Evaluation of the Medicaid Innovation Accelerator Program (IAP): Interim Report

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Acronyms and Abbreviations

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
CMS	Centers for Medicare and Medicaid Services
COBA	Coordination of Benefits Agreement
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	Innovation Accelerator Program
IQO	Incentivizing Quality and Outcomes
ISW	Integration Strategy Workgroup
MCO	Managed Care Organization
MIHI	Maternal and Infant Health Initiative
MLTSS	Managed Long-Term Services and Supports
MMDI	Medicare and Medicaid Data Integration
MMIS	Medicaid Management Information Systems
NAS	Neonatal Abstinence Syndrome
NDS	National Dissemination Strategy
OHI	Oral Health Initiative
PI	Performance Improvement
PMH Integration	Supporting Physical and Mental Health Integration
SBIRT	Screening, Brief Intervention and Referral to Treatment
SME	Subject Matter Expert
SUD	Reducing Substance Use Disorders
Supporting Tenancy Track	Supporting Housing Tenancy
TLO	Targeted Learning Opportunity
VBP	Value-Based Payment
VBPFS	Value-Based Payment and Financial Simulations

Executive Summary

The Medicaid Innovation Accelerator Program (IAP) is a collaboration between the Center for Medicare and Medicaid Innovation and the Center for Medicaid and Children's Health Insurance Program (CHIP) Services (CMCS) within the Centers for Medicare and Medicaid Services (CMS). The IAP provides targeted support and resources to state Medicaid programs and their partners to support states' ongoing efforts related to payment and delivery system reforms. CMS created the IAP in 2014 "to ensure that Medicaid had an imprint in the delivery system reform efforts that were going on across the country."[1] The IAP delivers targeted support to participating state teams through various means of individual and group support, tool development, cross-state learning opportunities, and national dissemination of lessons and best practices to accelerate Medicaid-focused innovations.

The IAP offers support to states in four priority program areas: 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); and Supporting Physical and Mental Health Integration (PMH).The IAP also provides targeted support to states in four functional areas intended to serve as levers in furthering reform: Data Analytics (DA), Value-Based Payment and Financial Simulations (VBPFS), Performance Improvement (PI), and Quality Measurement (QM). Support to each IAP area involves a range of modes, in different timeframes and combinations.

This report presents the interim results of Abt Associates' qualitative evaluation of participants' experiences with the IAP targeted support along the four domains of the Kirkpatrick evaluation framework,[2] which was adopted for the IAP evaluation. These domains are Reaction (is the targeted support engaging and relevant?); Learning (do participants acquire intended knowledge and skills?); Response (how do participants apply what they've learned?); and Results (what outcomes result from participation?). Our data are gathered through observation of group learning events and through interviews and focus groups with program participants and coaches. This interim report encompasses our findings from the four IAP priority program areas and one track in one functional area that were actively engaged with states at different times from the IAP's inception in 2014 through mid-July 2017. Future reports will include findings from additional program and functional areas as they are implemented and evaluation data are collected and analyzed. It is important to note that some tracks within priority program areas are continuing to provide targeted support beyond the "structured"[3] period of support (e.g., SUD, BCN) and for some tracks there will be a second round of support with new states (e.g., CI-LTSS Partnership Track).

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1 Hill, T. Welcoming in the Third Year of the Medicaid Innovation Accelerator Program! IAP Commentary. August 1, 2017. https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-commentary/index.html#/entry/43422

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

3 Some priority program tracks continued to offer targeted support beyond the originally planned program end date. The support in the "unstructured" period is less formal and available upon request from the state.

A synopsis of interim key findings to date across the six active IAP areas is presented in the table below.

	REACTION: • The IAP's blend of group learning and individual support modes was appropriate for state participants. The various modes of targeted support allowed participants to explore substantive and operational concepts both broadly and deeply. • IAP participants reported that the targeted support they were offered aligned with their needs and reform goals. • CMS IAP staff have refined the approach to selecting states for IAP participation in order to best match targeted support to Medicaid programs' reform status, team composition, and resources. • IAP participants received targeted support primarily through individual coaching or group webinars, depending on the IAP area. Overall, participants reported positive experiences, and rated the quality of targeted support highly. • IAP participant engagement in most targeted support modes was high, indicating that the support was seen as appropriate, convenient, and minimally burdensome. Less intensive engagement, when it did occur, was largely a function of participants' competing demands. • State participants varied in their assessment of the intensity of coaching support offered, with some finding it too limited, others too intensive, and others just right. Almost uniformly, IAP participants wanted a longer period of targeted support than was initially offered, and CMS IAP staff accommodated these requests.
	LEARNING • IAP participants could identify specific new knowledge that they had gained from their participation in the IAP. • Participants obtained actionable knowledge from both experts and peers.
	RESPONSE • In states focused on planning, participants' activities included: narrowing goals for their IAP projects, strengthening interagency partnerships, educating providers and other stakeholders, and connecting with peers from other states to develop their project plans. • In states focused on implementation, examples of participants' activities include: identifying measures and tracking outcomes, expanding data mining, making changes to provider and Managed Care Organization (MCO) payments, and drafting Medicaid section 1115 waiver[4] applications. • CMS IAP staff were responsive to participants' feedback about the targeted support offered.
	RESULTS • In general, IAP program area tracks that included one-on-one coaching as one mode of targeted support had more concrete results to share than did tracks that received only virtual, group support. However, enough time has not yet elapsed to fully assess state Medicaid reform outcomes. • Across the IAP program areas, state participants indicated that being involved in the IAP helped to raise their state's awareness of ongoing Medicaid reforms, and they had begun to implement some of the lessons learned through the IAP to further their intended health systems reforms.

At this time, the mid-point in the implementation of the IAP, these interim findings provide a window into the IAP's early successes, and suggest possible directions for future program modifications. Specific challenges and suggestions for program improvement have emerged from the evaluation data. In a rapid-

[4] Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to waive provisions of certain Medicaid requirements, and to allow a state to use federal Medicaid funds in ways that are not otherwise allowed under federal rules.

cycle feedback process, these lessons learned have been shared with CMS IAP staff. Using a continuous quality improvement approach, CMS IAP staff have refined program elements based on the suggestions received and the learning styles of program participants.

This report is composed of two sections. Section 1, Program and Functional Area-Specific Findings, expands on the experiences of participants and targeted support providers in each of the IAP's active program and functional areas. This section is divided into five chapters, corresponding to the four program areas and one functional area. Each chapter assesses participants' IAP experiences along the four Kirkpatrick domains. Section 2, Synthesis of Key Findings, provides more detail about findings, summarized above, that apply across the IAP. This section also explores challenges faced during IAP design, start-up, and execution, and subsequent lessons learned.

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.

Through the IAP, the CMS provides targeted support and technical resources to state Medicaid programs and their partners to assist with states' ongoing efforts related to payment and delivery system reforms. This support, which is not financial in nature, is directed toward key content and technical areas identified as priorities by CMS, states, and other stakeholders. The IAP provides individual support to state teams; tool development; cross-state learning opportunities; and national dissemination of lessons and best practices to support Medicaid-focused innovations.

IAP Project Background

The IAP, a collaboration between the Center for Medicare and Medicaid Innovation and the CMCS, was launched in 2014. It addresses four priority program areas:

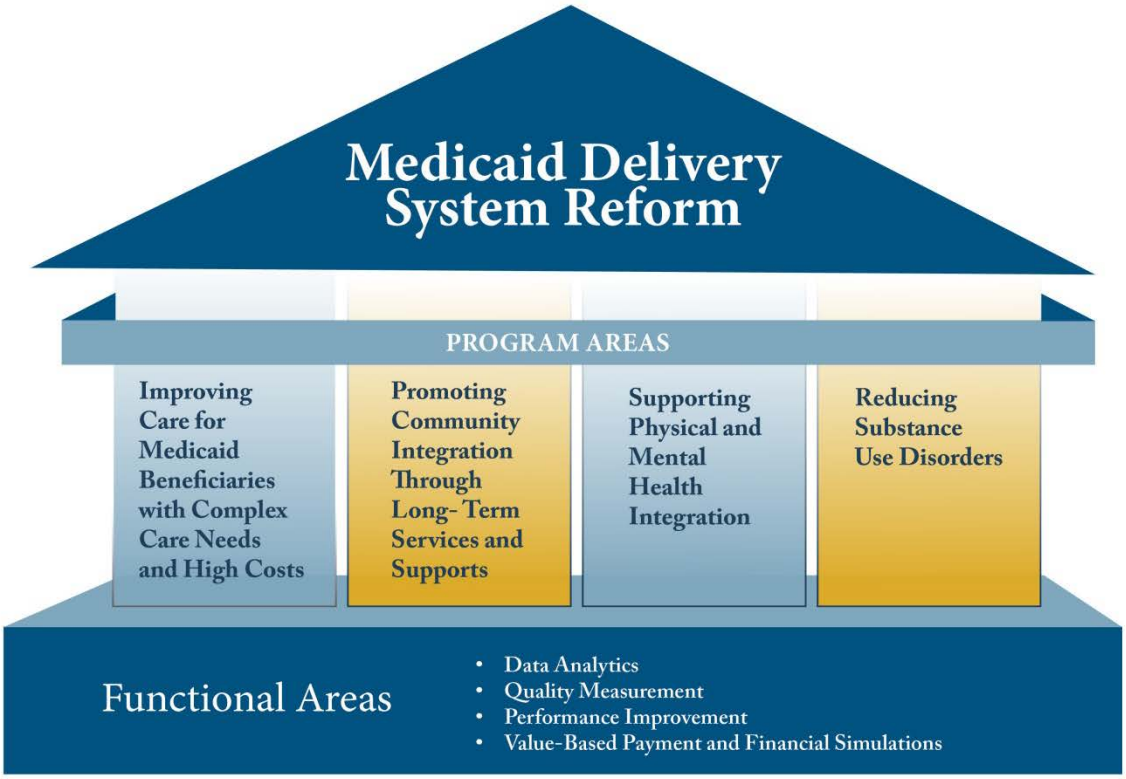
- Reducing Substance Use Disorders (SUD)
- Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs (BCN)
- Promoting Community Integration through Long-Term Services and Supports (CI-LTSS)
- Supporting Physical and Mental Health (PMH) Integration

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

- Data Analytics (DA)
- Value-Based Payment and Financial Simulations (VBPFS)
- Performance Improvement (PI)
- Quality Measurement (QM)

The IAP engages states directly in DA and VBPFS functional area activities. In addition, states participating in the SUD, BCN, CI-LTSS, and PMH program areas have access to expert assistance with PI methods, such as driver diagrams, and with addressing their QM needs. IAP is also developing quality measures related to each of the program area topics that will be available for all interested states. Exhibit 1 graphically represents the relationship among the IAP program and functional areas. Due to the timing of program rollout, evaluation results for only the four program areas and the DA functional area are included in this report. Future reports will include findings from additional areas as they are implemented and evaluation data are collected and analyzed.

Exhibit 1. Graphical Representation of IAP Program and Functional Areas in Support of Medicaid Delivery System Reform

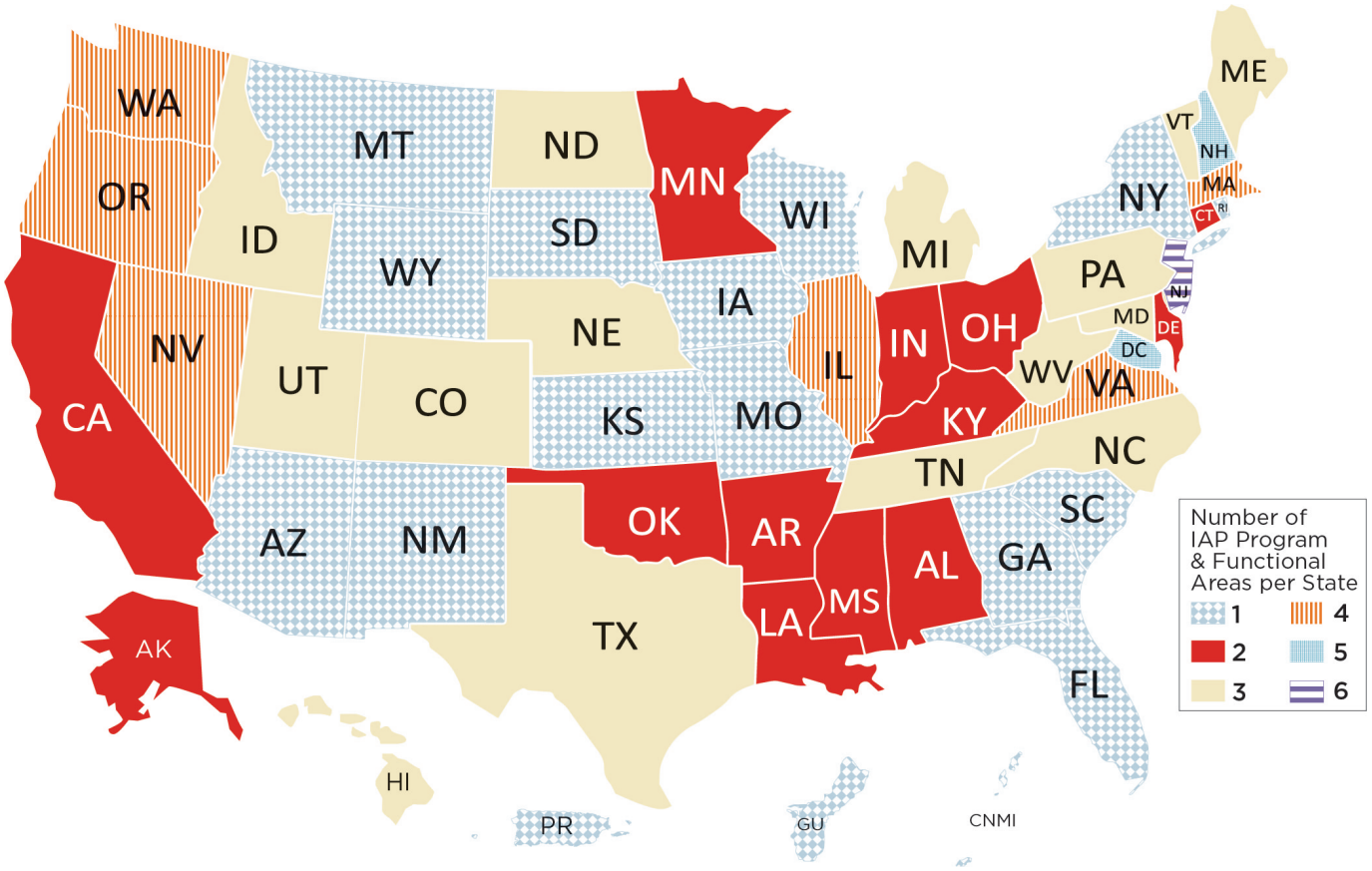


Source. CMCS.

