings a component of IAP participation in your state?

- ☐ Yes
- ☐ No *[the program will skip to item 38]*

30. The information we obtained at the in-person meeting(s) was directly relevant to our state's **[program/functional area or track]** delivery system reform efforts.
    - ☐ Strongly Agree
    - ☐ Agree
    - ☐ Neither agree nor disagree
    - ☐ Disagree
    - ☐ Strongly Disagree
31. We were able to apply information we obtained from the presentations at the in-person meeting(s) to our state's **[program/functional area or track]** reform efforts (e.g., to make program or policy changes).
    - ☐ Strongly Agree
    - ☐ Agree
    - ☐ Neither agree nor disagree
    - ☐ Disagree *[Skip to Item 33]*
    - ☐ Strongly Disagree *[Skip to Item 33]*

[If response to Item 31 is Strongly Agree or Agree, Item 32 will appear. If response to Item 31 is Strongly Agree or Agree, then the program will skip to Item 33.]

32. Please provide an example of how you applied information learned from the in-person meeting(s) to your state's **[program/functional area or track]** reform efforts.

[Short open text response]

33. Please describe any barriers to applying the information learned from the in-person meeting(s) to your state's **[program/functional area or track]** reform efforts.

[Short open text response]

34. The in-person meeting(s) provided enough time to engage with other states and share strategies for achieving **[program/functional area or track]** reform.
    - ☐ Strongly Agree
    - ☐ Agree
    - ☐ Neither agree nor disagree
    - ☐ Disagree
    - ☐ Strongly Disagree
35. The in-person meetings provided enough time to work independently with our teams and coaches.
    - ☐ Strongly Agree
    - ☐ Agree
    - ☐ Neither agree nor disagree

- ☐ Disagree
- ☐ Strongly Disagree

36. Please describe what was most useful about the in-persons meeting(s) for your state's **[program/functional area or track]** reform efforts.

[Short open text response]

37. Can you recommend any modifications to the in-person meetings to make them more useful to your state's **[program/functional area or track]** reform efforts?

[Short open text response]

38. Did you apply information learned from any of the **[program/functional area or track]** states during the following IAP activities? Check all that apply.

- ☐ Webinars

[If checked] **Please provide an example: [Short open text response]**

- ☐ In-person meetings

[If checked] **Please provide an example: [Short open text response]**

- ☐ Peer-to-peer webinars

[If checked] **Please provide an example: [Short open text response]**

- ☐ Discussion groups

[If checked] **Please provide an example: [Short open text response]**

39. Have you contacted any of the [**program/functional area or track**] states [**LIST STATES**] outside of the structured [program/functional area or track, if appropriate] activities?

40. Would you recommend this program to other Medicaid agencies?

- ☐ Yes
- ☐ No

Thank you for participating in this survey. By submitting the completed survey, you are agreeing to participate. We would like to follow-up with you to obtain more in-depth information about your experience with the [program/functional area or track]. Would you be willing to be contacted for further follow-up?

Statement of Informed Consent

INFORMED CONSENT

The purpose of this interview is to help provide CMS with an understanding of the effect of the IAP program in which you are participating. You are being asked to participate to help provide an understanding of the impact of the IAP program on supporting Medicaid system reform.

Our interview today should take a maximum of 60 minutes. Please understand that your participation in this study is voluntary and that if you choose not to participate you will not be penalized in any way. You can refuse to answer any question I ask and may ask to stop the interview at any time.

The discussion will be audio recorded so that we can be sure to capture everything that is said. The recordings will not be shared with anyone outside Abt Associates. The discussion will be confidential. Your comments, and those of others in the group, will be used in reports to the government, in summary form. Your name will not be shared with CMS.

Do you have any questions?

If you have any questions that I cannot answer at this time, or at any time after this interview, you may contact Vetisha McClair/Steve Blackwell at the Centers for Medicare and Medicare Services at (410) 786-4923/6852. Please note that this is a toll call.

Given the information that I have just reviewed with you, do you still wish to participate in this study/interview?

If Yes, Great. [RECORD VERBAL CONSENT]

If No, That is fine. We appreciate your time. Thank you.