CMS IAP staff publicize IAP targeted support opportunities through Medicaid.gov, webinars, and emails to state Medicaid programs. IAP support is available to state Medicaid programs through an application process. Interested Medicaid programs submit Expression of Interest (EOI) forms in response to specific IAP opportunities. CMS IAP staff then hold conference calls with each interested state to gather more information about each state's needs and readiness for reform, and to answer questions about IAP participation. CMS IAP staff choose states to participate in each program or functional area based on tailored selection criteria.

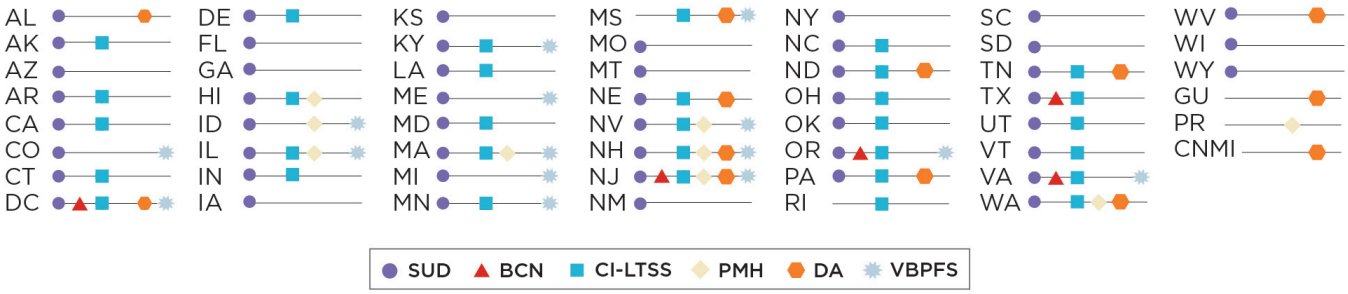
States may apply to participate in one or more IAP program and functional areas. The map in Exhibit 2 shows the total number of IAP program and functional areas that each state has joined from the inception of the IAP through July 2017. Exhibit 3 provides detail on state participation to date in any component of each of the six IAP program and functional area offerings.

Exhibit 2. State Participation in the IAP Program and Functional Areas



Note. Timeframe spans from the inception of the IAP through July 2017 and includes all tracks and components of each program and functional area.

Exhibit 3. States Involvement in Specific IAP Program and Functional Areas



Note. Timeframe spans from the inception of the IAP through September 2017 and includes all tracks and components of each program and functional area.

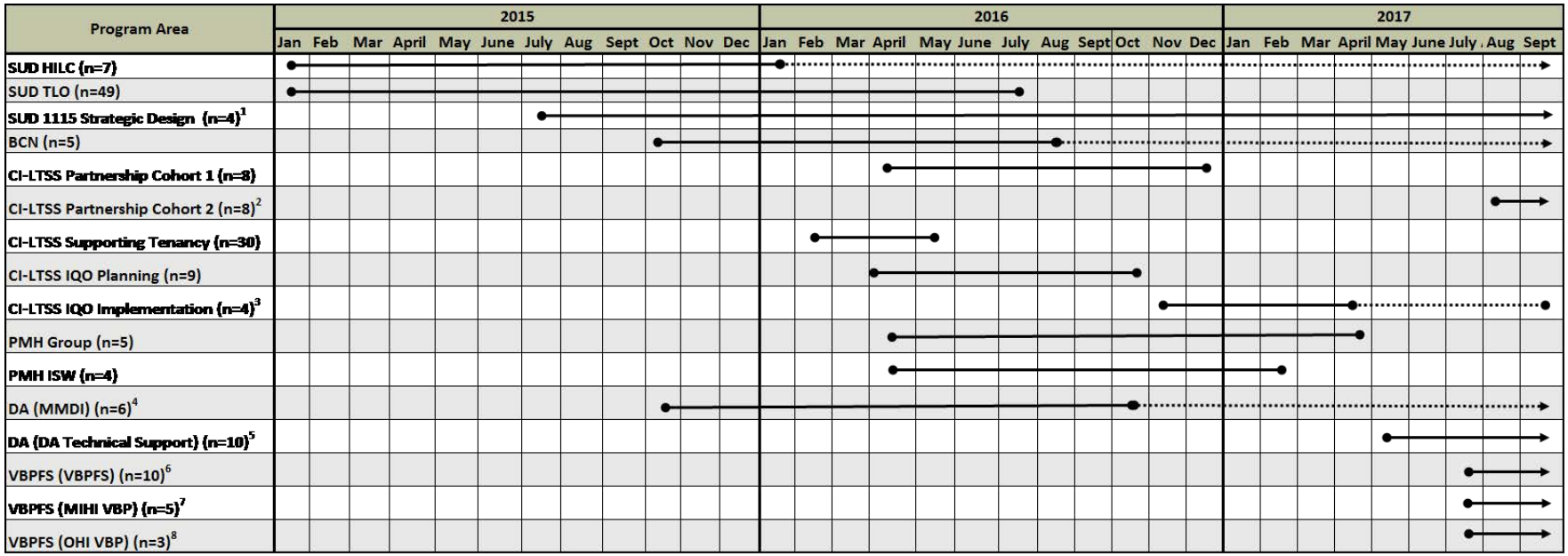
Targeted support offered by the IAP can include group learning for cohorts of states around common themes and challenges as well as individual assistance provided specifically to a state team. The various modes of targeted support are listed in Exhibit 4. Each of the six IAP program and functional areas provides targeted support using some or all of these modes. More details are provided in Section 1, Program and Functional Area Specific Findings. Each IAP program and functional area also includes a National Dissemination Strategy (NDS) that makes tools and resources developed through the IAP available to all state Medicaid agencies regardless of their current level of IAP participation.

Exhibit 4. Modes of Targeted Support Offered Through the IAP

Group Learning Approaches/Activities	Individual Support Approaches/Activities
Webinars	Coaching
Post-webinar discussions	Driver diagrams
In-person meetings	Use cases
Email updates	Work plans or action plans
Peer-to-peer webinars	Policy crosswalks
Discussion groups	Site visits
Targeted support summary memos	
Groupsite virtual resource library	

The support opportunities provided by CMS through the IAP vary in focus, length, and intensity. Some of the program and functional areas offer multiple tracks of support. Exhibit 5 illustrates the implementation status of each of the tracks in the IAP program and functional areas.

Exhibit 5. Implementation Status by Priority Program and Functional Area



Note. ●——● Solid line indicates structured period. ●- - - - -→ Dashed line indicates unstructured period (or period during which states can request ongoing support). ● A dot indicates a finite beginning or end. → An arrow indicates program continuation. [1]Four states received support and their waivers were approved. [2]This is planned as a nine-month opportunity. [3]This is a six-month opportunity with six-month extension. [4]Originally planned for 12 months, and IAP will continue to offer support based on states' needs. [5, 6]Anticipated 12-month duration of support; results not presented in this report [7,8]Anticipated 24-month duration of support; results not presented in this report.

Evaluation Goals and Purpose of this Report

The Center for Medicare and Medicaid Innovation contracted with Abt Associates to conduct an independent evaluation of the IAP to assess participants' experiences. The evaluation is intended to inform ongoing modification and enhancement of the IAP, as well as to assess the efficacy and appropriateness of the targeted support modes in promoting state Medicaid reform. The evaluation does not assess the performance of state teams receiving targeted support through the IAP, or the capabilities of targeted support providers working with the IAP participants.

This report provides the interim results of our evaluation of participants' experiences with the IAP along the domains of the Kirkpatrick evaluation framework[5] as described below, as well as recommendations for modifying the program. This interim report encompasses our findings from the four IAP priority program areas and one IAP functional area in which states were actively engaged at some point from the inception of the program through mid-July 2017. A final report to be published in 2020, at the conclusion of this contract that will include updated findings.

Evaluation Framework and Overview of Methods

Abt's evaluation of the IAP uses a qualitative research approach. Ongoing systematic analysis of primary and secondary qualitative data is supplemented with descriptive statistics obtained through web-based surveys. Our evaluation framework is based on the Kirkpatrick model for evaluating training and technical assistance (i.e., targeted support), adapted to our research design. Evaluation research questions are categorized by the four domains of the Kirkpatrick model: Reaction, Learning, Response, and Results. Please see Appendix A for details on our methodology and analytic approach, including data sources.

Exhibit 6 presents our primary research questions by each framework domain. We use this framework to structure the presentation of the findings for each of the four program areas and one functional area, as well as the overall synthesis of findings in this report.

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

Exhibit 6. Primary Research Questions Presented by the Evaluation Framework

Reaction
Did the application and targeted support planning process identify the most needed targeted support, the most appropriate mode of delivering targeted support, the most appropriate target audiences, and realistic timing/sequencing for targeted support?
How did state participants (including any stakeholder groups) experience the targeted support process? How did they engage with the targeted support providers?
Were the targeted support offerings aligned with states' needs and reform goals?
Was targeted support provided in an appropriate, convenient, and minimally burdensome format?
Was the amount of targeted support sufficient (for both high- and low-intensity users)? Was it targeted to the appropriate audiences?
Was the quality of the targeted support adequate and sufficiently targeted to meet states' needs?
Learning
What specific, actionable knowledge did participants acquire from the IAP?
Response
What specific activities or changes did participants undertake in their programs as a result of participating?
Were CMS IAP staff responsive to performance improvement feedback on participant reaction and learning?
Results
What happened as the result of the IAP? Did the program support ongoing reform?
What barriers, if any, reduced the impact of the targeted support and other resources?

To address the evaluation research questions we analyzed data obtained from the following primary and secondary sources, as relevant for each area (Appendix A contains a detailed description of data sources):

- Interviews with state participants
- Interviews with coaches
- CMS IAP lead staff exit interviews
- Support contractor lead staff exit interviews
- Focus groups with state participants
- Focus groups with coaches
- Webinar and in-person meeting observations
- Post-in-person meeting evaluation surveys
- Post-webinar series surveys
- Summative surveys
- Post-webinar materials (e.g., attendance, responses to polling questions, and evaluation results)
- Materials generated for or by the IAP (e.g., crosswalks, driver diagrams, action plans)

In addition to the data sources listed, area-specific evaluation teams hold routine conference calls with CMS IAP lead staff for each program and functional area. The purpose of the calls is to inform the evaluation teams about activities of each program and functional area as they are rolled out, and to alert

the teams to any program changes that arise (e.g., extension of the timeline). Information gathered from the CMS IAP lead staff calls is not incorporated into the evaluation per se; rather, it is used to inform our evaluation efforts.

The evaluation team developed generic interview guides, observation tools, surveys, and focus group discussion guides, which were then tailored to each program and functional area. A copy of the generic protocols is available from CMS on request.

All collected qualitative data were coded and entered into NVivo to standardize analytical processes across priority program and functional areas and across data collection time periods. Data were analyzed by aggregating them at the theme level and by type of participant. Quantitative data collected from webinar surveys and polls were summarized using the Excel program, and the findings are presented graphically.

Report Structure

The first section reports on the experiences of participants and targeted support providers in each of the IAP's priority program and functional areas. This section is divided into five chapters, corresponding to the four program areas and one functional area. Within each chapter we first describe the area's focus and major activities. Second, we offer key findings, challenges and suggestions for modification corresponding to each domain of the evaluation framework—Reaction, Learning, Response, and Results.

The second section, Synthesis of Key Findings, Challenges, and Lessons Learned, presents findings that apply across the IAP. This section also summarizes challenges faced during IAP roll-out and execution, and subsequent lessons learned. Based on the feedback of participants across the IAP's program and functional areas, this section identifies the IAP's effective strategies for working with states, and suggests further modifications to the program in order to improve efficiency and effectiveness and ultimately to better support ongoing Medicaid reform efforts.

Throughout this report, the word "state" applies to the 50 states, the District of Columbia, and the U.S. territories. Additionally, the word "coach" refers to individuals who provided or coordinated individual support to IAP state teams, although the teams themselves may refer to these people by a variety of titles.

Program and Functional Area-Specific Findings

In this section, each area-specific chapter is preceded by a one-page summary of the program or functional area and the chapter's main findings, organized by Kirkpatrick evaluation framework domain. Each chapter begins with an overview describing the IAP area's focus, major activities, and participating states. Next, each chapter provides key findings corresponding to the domains of the evaluation framework— Reaction, Learning, Response, and Results. Within each of the evaluation domains, challenges are outlined and suggestions for program modifications are provided, when applicable. Because IAP program and functional areas began working with states at different times, data to answer some of the research questions has not yet been collected, or is preliminary.

Interim Key Findings: SUD

This IAP priority program area provides targeted technical support to states that are developing and testing SUD service delivery reforms, including payment and health care delivery models, data analytics, and quality measures. The SUD program area consists of the High Intensity Learning Collaborative (HILC) and the targeted learning opportunity (TLO) Tracks, section 1115 strategic design support, and the NDS. The program area began in January 2015, with select tracks offering various ongoing targeted support activities.

Track: High-Intensity Learning Collaborative (HILC)
Dates of support: January 2015-January 2016 (structured period); January 2016-present: ongoing, ad hoc coaching support available (unstructured period)
Targeted support approaches/activities: Webinars, coaching (including driver diagrams and other performance improvement tools), in-person meetings, email updates, check-in calls with CMS staff, additional quarterly webinars, Groupsite
Participating states: Kentucky, Louisiana, Michigan, Minnesota, Pennsylvania, Texas, and Washington

Track: Targeted Learning Opportunity (TLO)
Dates of support: January 2015-July 2016
Targeted support approaches/activities: Webinars, post-webinar discussions
Participating states: 49 states (see Exhibit 3)

Track: Section 1115 Strategic Design Support
Dates of Support: July 2015-ongoing
Modes of target support offered: Coaching, discussion groups, check-in calls with CMS IAP staff
Participating States: As of July 2017, four states have received approval for their SUD-related waivers: California, Maryland, Massachusetts, and Virginia

National Dissemination Strategy activities to date: Webinars, post-webinar discussions, fact sheets, online tools.

Key Findings:

	REACTION • A high level of state engagement indicated that SUD targeted support generally aligned with state needs and reform goals. • Participants noted that webinars were convenient and topics were relevant; coaching support was high-quality and customized; and the overall amount of support offered was sufficient.
	LEARNING • HILC states indicated that in-state knowledge of SUD delivery system reform options had increased as a result of working in the SUD program area. • All four states that received section 1115 strategic design support indicated that the support allowed them to better understand the overall waiver requirements, process, and CMS expectations of related to the waiver.
	RESPONSE • State activities in response to IAP participation include creating a repository to retain information, developing data indicators and tracking outcomes, educating providers and other stakeholders within their state, interagency partnerships, and developing section 1115 demonstration waivers. • Participants appreciated the overall responsiveness of CMS, and the ongoing modifications made to the IAP to account for state feedback and shifting needs.
	RESULTS • States have initiated health system and Medicaid reforms as a result of their work in the SUD IAP program area including approval of section 1115 demonstration applications; development of a screening, brief intervention and referral to treatment (SBIRT) toolkit for physicians and clinicians; implementation of a statewide assessment of behavioral health provider capacity; and reimbursement for certain SUD treatment services.

In October 2014, CMS released an informational bulletin that invited states interested in improving their delivery system for individuals with an SUD to submit an EOI form to receive targeted support through the IAP. The bulletin indicated CMS's expressed interest in partnering with states that demonstrated significant interest and that showed their ability to contribute the expected staff and technical resources necessary to collect data analytics and programmatic specifics and share these with other participants. The state Medicaid agency was asked to complete the EOI form detailing the state's interest and readiness to meet the expectations of participation.

Starting in January 2015, targeted technical support was provided to states to develop and test SUD delivery system reforms, including reforms to the payment and health care delivery models, data analytics, and quality measures. The SUD program area consists of the HILC and the TLO Tracks, section 1115 strategic design support, and the NDS.

The HILC Track was a year-long targeted support initiative to assist seven Medicaid programs in developing policy and infrastructure transformations to improve care and outcomes for individuals with SUD. The seven states were Kentucky, Louisiana, Michigan, Minnesota, Pennsylvania, Texas, and Washington. While the HILC Track's period of structured support concluded in January 2016 (for example, participants are still able to receive coaching support as needed and requested, particularly around the design of a Medicaid section 1115 waiver SUD demonstration project, data analytic support, etc.).

The TLO Track was a web-based, learning series comprising 15 webinars, available to all states. While the sessions were primarily designed for state Medicaid programs, participants also included attendees from other state agencies, health professionals, behavioral health providers, and insurers. TLO webinars aimed to provide states with information needed to design and implement SUD service delivery system reforms. Participants attended as many or few TLO webinars as desired. The series ended in July 2016.

Individual strategic design support is offered to states that are interested in submitting a section 1115 demonstration waiver to test innovative SUD policy and service delivery approaches. Section 1115 Medicaid demonstration waivers provide states an opportunity to test new approaches in Medicaid that differ from federal program rules. As of July 2017, four states (California, Maryland, Massachusetts, and Virginia) have received approval for their SUD-related waivers. These states received support from CMS IAP staff, and from targeted support providers, including HILC coaches, during the waiver planning process. States are responsible for the waiver application. Several other states are currently engaging in this strategic design support opportunity.

As with all IAP program areas, an NDS is being implemented in the SUD program area through webinars and development and dissemination of resources (e.g., fact sheets). Through the NDS, key learnings from the SUD program area are conveyed to a broader audience of state Medicaid officials and other stakeholders.

Exhibit 7 outlines the status of planned and completed activities for SUD participants as of July 2017.

Exhibit 7. SUD Program Area Interventions

Intervention	Frequency	Intervention Activity[1]	Intervention Status
HILC Track			
Webinars	Nine times (monthly)	IAP staff held nine HILC webinars during the structured program period.	Completed
In-person meetings	Twice	In-person HILC meetings were held in May 2015 in Baltimore and January 2016 in Chicago.	Completed
Coaching	Varied	HILC Track state participants received one-on-one support from their assigned coach, tailored to individual state needs and aims.	Ongoing
	Twice	At the start of the program, HILC Track state participants developed driver diagrams and other project planning tools with their coaches to set goals and priorities. The participants updated the diagrams in advance of the January 2016 in-person meeting.	Completed
CMS IAP staff check-in calls with state teams	Quarterly	CMS IAP staff held informal check-in calls throughout the structured program period with each HILC state team.	Completed
Email updates	Biweekly	CMS IAP staff sent HILC Track state participants biweekly emails detailing milestones, next steps and upcoming events, and providing resources.	Completed
Additional quarterly webinars	Quarterly	Quarterly webinars offered continued support to HILC states following the completion of the structured program period.	Completed
Groupsite	N/A	Groupsite is a web-based library of materials and tools available to IAP participants. It was established to store and maintain information online.	Ongoing
TLO Track			
Webinars	15 times (monthly)	IAP staff held 15 TLO webinars.	Completed
Post-webinar discussions	11 times (monthly)	Informal discussions were held with webinar presenters following TLO webinars to address remaining questions.	Completed
Section 1115 Demonstration Waiver			
Strategic Design Support	Varies	Strategic design support for section 1115 demonstration waiver applicants included one-on-one support from an assigned coach; check-in calls with CMS IAP staff, tailored to state needs and aims; and peer learning discussion groups.	Ongoing
NDS			
NDS Webinars	Eight times	IAP staff held eight NDS webinars for Medicaid agencies and SUD stakeholders.	Ongoing
NDS Post-Webinar Discussions	One time	Informal discussions were held following selected NDS webinars to address remaining questions.	Ongoing
NDS Fact Sheets and Online Tools	N/A	Resources are available on CMS IAP website.	Ongoing

Note. [1] Activities included as of July 2017.

To assess the impact of the targeted support activities, the SUD evaluation team analyzed data from various primary and secondary sources (see Appendix A for greater detail on data sources).

Reaction

Did the application and targeted support planning process identify the most needed targeted support, the most appropriate mode of delivering targeted support, the most appropriate target audiences, and realistic timing/sequencing for targeted support?

The IAP SUD area identified states' targeted support needs through the application and planning process. This application and planning process included reviewing states' EOI forms, selecting states to participate in the HILC, and garnering ongoing feedback through regular check-in calls with states. Exhibit 8 describes the selection factors conveyed in the informational bulletin released in October 2014. CMS chose states to participate in the SUD program area based on these criteria. Twenty-three states submitted EOI forms, underscoring the high level of interest in and need for targeted support around SUD. Following receipt of the EOI forms, CMS held one-on-one conference calls with states to better assess their readiness and to explore states' specific topics of interest to inform the development of the targeted support.

State teams included representatives from state Medicaid agencies with policy and data proficiency, as well as staff from the Single State Agency[6] for SUD. The large number of responses received from states inspired CMS IAP staff to expand learning opportunities to additional states through the TLO Track.

Exhibit 8. SUD HILC Track Selection Factors

Selection Factors
Factor 1: Commitment and Leadership of State Team • State Medicaid agency or Governor's office submitted the EOI form • EOI includes staff with policy and data proficiency on the IAP team • EOI includes staff from the Single State Agency for substance use disorders on the IAP team
Factor 2: State Needs and Interest • Interest in significantly improving their delivery system for individuals with an SUD • Exercise strong leadership and commit to meaningful delivery system reforms • Express a significant interest and readiness to devote the necessary staff and technical resources to produce and share data analytics and programmatic progress with other states participating in the Learning Collaborative

Source. The CMCS Informational Bulletin published on October 29, 2014, titled, "Delivery Opportunities for Individuals with a Substance Use Disorder."

Interviews with HILC Track participants indicated that the application process was too general. For example, one state indicated that the EOI form led them to believe they needed to assemble a large, multidisciplinary team to participate in the program. Many of the initial team members were unable to discern their roles on the team or the value of the IAP SUD initiative and ultimately left the team. The participants from that state team who remained, provided feedback that a more detailed application and

[6] Single State Agencies are the state government organizations responsible for planning, organizing, delivering, and monitoring the publicly funded substance use disorder prevention, treatment, and recovery service system in each state. They provide safety-net services to individuals with SUDs who are uninsured or under-insured and/or have high levels of service needs.

clearer instructions would have allowed them to select team members with the most relevant expertise at the beginning of the program, instead of winnowing the team as they narrowed their IAP program goals over time.

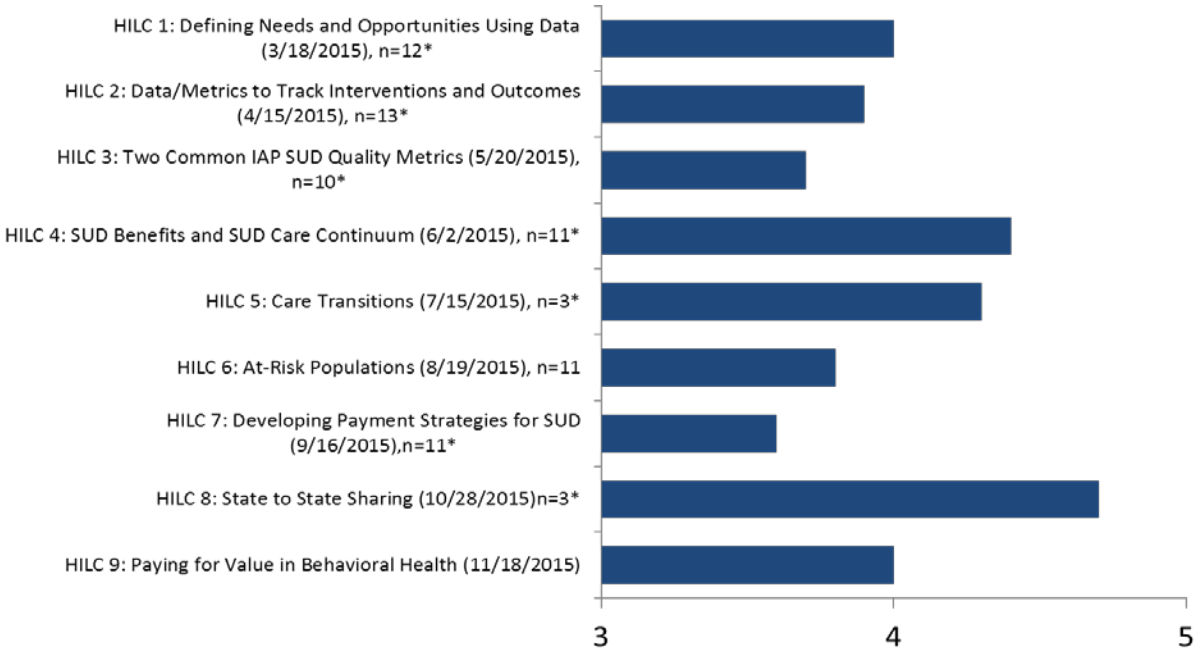
The CMS IAP staff conducted periodic calls with the HILC states, during which states could discuss their reaction to targeted support that they had received to that point, and suggest topics to cover in future webinars and meetings. This feedback informed the development of the agenda for the HILC in-person meeting as well as the topics selected for the TLO webinars. The state feedback also led to changes in the targeted support modes. For example, based on state feedback, the CMS IAP staff reduced the volume of homework assignments, included coaching in the targeted support delivery modes, and added the second in-person meeting for HILC states.

How did state participants (including any stakeholder groups) experience the targeted support process? How did they engage with the targeted support providers?

To gauge HILC Track state participants' engagement with targeted support, we examined their attendance at HILC, TLO, and NDS webinars and two in-person meetings.

CMS IAP staff convened nine webinars plus an introductory kick off webinar for HILC states as illustrated in Exhibit 9. All webinars were attended by all of the seven states, and served to facilitate exchange of information and learning through state presentations and polling questions. As shown in Exhibit 9, participants gave high marks for robust and effectively facilitated webinars.

Exhibit 9. SUD HILC Track: Average Ratings of the Robustness and Effectiveness of Webinars as Reported in the Post-Webinar Evaluation Surveys



Note. *The post-webinar survey did not assess "overall quality," so Abt used an average rating of survey responses on "robustness and effectiveness" as a proxy. The x-axis represents a 5-point Likert scale ranging from 1 (poor) to 5 (excellent).

CMS IAP staff convened 15 TLO webinars, plus an introductory kick off webinar, addressing a wide array of topics shown in Exhibit 10. The TLO webinars reached a broad range of states and individuals; 49 states participated in at least one webinar, and one state attended all TLO webinars. An average of 68

individuals attended each webinar. Both the number of states represented and the total number of individuals participating in the TLO webinar series remained steady over time. The webinars on provider capacity, the opioid crisis, and developing pay-for-performance initiatives recorded the highest percentage of state official attendance, suggesting these were particularly salient topics for this group.

In general, a high level of engagement suggests that the content and means of targeted support provided via TLO webinars resonated with states' needs. This level of engagement is reflected in both the breadth (number of Medicaid programs that had staff attending each webinar) and continuity of attendance (number of webinars attended by staff from each state).

Exhibit 10. SUD TLO Track Webinar Topics

Webinar Number	Date	Topic
1	March 16, 2015	Increasing Provider Capacity
2	April 13, 2015	Information Sharing under 42 CFR Part II
3	May 11, 2015	Continuum of Care in Rural Environments
4	June 8, 2015	Brief Intervention and Referral to Treatment in Primary Care
5	July 13, 2015	Integrating SUD into Primary Care Settings
6	August 17, 2015	Program Integrity for SUD Programs
7	September 14, 2015	Managed Care Contracts
8	November 9, 2015	Merging Data Sources
9	December 14, 2015	Opioid Crisis
10	January 11, 2016	Medication-Assisted Treatment
11	February 8, 2016	Recovery and Supportive Housing
12	March 14, 2016	Neonatal Abstinence Syndrome
13	April 11, 2016	Developing Pay for Performance Initiatives
14	June 13, 2016	CDC Guidelines for Prescribing Opioids
15	July 11, 2016	SUD-Related Quality Metrics

As of July 2017, CMS IAP staff had convened eight NDS webinars, covering topics identified as important to states' SUD system reform through HILC and TLO efforts. Exhibit 11 presents the topics and dates of the SUD NDS webinars. In total, 834 people (498 state officials and 336 non-state officials) registered to attend the webinars across the eight sessions. On average, 104 people attended each webinar (62 state officials and 42 non-state officials). These numbers are likely an underestimate of the actual number of individual attendees, as we learned during key informant interviews with HILC state participants that in some instances, several individuals gathered in one room to participate in the webinars. The sixth webinar, on the topic of American Society of Addiction Medicine (ASAM) Criteria, resulted in the highest attendance (234 individuals), both by state officials and non-state officials (i.e., individuals from behavioral or SUD care provider organizations, counseling centers, universities, national associations, and consulting or law firms). The webinar on strategies for enhancing SUD treatment workforce skills was the least attended by non-state officials, while the webinar on SUD care continuum was the least attended by state officials.

Exhibit 11. SUD NDS Webinar Topics

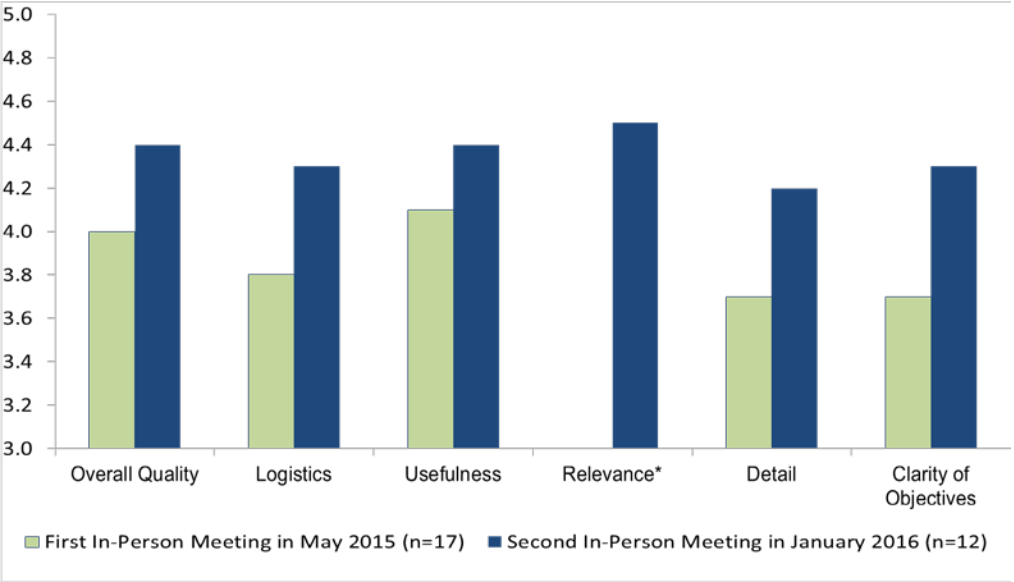
Webinar Number	Date	Topic
1	April 4, 2016	Kickoff: IAP SUD HILC Overview
2	July 20, 2016	SUD Care Continuum
3	September 28, 2016	Linking and Merging Data Sources
4	December 7, 2016	Leveraging Managed Care Contract Language to Improve SUD Purchasing Strategies
5	January 17, 2017	Clinical Pathways & Payment Bundles for Medication-Assisted Treatment
6	April 24, 2017	Introduction to the ASAM Criteria for Clinical and Program Standards
7	May 2, 2017	Assessing SUD Provider and Service Capacity
8	June 28, 2017	Strategies for Enhancing SUD Treatment Workforce Skills

Participants were presented with a brief evaluation survey at the end of each webinar. When asked how they had learned about the NDS webinar series, 55 percent of the 160 respondents said they had learned about the webinar from their colleagues. The relatively high percentage of participants who heard about the NDS through colleagues could mean that NDS webinar participants found the webinar series effective and useful; otherwise they would not have encouraged their colleagues to participate.

The majority of SUD HILC and TLO webinars occurred prior to the onset of the evaluation in 2015. During those webinars observed by the evaluation team, participants asked many questions, typically through the webinar's chat function. During several TLO and NDS webinars, the presenters received many more questions than they were able to address. Post-webinar discussions allowed participants to ask additional questions and afforded the speakers time to respond.

CMS IAP staff hosted two in-person meetings for HILC states. The first meeting took place in Baltimore, Maryland, in May 2015, and the second meeting took place in Chicago, Illinois, in January 2016. CMS is not able to pay for states' travel, so states were responsible for their travel to attend these in-person meetings. All seven states attended the first in-person meeting, and only one of the seven HILC states was not able to attend the second in-person meeting, confirming that states perceived this mode of support and peer interaction as being sufficiently valuable to justify investing their own funds. Exhibit 12 presents the average ratings by dimension based on the evaluation survey results following the in-person meetings. The second meeting was more highly rated on all of the dimensions.

Exhibit 12. Average Rating by Dimension of SUD HILC Track In-Person Meetings



Note. *The question on relevance was not asked in the evaluation survey after the first meeting. The y-axis represents an average rating on a 5-point Likert scale ranging from 1 (poor) to 5 (excellent).

States receiving strategic design support from IAP staff on Medicaid section 1115 waiver applications engaged with the IAP through regular meetings, and group calls with other state waiver applicants. As of July 2017, CMS had approved four states' waiver applications. Two of these states indicated they are now receiving support to implement aspects of their applications.

Were the targeted support offerings aligned with states' needs and reform goals?

In the EOI letters submitted to CMS, states provided varying levels of detail and specificity about their motivation and goals for participating in the IAP. The EOI instructions asked applicants to insert a brief description of what the state hoped to achieve through participating in the learning collaborative. Our analyses of 23 EOI forms revealed the following topics of interest (see Exhibit 13), many of which were subsequently addressed in TLO and HILC webinars:

Exhibit 13. States' Interest in SUD Areas of Targeted Support (N=23)

Topic	Number of States Expressing Interest[1]
Care management and care coordination of services on SUD continuum of care (including coordination/integration with other primary/physical health care services)	18
SUD benefit design	14
Data analytic support	10
Reform payment and financing systems for SUD systems of care	10
Quality measurement	8
Policy/program strategies to prevent abuse of prescription medication/opioids	5
Other[1]	9

Note. This table is based on Abt's interpretation of all EOI forms received. [1]Includes: addressing SUD in pregnant women, assistance with planning in-state stakeholder meetings, managed care implementation, provider licensing issues, provider education around SUD, and network adequacy.

HILC Track state participants regarded the IAP as an opportunity to connect and interact with CMS and to leverage federal agency involvement to reinforce support for SUD-related initiatives within their states. One state indicated that "*having the CMS initials*" provided the "*energy of activation*," as a formal initiative headed by a federal agency reinforced support for SUD system reform within the state.

Overall, interviews with HILC Track state participants and with states that received section 1115 strategic design support revealed that SUD topics were generally well-aligned with states' needs, interests, and reform goals. Through examinations of statewide SUD screening, assessment, and treatment rates and/or legislative review of the SUD Medicaid treatment benefit, participating states had already identified SUD to be a pertinent issue for Medicaid reform. Other ongoing reforms such as Medicaid expansion and integration of behavioral health and primary care in some states created the impetus to focus on SUD issues and participate in the IAP. States reported that occasionally, topics or state examples presented in webinars were not directly applicable to their current work, but nevertheless noted the utility of being present on webinars to obtain information for future use.

There were two notable exceptions to the alignment of IAP offerings with states' needs and goals in the HILC Track. One state perceived that they had been recruited to participate in the IAP SUD program area because they are considered a leader in SUD system reform. This state's participants expressed the confusion they felt early on in the IAP: *"We didn't have a great understanding of what CMS wanted from us … It took a few months of phone calls and participation to realize what the direction CMS was hoping we'd be headed."* Eventually, by working with the coach, the state identified ways to leverage the offerings of the IAP to make progress on their SUD goals. Another state's SUD coaches noted that the state's goals were misaligned with their readiness to participate in the IAP. Despite numerous efforts to communicate, engage, and follow up with members of that state team, the state's coach felt, "*They really are not buying what we are selling. They are not in a space to take advantage of IAP*." Although the state Medicaid agency staff were unable to participate in all of the IAP targeted support activities, the targeted support provider organization and CMS IAP staff worked collaboratively to accommodate the state's interests and support their SUD reform efforts.

All four states receiving strategic design support on section 1115 waiver applications affirmed that the assistance was aligned with and customized to address their needs. Each state had the opportunity to draft their waiver application and obtain feedback and clarification to comply with national guidance. One state team member articulated, "*Each state's 1115 application will look different. … Ultimately, when it came time for CMS to review and approve our plan, we'd already been through a very extensive review and technical support encouraging us to modify or clarify certain aspects with our application*." States also found the group calls with other states involved with the section 1115 applications to be a helpful learning opportunity, although states' approaches to implementing innovation and improving SUD systems were wide-ranging and not always relevant for all participants.

Was targeted support provided in an appropriate, convenient, and minimally burdensome format?

We examined HILC Track state participants' perception of whether the format of targeted support was appropriate, convenient, and minimally burdensome, through interviews and post-webinar surveys. HILC states valued their coaches' availability, responsiveness, and ability to provide intensive, high-quality targeted support tailored to meet states' unique needs. HILC Track state participants reported that coaches helped to keep them accountable to their goals through regular communication, with more-frequent contact at the beginning of the initiative to support finalizing goals and work plans. In particular, states enjoyed the ability to communicate with their coaches on an ad hoc basis, outside of formal meetings, via email or over the phone.

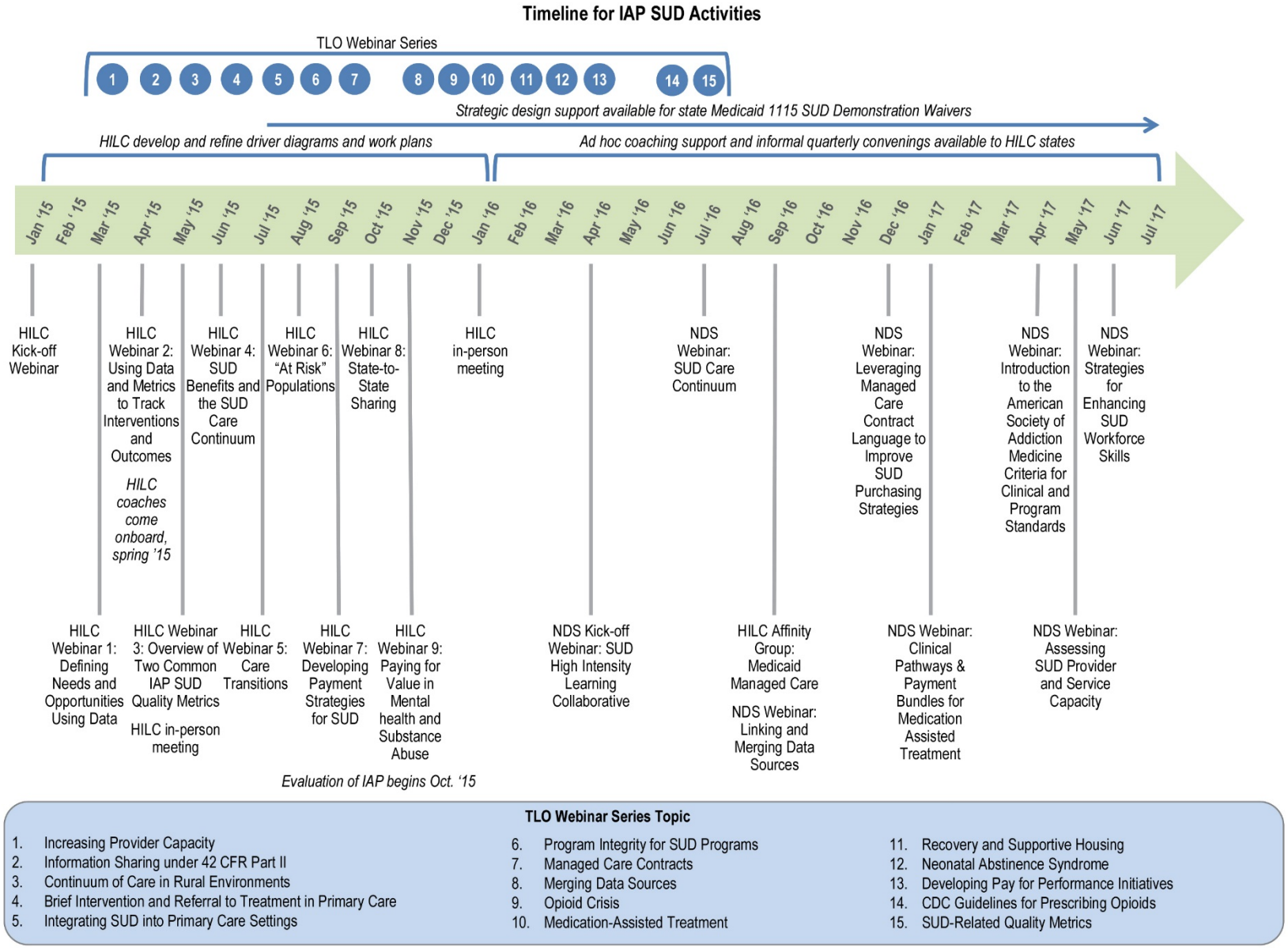
The IAP coaches supported HILC states in completing a driver diagram and several other planning tools as a way to establish goals and plan activities to achieve them. One state participant described the driver diagram as a tool that helped to "*codify our thinking and verify what was important for achieving a certain goal*." Another participant acknowledged that the structure and accountability surrounding the tools and exercises had proven valuable. However, several HILC Track state participants said that although these planning tools were critical to jumpstart the initial efforts, they did not remain pertinent later in the program. Although states were encouraged to update their diagrams through the structured period, one state participant said, "*[It] was a nice activity that allowed the two offices, Medicaid and the Office of Behavioral Health, to begin to engage with each other and build rapport with each other … but I don't know how useful they are to us now*." Another state agreed with this sentiment and expressed that prior to being assigned a coach, the program felt like a *"heavy duty paperwork exercise with questionable value."* At the same time, one state official reported that CMCS was receptive to feedback on the overwhelming initial intensity of assignments and the need to *"back off on homework so we can plan and implement our programs."*

Flexibility to attend webinars of interest as time permitted was important to HILC states participating in the TLO webinars. State participants (including HILC and TLO participants) also expressed appreciation regarding the format of the webinars, which included time for questions and answers in addition to presentation of valuable information. A few HILC states that attended TLO webinars noted that making slides and other resources available after the webinar was helpful, but wished the sessions had also been audio-recorded so that they could listen at their convenience.

Was the amount of targeted support sufficient? Was it targeted to the appropriate audiences?

Overall, states involved in HILC, TLO, NDS, and section 1115 strategic design support activities confirmed that the amount of targeted support was sufficient. Exhibit 14 shows the timeline of targeted support provided for the SUD program area.

Exhibit 14. SUD Timeline



Many HILC Track state participants indicated that the amount of targeted support they received through coaching, monthly webinars, and post-webinar discussions was sufficient. However, participants also conveyed that competing priorities made it challenging to participate in targeted support activities or implement lessons learned.

The TLO webinar series originally had been planned and introduced during the kick-off webinar as a seven webinar series. However, because of the importance and relevance of topics related to SUD, IAP staff added eight more webinar sessions (e.g., webinars on the opioid crisis, U.S. Centers for Disease Control and Prevention guidelines for prescribing opioids) to the TLO webinar series, The average, overall quality rating was high in each of the 15 webinars, according to post-webinar evaluation surveys (see Exhibit 15).

Exhibit 15. SUD TLO Track Post-Webinar Evaluation Survey Findings: Total Attendance and Average Rating of Overall Quality

Note. The left y-axis represents an average rating on a 5-point Likert scale ranging from 1 (poor) to 5 (excellent). The right y-axis refers to the number of registered participants at each TLO webinar. The number of post-webinar survey respondents for each webinar is represented by n.

All four states receiving strategic design support on their section 1115 waivers said the amount of assistance they received through regular calls and meetings with targeted support providers was sufficient to meet their needs.

Was the quality of targeted support adequate and sufficiently targeted to meet states' needs?

Most states participating in HILC, TLO, NDS, and section 1115 strategic design support opportunities stated that the quality of targeted support was adequate and that the support was sufficiently targeted to meet their needs. All HILC states received coaching, and regarded this aspect of the targeted support as the "*best part*" of the IAP. A few states suggested that the IAP became more useful and relevant to them once their coaches

> *"The IAP coaching received was the most useful in providing support to our state's SUD reform efforts."*
>
> ~HILC participant

were in place a few months into the HILC Track, noting that coaches helped them focus their goals. States also appreciated their coaches' availability to answer questions, attend states' internal planning meetings, connect state teams to resources and experts, keep the state team accountable with respect to their goals, and provide intensive technical support tailored to unique state needs.

Regarding the HILC webinars, one state participant conveyed that webinar content was not always detailed enough for the state to be able to *"do something with it."* With quality measures in particular, the states would have liked more tangible and concrete guidelines and suggested having "*robust conversations distilled down*" to practical, actionable items. "*Give us the exact measures, the numerator and denominator you're using. The devil is in the details and if you don't have those details, it's really hard to get it into practice*." This state participant suggested that each webinar conclude with key points and next steps that were detailed, practical, and actionable.

TLO webinar participants appreciated the opportunity to learn from peers (i.e., presenters from other state Medicaid agencies). Respondents to the post-webinar surveys appreciated the variety of experiences presented in TLO webinars, as they could identify a state program similar to their own and learn from that example. Similarly, NDS webinar participants gave high marks on the overall quality of the webinars (see Exhibit 16). Participants especially appreciated learning about other states' concrete experiences in data integration and aligning ASAM criteria with state regulations.

Exhibit 16. SUD NDS Post-Webinar Evaluation Survey Findings: Total Attendance and Average Rating of Overall Quality

Note. The left y-axis represents the average rating on a 5-point Likert scale ranging from 1 (poor) to 5 (excellent). The right y-axis refers to the number of registered participants at each NDS webinar. The number of post-webinar survey respondents for each webinar is represented by n.

All four states receiving strategic design support on their section 1115 waiver applications stated they would recommend the IAP support to other states that are developing their waivers. In particular, the four states valued the quality of the customized support tailored to each state's situation. One state shared that the IAP support "*exceeded expectations*" and that the rapid response and availability of coaching staff "*raised the bar on how we expect to work with CMS.*"

Learning

What specific, actionable knowledge did participants acquire from the IAP?

HILC state participants gained specific technical knowledge from the IAP. Summative survey respondents from all six states agreed or strongly agreed that in-state knowledge of SUD delivery system reform options had increased as a result of participation in the IAP, and cited increased knowledge about:

- SUD services and expected use of these 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 the state's 1115 waiver application
- Framing SUD as a chronic disease
- Alternative Payment Models, bundled payments, and value-based payment (VBP)

One state mentioned SUD penetration rates (i.e., the proportion of Medicaid enrollees with an SUD who receive treatment), and noted that their coach was able to very quickly provide a report to support their work on this issue. This HILC team also noted that learning how different states measure use of SUD treatment was particularly useful information gained through the IAP.

A HILC Track state participant noted in a follow-up interview in spring 2017 that participating in the IAP provided an opportunity to learn from other state experts. This team contacted another state directly to learn about their data system and analytic capacity to better understand use of the Medicaid SUD benefit and apply it to ongoing work in their own state. Three of the four states who received section 1115 strategic design support echoed this sentiment, and indicated that they appreciated the opportunity to learn directly from other states about their waiver development processes. One state said that learning from their peers helped them address questions about the SUD reforms that they were considering in their own state. Another state noted the value of seeing examples of sections from an approved state waiver application and gaining insight into other states' approaches to their waivers.

> *"Being asked questions, like how we would handle some things that we had not thought of, those were hard questions, but also helpful to get us into the weeds."*
>
> ~1115 waiver participant

All four states that received section 1115 strategic design support indicated that the support allowed them to better understand the overall waiver requirements, process, and expectations of CMS. States noted that the support enabled their teams to thoughtfully think through the specific elements they would include in their state's waiver.

Response

What specific activities or changes did participants undertake in their programs as a result of participating?

HILC and section 1115 strategic design support states discussed the activities they have undertaken because of their work in the SUD program area, during interviews and in their responses to the HILC summative survey. State activities included: creating repositories to retain information; developing data indicators and tracking outcomes; educating providers and other stakeholders within their states about activities or changes that they undertook as a result of participating in the IAP; developing collaborative interagency partnerships; applying for section 1115 SUD demonstration waivers; and building capacity

for data analytics. States varied in their degree of participation with SUD targeted support, which may have affected the extent and types of activities and changes that they undertook.

- *Retaining Information*: 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 set up a SharePoint website and another state stored everything in an internal network folder, so that any participating member or interested party from the state would have access to the information. Other states forwarded materials via email.
- *Establishing data indicators and tracking outcomes*: Four HILC states indicated that the IAP targeted support facilitated identification and implementation of quality measures. One state identified indicators to track and monitor outcomes pertaining to NAS with assistance from their coach, and drawing from lessons learned in webinars and from other states' experiences. Another state examined patients' length of engagement with methadone and suboxone treatments, which revealed inadequate patient engagement rates and motivated the team to continue selecting and using quality metrics to monitor improvement. Another state identified quality measures around withdrawal management, which were useful to have during their conversations with behavioral health organizations during the state's transition to managed care. Three HILC states that responded to the summative survey indicated that they are tracking SUD indictors among Medicaid beneficiaries as a result of their participation in the IAP.
- *Educating providers and other state stakeholders*: The IAP enabled participants to engage with and educate stakeholders beyond state agencies. One state educated MCOs, hospitals, and other stakeholders through webinars and other learning opportunities around SUD, in a manner modeled after the structure of the IAP's SUD work. Another state noted that the information they received about medication-assisted treatment through the IAP has been beneficial in working with stakeholders to implement the benefit within the state.
- *Interagency partnerships*: HILC Track and section 1115 strategic design support state participants noted that the IAP targeted support facilitated more focused and intentional collaborative efforts among various state agencies, such as the Medicaid agency and others whose work involves mental health, behavioral health, drug and alcohol programs, corrections, and the Governor's Office. HILC work provided one state the opportunity to collaborate with their Department of Children and Family Services, the Office of Juvenile Justice, hospitals, and social services agencies throughout the state. State team members 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.*" State involvement in the IAP became an important and valuable lever for engaging and organizing state agencies around the issue of SUD. A section 1115 strategic design support participant noted that their state Medicaid agency and Department of Public Health are working much more closely than ever before as a direct result of the support provided through the IAP. The state explained that the two agencies are seen as "*being joined at the hip in this initiative. We have different organizational cultures and structures, but we've managed to work through all of that with the goal of enhancing services for individuals at risk and those who have a goal of entering and sustaining recovery… I can't imagine doing anything along these lines without this interactive support [from the IAP] and collegial relationship [between agencies]*."

  In addition, states explained that IAP activities such as planning tools and webinars fostered collaborative relationships within their state. One state mentioned that webinars served the dual

> *"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 participant

purpose of sharing rich knowledge and also facilitating a communication avenue for internal conversations, as they were able to include staff members and subject matter experts (SMEs) with whom they normally do not interact.

- *Section 1115 SUD demonstration waivers:* Three HILC states reported that they had applied or were in the process of applying for a section 1115 SUD demonstration waiver. One of the three waiver states elected to continue to work with their HILC coach for design and strategic guidance on the development of the state's section 1115 waiver application.
- *Data analytics:* Participants from five HILC states who responded to the summative survey reported that the IAP targeted support allowed them to create, refine, or build capacity in data analytics. One state is developing a behavioral health "data dictionary" that maps specific codes to outcomes like hospitalization, outpatient therapy, and inpatient admissions. The team noted that the foundation of this work is based on what they learned from the IAP.

Exhibit 17 illustrates select HILC state successes and accomplishments, based on information obtained from the NDS kick off webinar and the IAP SUD Fact Sheet listed on the CMS IAP website (April 2016).

Exhibit 17. Select Activities of SUD HILC Track Participating States

HILC State	Activities
Kentucky	• Standardize its MCO data • Develop structured programming language to facilitate reporting of quality measures
Louisiana	• Develop a tool kit to help health systems identify and address neonatal abstinence syndrome • Select quality measures to track client, provider, and system-level impact • Engage local health systems to adopt new strategies and approaches to improve health outcomes for the target population
Michigan	• Apply for section 1115 demonstration project to expand treatment capacity within the care continuum • Improve access to a full continuum of SUD services for Medicaid beneficiaries based on American Society of Addiction Medicine Treatment Criteria, including short-term residential services • Establish quality measures to assess impact of the SUD service system
Pennsylvania	• Implement an SUD health home model to improve the initiation and engagement in treatment of individuals with opioid use disorders, moving toward integration of behavioral health and physical health in the care and treatment of SUD • Improve availability of naloxone, particularly among first responders
Texas	• Engage with MCOs, providers, consumers and other stakeholders to identify the access barriers that exist in the system and to help all stakeholders overcome these barriers
Washington	• Improve access to appropriate American Society of Addiction Medicine levels of care placement through and beyond the state's transition to integrated purchasing by Behavioral Health Organizations

Source. Abt analysis of information shared by CMS during the NDS Kick-off webinar (April 2016) and posted on the CMS IAP website (April 2016).

Were CMS IAP staff responsive to performance improvement feedback on participant reaction and learning?

Our analysis found that state participants appreciated the overall responsiveness of CMS, and the ongoing modifications made to the IAP based on state feedback and shifting needs. States, coaches, and CMS IAP staff all reported that there were regular opportunities to provide and garner feedback about the initiative through check-in calls, meeting evaluation forms, and in-person meetings. As a result, the design and content of the SUD program area evolved and the SUD feedback also informed other IAP program areas.

CMS IAP staff have revised and enhanced their multi-modal support approach, reducing some elements and adding others.

Discussions with HILC states, coaches, the targeted support contractor, and CMS IAP staff, and our observations during webinars and in-person events, confirmed that CMS IAP staff and the support contractor have been responsive to state feedback in the following areas:

- *Homework assignments*: States initially reported that the homework assignments, including the PI driver diagrams, at the beginning of the SUD program area were intense and sometimes burdensome. CMS IAP staff responded to this feedback by reducing the amount of homework requested of state participants.
- *Additional TLO webinars*: The targeted support contractor created a spreadsheet to track states' requests and ensure that webinar topics aligned with states' interests and needs. CMS IAP staff incorporated topics of interest for states, such as SUD-related quality metrics and VBP, into later TLO webinars. In addition, in response to states' ongoing interest, CMS extended the TLO webinar series and included two topics that were not initially planned (opioid guidelines and quality measures).
- *Post-webinar discussions*: Starting with the fifth TLO webinar, CMS IAP staff added post-webinar follow-up discussions between presenters and interested states to expand opportunities for interaction, Q&A and more in-depth conversations between participants and speakers. CMS IAP staff also implemented this type of discussion following the NDS webinar in May 2017.
- *Quarterly webinars for HILC states*: After the HILC structured program period ended, CMS IAP staff began hosting informal webinars for states to share brief updates about their progress to provide continued support and foster connections among fellow states. This was continued for approximately one year after the structured program ended, and then discontinued.

Results

What happened as a result of the IAP? Did the program support ongoing reform?

Interim findings indicate that states have initiated health system and Medicaid reforms as a result of their work in the IAP's SUD program area. HILC states and three section 1115 strategic design support states to date, described specific outcomes that were prompted by the IAP, which included:

> *"Because of our work in IAP, we knew about the gaps in our system around MAT. We were able to use that funding around opioid STR [SAMHSA's State Targeted Response grants] and bridge those two works together."*
>
> ~1115 waiver participant

- Approval of section 1115 demonstration applications
- Development of a toolkit for physicians and clinicians to facilitate substance use SBIRT services to address NAS
- Implementation of Current Procedural Terminology codes to be used in billing for certain SUD treatment services
- Authorization of tribal health delivery system to participate in the state's Medicaid section 1115 demonstration project
- Design of an approach for credentialing office-based buprenorphine provider treatment criteria that qualifies providers for enhanced payments for care coordination
- Statewide assessments to learn about behavioral health provider capacity
- Leveraging other federal initiatives to expand SUD reforms

As noted by one state participant, "*The money [the State Targeted Response grant from the* Substance Abuse and Mental Health Services Administration*] was unexpected but it flowed naturally into what we were already doing with the 1115 waiver."*

What barriers, if any, reduced the impact of the targeted support and other resources?

Participants from all HILC states identified barriers that diminished the impact of the program. One of the barriers was that participants were in varying stages of thinking about SUD reform efforts when the program started. While one state had already addressed many of the issues that the SUD program area was designed to cover, another state was not yet equipped in terms of capacity or resources to implement the support received from the IAP. As one state noted, *"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 participants also pointed to competing demands and priorities, limited resources, and disagreement within the state agency about how to approach specific problems. Coaches needed to customize their support to each state and to acknowledge concurrent reforms occurring within each state. The targeted support contractor echoed these thoughts. Discussing challenges experienced by one HILC participant, a targeted supported contractor explained, *"[This state] didn't have the bandwidth. Their lead was in a substance use agency, rather than Medicaid. … We worked with them extensively, and tried to help, but potentially there may not have been enough cohesion between Medicaid and their other office."* This also suggests that participant team composition factored into the state's ability to take advantage of targeted support offerings and apply these to their state Medicaid SUD work.

Interim Key Findings: BCN

The goal of the BCN priority program area is to support the participating state Medicaid programs' efforts to improve care coordination for their BCN populations by: (1) enhancing participants' capacity to use data analytics, (2) developing/refining payment reforms to provide better care to their BCN populations, and (3) assisting participants in identifying, replicating, or spreading promising programs.

Track: Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs (BCN) Targeted Support
Dates of support: Structured period: Oct. 2015-Aug. 2016; unstructured period Aug. 2016-ongoing
Targeted support approaches/activities: Webinars, coaching (including driver diagrams and site visits), in-person meeting, email updates, discussion groups, check-in calls with CMS staff, and Groupsite
Participating states: District of Columbia, New Jersey, Oregon, Texas, and Virginia

National Dissemination Strategy activities to date: Webinars, fact sheets

Key Findings:

REACTION

- The in-person meeting was the most positively received form of support.
- Participants had mixed feedback about the utility of the coaching support.
- Throughout the program, participants appreciated the connections coaches made for them—not only to resources, but also to other states for peer-to-peer learning/sharing.
- The webinars were met with moderate satisfaction; participants consistently appreciated the time spent learning from other states during the webinars.
- Participants had mixed feelings about the utility of the driver diagrams; the expectation to create them was not well understood initially, and the process was reportedly long and burdensome; however, for some states they became a useful tool to represent the project to others and to track program progress.
- Participants reported that the email communications, and the list of resources included in the communications, were particularly helpful.

LEARNING

- Participants used information learned from their coaches, for example, defining key populations, using and merging data sources, and interpreting federal regulations in their BCN programs.
- Through participation in the in-person meeting, participants gained knowledge of: social determinants of health data in program discussions; risk stratification methods; ways to create predictive models; and finding indicators for emerging risk.
- Participants learned from each other about section 1115 waivers and how to address budget challenges, for example.

RESPONSE

- Participants reported increased understanding of patient populations, strategies related to potentially preventable events, and how to review trends and assess outcome measures.
- One participant described narrowing program goals, which helped them refine the list of measures used to track progress.
- One participant discussed creating a strategy to manage their BCN population through the use of Managed Long-Term Services and Supports (MLTSS) contracts.

RESULTS

- Developed changes to payments related to incentives and reimbursement rates.
- One state launched a health homes initiative using the resources made available through BCN.
- Participants used the results of data analyses to (1) inform the development of their preventable events reduction program, and (2) support programs aimed at improving health outcomes for dual eligible beneficiaries, super utilizers and other BCN populations.

The BCN program area, launched in October 2015, was the second of the Medicaid IAP program areas to be offered. This program area consists of a single targeted support initiative with five participating states (the District of Columbia, New Jersey, Oregon, Texas, and Virginia) and an NDS.

The goal of the BCN priority program area is to support the participating Medicaid programs' efforts to improve care coordination for their BCN populations by:

- Enhancing participants' capacity to use data analytics
- Developing/refining payment reforms that will allow them to provide better care to their BCN populations
- Assisting participants in identifying, replicating, or spreading promising BCN programs

To reach this goal, IAP staff provided targeted support over the course of 10 months (i.e., the "structured period") by facilitating state-to-state interaction and learning, and providing individual coaching support to each BCN-participating Medicaid program. The second period of the program (i.e., the "unstructured period") began in September 2016. During the unstructured period BCN participants continued work with their coaches, and participated in quarterly peer-to-peer webinars. CMS initially planned to conduct four webinars during the unstructured period. However, when asked about potential topics for the last two webinars, states did not have cross-cutting topics of interest. As a result, CMS IAP staff offered states additional targeted support from coaches in lieu of the final two planned webinars. The unstructured period is expected to last until states no longer request support, although as of the date of this report, only one state is receiving support.

The BCN NDS activities included four webinars that occurred between October 2016 and March 2017, and were open to a national audience. The NDS webinars covered a range of BCN-focused topics including participating states' learnings from the 10-month structured period.

Exhibit 18 summarizes the status of planned and completed activities for BCN participants as of July 2017.

Exhibit 18. BCN Program Area Interventions

Intervention	Frequency	Intervention Activity[1]	Intervention Status
In-person meetings	One time	One in-person meeting was held on April 5-6, 2016 in Baltimore, Maryland.	Completed
Webinars	10 times during the structured period (monthly)	IAP staff held 10 planned monthly webinars during the structured period.	Completed
	Twice during the unstructured period	IAP staff held two webinars on cross-cutting topics of interest to the BCN states.	Completed
Coaching	Varied (monthly or less)	BCN state participants received one-on-one support from their assigned coach, tailored to individual state needs and aims. A performance improvement coach worked with BCN state participants to complete their driver diagrams.	Ongoing
	Ongoing	At the start of the program, participants developed driver diagrams and other project planning tools with their coaches to set goals and priorities. The participants updated the diagrams in advance of the April 2016 in-person meeting.	Working documents, updated as needed
	As needed	Two of the coaches conducted site visits (in-person coaching) in their assigned states. As of the time of this report, one state had received two visits and the other state had received one visit.	Ongoing
Discussion groups	Varied (as needed/requested)	IAP staff facilitated group discussions on an ad hoc basis with BCN state participants.	Completed
Email updates	Weekly to bi-weekly	CMS IAP staff send emails detailing milestones, next steps, and providing resources.	Ongoing
CMS IAP leads check-in calls with state teams	Varies (every few months)	CMS IAP leads hold informal check-in calls with state program leads.	Ongoing
Groupsite	N/A	Groupsite is a web-based library of materials and tools available to IAP participants. It was established to share, store and maintain information online.	Ongoing
NDS			
NDS Webinars	Four times	IAP staff held four NDS webinars for Medicaid agencies and stakeholders.	Completed
NDS Fact Sheets and Online Tools	N/A	Resources available on CMS IAP website	Ongoing

Note. [1] Activities included as of September 2017.

To assess the impact of these targeted support activities during the structured period, the BCN evaluation team analyzed data from various primary and secondary sources (see Appendix A for greater detail on data sources).

Reaction

Did the application and targeted support planning process identify the most needed targeted support, the most appropriate mode of delivering targeted support, the most appropriate target audiences, and realistic timing/sequencing for targeted support?

To participate in the IAP BCN program area, applicants submitted EOI forms that broadly described their existing and planned BCN activities and their capacity to carry out the planned activities. Six states submitted EOI forms. CMS IAP staff held a one-hour conference call with each of the six Medicaid programs that had submitted an EOI, to discuss their submissions and address any questions. Following these calls, five Medicaid programs chose to participate in BCN.[7] Most BCN state teams were led by staff from units of the state Medicaid agency's office of policy or health reform. One BCN participant suggested that there should be a more thorough application process to help both CMS IAP staff and the states establish clear expectations for participation. Several BCN coaches offered suggestions for improving the application and selection process. For example, CMS IAP staff can more clearly define the state initiatives and activities that are appropriate for BCN targeted support. The BCN application process was *"pretty wide open,"* leading to a wide range of proposed projects. This, in turn, made it challenging to identify commonalities across the states and to target support opportunities simultaneously to all BCN participants. Another recommendation was to have more in-depth follow-up conversations with the BCN state participants at the onset of the program to align expectations for participation and clarify the most immediate needs. Alternatively, a coach suggested asking states to submit preliminary project plans as part of their application. These recommendations were provided early in the IAP program's development process, and CMS IAP staff have since refined the application process for subsequent priority program areas.

How did state participants (including any stakeholder groups) experience the targeted support process? How did they engage with the targeted support providers?

Generally, BCN state participants experienced varying degrees of satisfaction with the different modes of program support. For example, BCN state participants provided mixed feedback about the coaching support early in the program; however, their satisfaction improved over time. States expressed moderate satisfaction with the webinars during both the structured and unstructured time period, and the highest level of satisfaction was reported in reaction to the in-person meeting.

The original intent of the coaching structure was that each state would be assigned one BCN coach, augmented by one PI SME. The BCN coach was an employee of the targeted support contractor and the PI SME was a CMS employee. The first major coaching activity was for the PI SME to work with each of the BCN state teams, in conjunction with the BCN coaches, to complete a driver diagram. However, some of the BCN state participants were hesitant to reveal their PI needs and concerns to a CMS representative, uncertain how that information might be shared beyond the CMS IAP team.

[7] Six Medicaid programs expressed interest in IAP support; ultimately five are participating. One state chose not to participate because they were working on another initiative sponsored by the National Governors Association, which had started just two months prior to the Medicaid IAP. The state reportedly did not have enough staffing capacity to participate in both initiatives simultaneously.

The state participants noted that their goals and priorities for participating changed as they refined their plans—sometimes significantly—between the time of their initial application in fall 2015 and submitting their driver diagrams in February 2016. The state participants dedicated the early months of the program identifying their most pressing and needed areas of support. Although BCN state participants largely reported that honing in on the goals of their project proved beneficial, three of the five BCN state teams reported that creating the driver diagram was especially slow and some reported the final product was very dependent on coaching input. One coach explained that "*no matter how you spin it to the states, it felt like homework*." Following driver diagram completion, the focus shifted to the BCN coaches providing program support.

Early on, BCN state participants reported varying degrees of satisfaction with the support received from the coaches. Three of the five state participants explicitly expressed satisfaction with the assistance provided; however, nearly all of them indicated that the program support fell short due to delays in the start-up process and the slow initial response times to their requests. The coaches echoed the frustration about not being responsive to BCN states' needs in a timely manner, especially in the first few months. The coaches explained that early in the program, their interactions were more frequent with CMS IAP staff than with their assigned BCN state teams, and that a more *"coach centric"* approach to initiating relationships with the states would have been more effective. When they were asked to ensure that the BCN state participants completed driver diagrams and prepared for webinars, coaches reported feeling that they were initially expected to act more like project managers, than as coaches providing program support.

> *"By the time we got the response [to our request] we had already found another resource to get answers."*
>
> ~ BCN participant

Coaches also reported that there was some confusion among the BCN state participants about what support they could request from their coaches, *"One request early on was beyond what BCN could fund. An analogy would be expecting a list of plumbers who could fix your sink versus expecting a plumber who will come out and fix your sink. There was confusion about the level of technical assistance that could be provided."* The unclear expectations from CMS, coupled with the long timeframe for processing and approving requests early in the program, contributed to the coaches' slow start in providing individualized support. However, the consensus of the coaches was that CMS IAP staff's guidance and expectations were solidified as the program progressed.

The BCN participants have since reported faster turnaround times for requests for program support and coaching. Coaches were given more discretion by CMS IAP staff in responding to BCN participants, as long as the requests are within the scope of a BCN participant's driver diagram. Coaches suggested to CMS IAP staff that coach responses to BCN participant requests would be even more efficient if they had greater awareness of the activities and tools across all IAP programs.[8] One coach said the coaches could be more proactive in responding to participants' needs if there was *"some kind of compilation of the tools and products that were being developed across [program areas] … so we could leverage that more quickly."*

[8] Note that CMS has since responded to this suggestion by, e.g. creating a combined TA log that is shard across IAP areas and adding a staff/coach area on Groupsite.

In addition to providing coaching support, IAP staff convened 10 BCN webinars during the structured period, as listed in Exhibit 19. Overall, the BCN webinars were well attended, by at least one person per state in most cases. The number of attendees per state ranged from one to six, and varied from month to month.

Exhibit 19. BCN Webinar Topics

Date	Topic
October 12, 2015	IAP BCN Kick-Off Webinar
November 16, 2015	Performance Improvement: The Model for Improvement & Driver Diagrams
December 14, 2015	Targeting Methodologies
January 25, 2016	Targeting Beneficiaries: A Deeper Dive
February 22, 2016	Data Sharing Issues and Identification of Data Sets
March 21, 2016	Alternative Payment Strategies
April 18, 2016	Using Alternative Payment Strategies to Support BCN Programs (Deep Dive on Alternative Payment Models Built on Fee-for-Service Architecture)
May 16, 2016	A Deeper Dive into Monitoring and Measurement
June 20, 2016	Using Alternative Payment Strategies to Support BCN Programs (Deep Dive on Population-Based Payment)
August 22, 2016	Ongoing Program Support and Continued Progress in BCN

In order to assess state participants' engagement in the webinars, the evaluation team reviewed post-webinar evaluation surveys, as well as questions that BCN state participants had asked during the webinars. Following each webinar presentation, participants were asked to rate the following statements on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree): (1) the webinar addressed a specific area in which targeted support was needed to further my state's reform (BCN) efforts, (2) the time allotted for the webinar presentation was sufficient, and (3) the time allotted for questions during the webinar was sufficient. Despite high webinar attendance, the post-webinar survey response rates were low, so may not accurately reflect participant engagement, and thus are not presented in this report.

The evaluation team observed participant engagement in the BCN webinars and noted whether they had asked questions, completed online polls, and participated in the question and answer period. During the first few webinars, questions and discussions were frequently initiated by the moderator, coaches and experts, with little unsolicited sharing by BCN participants; this changed as the webinars continued, as did sharing among participants about how each addressed particular BCN challenges.

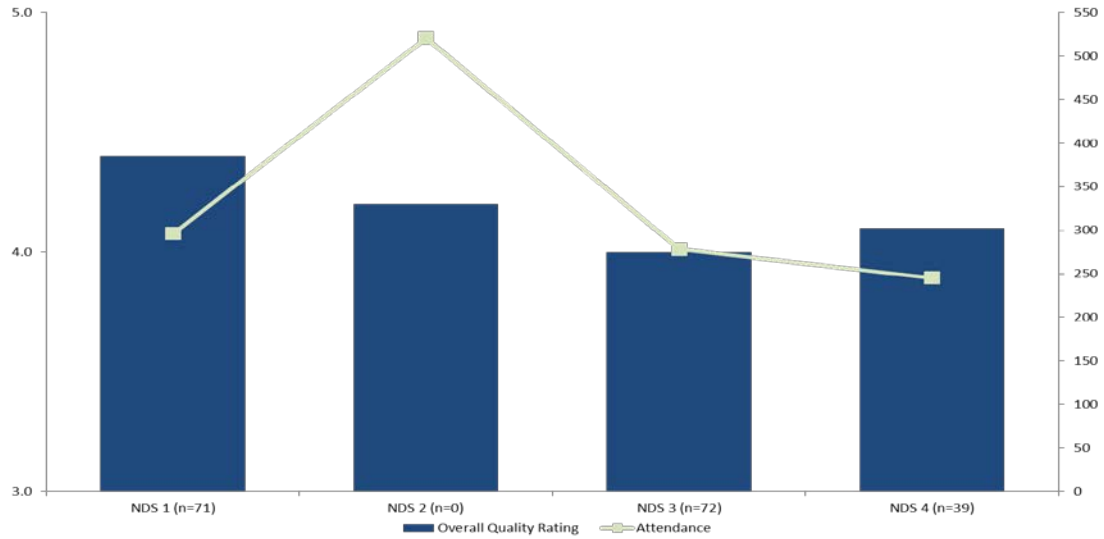
As of July 2017, IAP staff had also convened four NDS webinars, covering topics identified as important to states' BCN efforts shown in Exhibit 20.

Exhibit 20. BCN NDS Webinar Topics

Webinar Number	Date	Topic
1	October 31, 2017	Identification and Stratification of Medicaid Beneficiaries with Complex Needs and High Costs
2	January 9, 2017	Effective Care Management Strategies for Medicaid Beneficiaries with Complex Needs and High Costs
3	February 27, 2017	Creating Partnerships to Address Non-Medical Needs of Medicaid Beneficiaries with Complex Care Needs and High Costs
4	March 27, 2017	Applying Alternative Payment Strategies to Activities Focused on Medicaid Beneficiaries with Complex Care Needs and High Costs

A total of 1,340 people registered to attend the webinars across the four sessions. An average of 335 people attended each webinar; however, this is likely an underestimate of the actual number of individual attendees. As we learned during key informant interviews, some of the state teams gathered multiple people in one room to participate in the webinars, which was recorded as one attendee because they viewed the webinar from one computer. Exhibit 21 illustrates the average quality ratings from the post-webinar evaluation survey.

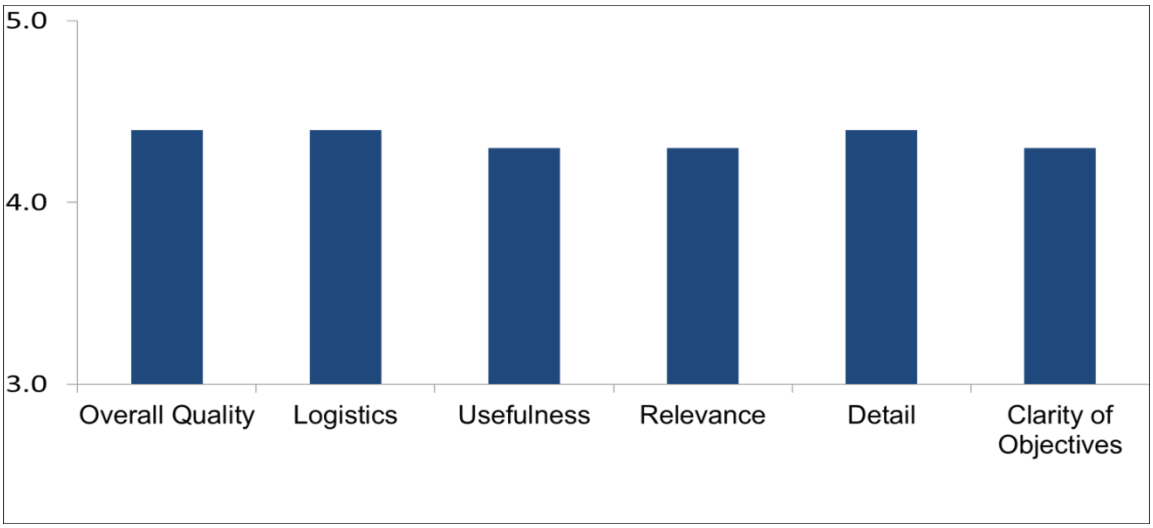
Exhibit 21. Average Ratings of BCN NDS Post-Webinar Evaluation Survey Findings



Note: The n on the horizontal axis refers to the number of respondents to the post-webinar survey after each NDS webinar.

The BCN in-person meeting was held on April 4-5, 2016, in Baltimore, Maryland. During the in-person meeting, the evaluation team conducted a focus group that was attended by at least one representative from four of the five participating Medicaid programs. The feedback from focus group and survey responses (see Exhibit 22) was overwhelmingly positive.

Exhibit 22. Average Rating by Dimension for the BCN In-Person Meeting (N=8)



Note. The y-axis represents an average rating on a 5-point Likert scale ranging from 1 (poor) to 5 (excellent).

BCN participants found the in-person meeting the most helpful activity of the BCN initiative up to that point, and would have preferred to meet in person much earlier in the process. A total of eight participants provided feedback for at least some of the sessions. These respondents reported that the most valuable elements of the in-person meeting were: networking with other programs, making personal connections with their coaches, and listening to the SME speakers. Criticisms of individual sessions were that a session about clinic-level data was too granular, and a data linking session was redundant. Several participants wished they had received the materials further in advance of the meeting, so they could share them with their BCN state participant colleagues and invite them to attend certain parts of the in-person meeting remotely. Two states suggested providing more state-to-state networking and problem-solving time, and including more relevant state examples.

> *"We've learned from other states as well as some of the other industry folks, particularly in the IAP face-to-face meeting—we got a lot of information from that discussion that we are still leveraging."*
>
> ~ BCN participant

Throughout the in-person meeting, state participants were generally very engaged. Several states had follow-up conversations with speakers and state representatives after making connections during the meeting. One BCN state participant later invited a speaker to visit their state to discuss that speaker's organization's experience in addressing challenges in serving the BCN population.

Were the targeted support offerings aligned with states' needs and reform goals?

Of the six states that expressed interest in participating in the BCN program area (including the state, which ultimately did not participate in BCN), more than half expressed interest in all of the support areas listed in the EOI forms, indicating a significant level of interest across a wide range of program support options as summarized in Exhibit 23. Rather than to turn down a state that was interested in technical support, CMS IAP staff relaxed their original selection criteria in order to accommodate all states' needs.

Exhibit 23. States' Interest in BCN Areas of Targeted Support (N=6)[1]

Topics	Number of States Expressing Interest[1]
Data sets to support program analytics	6
Risk stratification, targeting, and hot-spotting	5
Evidence-based interventions	4
Health Information Exchange	4
Aligning policy and payment reform	4
Understanding available federal funding authorities	4
Strategies to scale up successful pilot programs	3
Other, please explain	2

Note. [1]Includes all EOI forms received.

The BCN state participants found that the targeted support offerings were generally supportive of their needs and goals. Coaches and participants reported that the targeted support became more customized over time, as the monthly group webinars and other structured IAP activities wound down.

Generally, BCN state participants found the webinar content to be informative. Especially beneficial was hearing about what other BCN state participants encountered as the BCN IAP progressed. However, a few participants reported that some of the webinar content was too general and/or did not align with their goals.

BCN state participants had mixed feedback on how well the targeted support provided by their coaches aligned with their BCN goals during the structured period. The role of the coach varied across BCN state participants. Some participants needed a coach to react to plans and ideas, while others needed someone who could answer specific and technical questions to move the project forward. Some of the coaches highlighted the challenges created by different state timelines for BCN projects. One state participant suggested that to improve alignment, CMS IAP staff could have involved state BCN participants in the coach selection and matching process by asking the participants what expertise and professional backgrounds would be most beneficial to their projects. Coaches reported that they adjusted their interactions with the BCN state participants over time based on their observations of each program's technical needs and leadership approach.

> *"The challenge of running a coaching program like this is that this is a state-tailored piece of the overall initiative, so it runs on the timeline of the states. Each state has its own process and direction."*
>
> ~ BCN coach

Was targeted support provided in an appropriate, convenient, and minimally burdensome format?

Generally, the targeted support was provided in an appropriate and convenient format. The webinars were well attended and were of adequate lengths. The coaching was flexible with how often the BCN participants met with their coaches, which maximized convenience for the participants. One state that was paired with a coach in the same region received in-person coaching during site visits, which was helpful during state team transitions. Another state received a site visit from their coach as well.

Some state participants were confused about what resources were available, despite written information provided to them. One state recommended, in addition to written information, *"giving clear direction on what and how much they can offer states, and through when. One time they said that there were more coaching hours available since some of the other states weren't using the coaches as much, and I didn't actually know what that meant. Then as I started to put in requests that could use more hours, they said we actually can't do that now because we are ramping down."*

BCN state participants and coaches responded with mixed reviews on the process of developing the driver diagrams during the structured period. Several BCN state leaders said the diagramming process was too long and slow-going. Additionally, one BCN participant reported early in the process that the driver diagrams were not helpful: "*I have never used a driver diagram in my life, and I won't use this*". However, upon reflection later in the BCN structured period, most found the driver diagrams to be helpful in distilling their goals. Nearly all the BCN state participants found that the diagram was a useful tool for describing their project to other stakeholders. Further, some participants found the review of each state's diagram and the ensuing discussions with peers during the in-person meeting to be useful.

Was the amount of targeted support sufficient? Was it targeted to the appropriate audiences?

The BCN participants had mixed responses about support sufficiency. Three of the BCN participants reported that the BCN program support did not meet their needs early on; one of these programs faced internal challenges that delayed their ability to ramp up their BCN activities and coaching engagement, and the other two shared that the support was not consistently delivered in a timely manner. For the remainder of the structured period, BCN state participants and coaches indicated that they met on both a scheduled (e.g., standing weekly check-ins) and an ad hoc basis (e.g., *"quick calls"* or spontaneous emails), and that this worked well for them. Of the three BCN states that reported early concerns, two later reported that the timeliness of coaching improved and one continued to report limited coaching engagement.

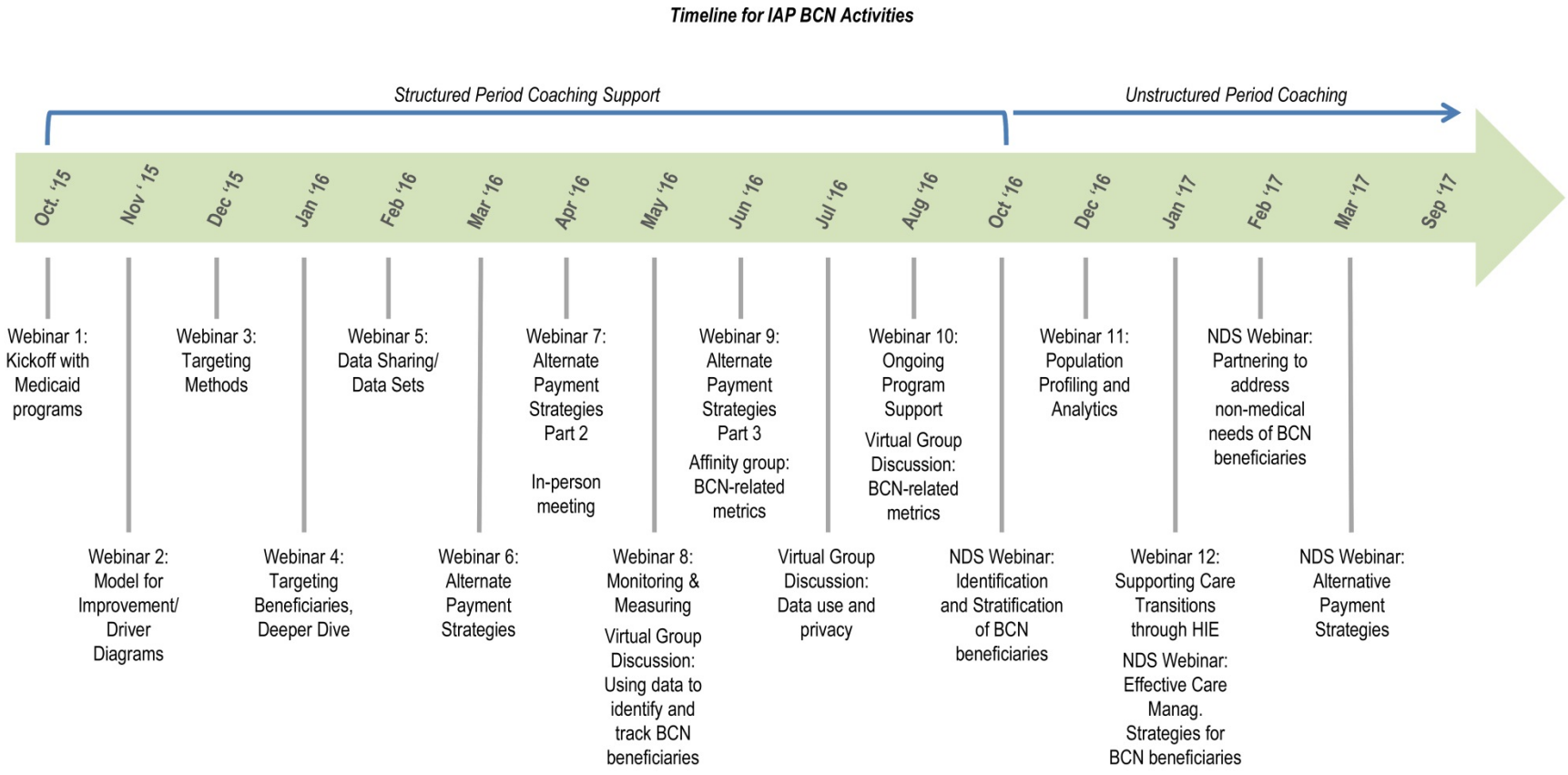
All of the coaches and a few of the BCN state participants experienced significant delays in processing requests for targeted program support in the first half of the structured period. During this period, one state sought resources outside of BCN due to the delayed response time of their coach. State participants believed that the delay occurred because the coaches were initially not permitted to fulfill requests until the states' driver diagrams were complete.

BCN participants experienced faster turnaround times for program support and coaching requests in the second half of the structured period and thereafter, once the teams articulated their goals. Coaches were given more discretion in responding to BCN participants' requests that fell within the scope of their driver diagrams. After the structured period came to a close, the BCN participants continued to receive targeted support.

The frequency of coaching interactions varied throughout the initiative. As of the end of the structured period, three of the BCN state participants had standing monthly meetings with their coaches, which was the right frequency given the participants' busy schedules. However, two coaches faced engagement challenges. One coach struggled to engage state participants, initially due to the lack of a team lead, and after the lead was identified, because he/she was not focused on the BCN initiative. Another coach was incorporated by the state into existing internal project meetings that included other contractors, rather than working independently. This led to the coach having concerns about *"stepping on toes"* and being unable to play a traditional coaching role.

The BCN timeline (see Exhibit 24) indicates when the major BCN activities occurred, and how the activities intersected and overlapped during the structured and unstructured periods. Note that the coaching interventions are not included, as the interactions were customized to the BCN state participants.

Exhibit 24. BCN Timeline



Initially, some of the participants indicated they felt pressure from CMS IAP staff to include their Medicaid leadership in key BCN events (e.g., webinars, calls with coaches). While state participants briefed their Medicaid leadership when appropriate, they indicated that it is not always practical or useful to have high-level staff members spending time on the details of the BCN project. CMS IAP staff adjusted expectations for attendance based on this feedback.

Was the quality of targeted support adequate and sufficiently targeted to meet states' needs?

BCN state participants had mixed feedback on the quality of the targeted support provided, particularly in the early phases of the initiative; the feedback varied by the mode of support provided.

BCN participants differed about the usefulness of the BCN webinars. Many found that the utility of individual webinar sessions was contingent on the topic's relevance to their current BCN work. Coaches echoed this sentiment, and noted that it was helpful to limit the number of speakers and time allotted to didactic presentation in favor of participant discussions. Coaches and at least one participant suggested that group *"problem-solving"* calls or *"grand rounds"* where participants could discuss challenges they had encountered and hear mitigation strategies from coaches would be useful. Of the 10 BCN webinars, most received high marks on post-webinar surveys. However, one webinar was ranked low by two of four state participants because the topic was not relevant to the states' BCN efforts. This reinforces comments from the state participants that not all webinars were applicable to all BCN goals.

A recurring theme in interviews with all the stakeholders was the high value of coaches connecting BCN participants with other BCN participants for peer-to-peer learning when working on similar issues. For instance, a BCN participant shared an approach to a budget justification with another participant, which was especially helpful. Another BCN participant benefited from looking at waivers that CMS had already approved in anticipation of writing their own. One of the coaches indicated that such facilitated peer learning increased as the program progressed.

CMS IAP staff developed the in-person meeting agenda with support from the BCN targeted support contractor and feedback from the BCN webinar polling. Each of the themes selected with this input were covered during one or more of the meeting sessions, which were a combination of presentations from well-known health care professionals on these topics, discussions following individual and panel presentations, and break-out sessions with smaller groups. The presentations and facilitated discussions resulted in full participation by all participants, with state participants eagerly continuing conversations during breaks and meals. Overall meeting quality was highly rated by participants on the post-meeting evaluation survey (see Exhibit 22).

In response to follow-up interviews during the unstructured period, BCN participants found the targeted support to be of high quality and sufficient to meet their needs. Coaches similarly reported that they consistently received positive feedback from state participants. In addition, during the unstructured period, two coaches began conducting site visits with their assigned states (two states in total); the coaches and one of the state participants noted that the in-person meetings have been helpful in garnering more engagement and support for the BCN work. One coach suggested that participants' satisfaction with the targeted support could in part be gauged by the states' continued engagement with coaches during the unstructured period.

Learning

What specific, actionable knowledge did participants acquire from the IAP?

BCN state participants identified actionable knowledge gained from multiple modes of program support and opportunities provided through their participation in the BCN initiative. Multiple state participants acquired knowledge from coaches, such as guidance on creating an appropriate "super utilizer" definition. Their coach gave them information about how other BCN state participants define "super utilizers." Another BCN participant gained expertise in combining and analyzing data from separate data sources. With this expertise, they were able to better identify and describe their priority population, and create and use data analytics. A third participant received help interpreting a federal regulation that significantly impacted their BCN project, and planned to further leverage the IAP resources to guide their application for a Medicaid waiver.

> *"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 participant

Two BCN state participants noted that the BCN IAP webinars presented content that has value for their other Medicaid programs, so they invited additional program staff to attend, as appropriate. Several BCN state participants commented on the value of hearing about how other Medicaid programs had approached similar issues during the webinars and in-person meetings, which helped them consider how they could incorporate those ideas.

Through the in-person meeting survey, four respondents reported having acquired specific, actionable information related to the following:

- Social determinants of health data in program discussions
- Risk stratification methods
- Creating predictive models
- Indicators for emerging risk
- Software packages for super utilizer analyses

Whether mediated by a coaching intervention, weekly/biweekly email messages sent by the CMS IAP staff, or interactions with presenters or other BCN participants at the in-person meeting, the BCN participants consistently commented that learning from each other was of paramount importance in finding specific solutions, especially by hearing about the experiences of others both within and across IAP priority program areas. In addition, two BCN participants spoke about cross-program area and cross-state learning specifically. For example, one BCN participant had learned about section 1115 waivers and MLTSS, and how to prepare for CMS evaluations and address related budget challenges. Another had learned about promising practices and lessons learned related to substance abuse; this cross-program area learning from SUD was particularly timely given the state elected officials' desire to improve their results on SUD measures.

The BCN state participants also demonstrated the value of specific, actionable knowledge acquired through their efforts to disseminate to others in their states what they had learned. One BCN state participant actively advocated sharing findings and recommendations beyond the IAP states. They suggested sharing accomplishments and innovations among MCOs to spur positive competition. In addition, BCN participants shared specific knowledge with other stakeholders:

- One of the BCN participants shared the email update newsletter (sent by CMS IAP staff) with health services organizations that work with super utilizers.
- A BCN participant shared their learnings about waivers more broadly across the state.
- One BCN participant shared BCN program materials with legislative auditors who were reviewing how the state manages BCN patients.
- This same BCN team also shared BCN program materials with a small workgroup of hospital administrators they are working with on BCN-related issues.

Response

What specific activities or changes did participants undertake in their programs as a result of participating?

Coaches and BCN state participants noted a marked transition in focus between the structured and unstructured period: the projects and activities turned from a conceptual phase, where participants refined and established goals, to implementing programs. A few of the BCN state participants discussed mechanisms that facilitated this transition, including the following:

- One BCN state narrowed their goals during the structured period, which helped them tighten up the list of measures they were using to track their program's progress. Their aim was to derive a manageable, reasonable and impactful set of measures with guidance from their coach, who shared what other BCN state participants had used.
- One BCN participant applied what they had learned from the work presented by an SME at the face-to-face meeting, to guide their preventable events analysis.
- Another BCN state created strategies to manage their BCN population through MLTSS contracts, and applied learnings from the BCN program to their efforts to move forward with managed care and value-based payments.

As the BCN program progressed into its second year, multiple coaches and BCN participants indicated that the program had moved the states closer to making program reforms. Some of the BCN state participants deepened their understanding and modified their approach as a result. Three BCN participants refined their data analyses. Such efforts involved increasing the understanding of patient populations, informing direction and strategies related to potentially preventable events, and reviewing trends and assessing outcome measures. Two BCN participants planned changes to payment programs related to incentives and payment rates.

And finally, one of the BCN participants has increasingly worked on dissemination activities. Specifically, the state described sharing their BCN work and efforts, as well as providing updates on the completed work to the state's Medicaid advisory council and to a state-wide task force focused on their BCN priority population.

Were CMS IAP staff responsive to performance improvement feedback on participant reaction and learning?

CMS IAP staff received feedback from BCN state participants and coaches through several avenues, including quarterly check-ins calls with BCN state participants, webinar polling responses, calls with coaches, reviewing state participants' requests for coaching support, and discussions with the BCN evaluation team.

Coaches relayed to CMS IAP staff the state participants' early frustrations with BCN PI activities which centered on creating driver diagrams. As one coach said, *"the coaches feel it is their role to advocate on behalf of the Medicaid programs with CMS IAP staff to help them get what they need out of the process."* CMS IAP staff made the decision to minimize the PI emphasis of the program, focusing only on the driver diagram development, and both coaches and the BCN state participants appreciated this change.

One BCN state participant told CMS IAP staff that they desired more consistent contact with the BCN program to supplement monthly interactions with their coach. Shortly after this request was made, CMS IAP staff began sending weekly email updates to all BCN participants in a standardized, easy to access format. This was encouraging to participants, and the updates, shifting to a biweekly schedule during the unstructured period, continued to be well received.

As discussed earlier in this report, states considered initial coach turnaround times on requests to be slow, but this improved over time. In addition, at the beginning of the unstructured period, one BCN participant noted that *"policy changes are not easy to make and they require more time than we anticipated. We are grateful for the extension [unstructured period]."*

After conducting two quarterly webinars in the unstructured period, CMS sought the input of the BCN state participants on topics for the remaining webinars. When CMS IAP staff and coaches realized that there was little overlap in the topics requested, they decided to replace the planned webinars in favor of providing more one-on-one technical support to BCN state participants. This decision was well received by states and coaches.

Results

What happened as a result of the IAP? Did the program support ongoing reform?

Although the BCN participating states have reported some early results, the results discussed below are not considered complete or final as the unstructured period is ongoing.

During the structured period, BCN state participants indicated that being involved in the IAP's BCN program area put a spotlight on the state's BCN work. This attention had the unanticipated benefit of encouraging more interest across the state and with partners; it has also helped get more stakeholders interested and engaged in BCN work. One of the BCN participants reported, *"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."*

BCN participants were able to form relationships with other Medicaid agencies and departments through the IAP. Several participants were able to leverage other Medicaid programs' experience and knowledge in BCN, and apply it to advance their own programs and initiatives. They were grateful for the ability to make connections with other states, and continue those relationships even without the coach. A BCN participant, when asked how they have they applied IAP information, replied *"I think collaborating and linking data. We have been able to reach out to other state agencies and departments. … It definitely informed all of our waiver initiatives and applications."*

> *"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 participant

Several BCN participants used the resources and information produced and disseminated through IAP BCN program activities to spur conversation among their constituents at the state and local levels. One BCN participant even used the IAP to disseminate information to all of their MCOs, inviting nearly a hundred people to listen to several NDS webinars. Other BCN participants used the resources and technical support to help 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 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."*

Almost all of the states reported meeting or making significant progress towards meeting their goals through participating in the IAP, and a couple of states reported having fewer targeted support needs by the time they entered the unstructured period. One coach said that most of the *"states accomplished what they set out to accomplish, and had the discussions and work done in the timeframe expected."*

Two states were able to design and launch programs aimed at improving health and reducing cost for the BCN population; one state used the IAP as a platform to disseminate information and evidence-based practices to its constituents at the state and local level; and two other states primarily used the targeted support to inform and support their data analysis efforts.

Thus far, the BCN participants have reported multiple successes and accomplishments, many of which are noted below.

Leveraging support for BCN initiatives:

- Achieved leadership buy-in and support from high-level state Medicaid officials
- Launched a health homes program; leveraged support provided through IAP to make the best policy decisions for the new initiative
- Formed new relationships with other Medicaid agencies and departments to support current and future initiatives
- Leveraged IAP support in conducting data analyses to develop a detox program, which is expected to launch soon
- Leveraged BCN support to draft and submit a successful section 1115 waiver

Enhanced data analytics:

- Used guidance and resources from the IAP to conduct several data analyses on the BCN population in order to improve health outcomes
- Gained expertise in combining and analyzing data from separate data sources; with this expertise, better identified and described priority population and created and used data analytics
- Conducted several data analyses on the dual eligible and super utilizer population to support programs aimed at improving health outcomes
- With IAP support on data analyses, developed a program that focuses on reducing preventable events such as emergency department visits or re-admissions, complications, and ancillary services

Additional refinements in payment and program models:

- Developed a prorated reimbursement rate using diagnosis codes and other available data
- Constructed an incentive payment structure using the information and resources provided through the IAP
- Renewed section 1115 waiver, and successfully eliminated budget challenges associated with the waiver

- Submitted a proposal to switch to passive enrollment for dual eligible beneficiaries
- Conducted a study on billing services for adults on Medicaid that was ultimately published
- Successfully supported MCOs in addressing the health of super utilizers and beneficiaries with complex needs

What barriers, if any, reduced the impact of the targeted support and other resources?

BCN state participants anticipate some challenges to implementing BCN lessons learned; most frequently mentioned was getting the right data use agreements (DUAs) in place to be able to share data. Participants also expressed concerns related to integrating data sets (Medicare and Medicaid), getting and using real-time data, and confidentiality. One state reported on the availability of data for their BCN analysis, "*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.*" Two other concerns that BCN state participants mentioned were related to the payer partners' acceptance of payment model reforms, and aligning key metrics between Medicare and Medicaid to reduce reporting burden on providers. Both of these issues require getting payers' support, which can take significant time to garner.

Interim Key Findings: CI-LTSS Housing Related Services and Partnerships (HRSP) Component

The HRSP component of the CI-LTSS program area aims to: increase adoption of individual tenancy sustaining services to assist Medicaid beneficiaries, and expand housing development opportunities for Medicaid beneficiaries through facilitation of partnerships with housing agencies. The CI-LTSS HRSP component supports housing tenancy services and develops partnerships between Medicaid and housing systems.

Track: Supporting Housing Tenancy
Dates of support: Feb 2016-May 2016
Targeted support approaches/activities: Webinars
Participating states: Supporting Housing Tenancy was open to all 32 applicants.

Track: Supporting Medicaid-Housing Agency Partnership
Dates of support: April 2016-Dec 2016 (to continue with Partnership Cohort 2, Aug 2017)
Targeted support approaches/activities: Webinars, in-person meetings, coaching (including driver diagrams and other performance improvement tools, crosswalks, and site visits), email updates, discussion groups, Groupsite
Participating states: Partnership Cohort 1: California, Connecticut, Hawaii, Illinois, Kentucky, Nevada, New Jersey, and Oregon.

National Dissemination Strategy activities to date: Webinars

Key Findings:

	REACTION • Supporting tenancy webinars were well-organized, covered a range of topics and included sufficient Q&A time. • Targeted, customized support was valuable. • State commitment to partnership activities was time-consuming; the original timeline was viewed as too short. • Housing partnership activities were well-aligned with states' health care reform goals.
	LEARNING • Activities increased knowledge of housing supports and strategies to integrate Medicaid. • Partnership activities increased awareness of tenancy support models and evidence-based practices.
	RESPONSE • Partnership activities are leading states to analyze housing-related services and funding sources. • States are establishing and strengthening interagency relationships, mining relevant data, and leveraging 1115 waivers for housing supports.
	RESULTS • Participation created expectations that progress would be made in housing supports. • Health and housing activities previously siloed are now more aligned and collaborative. • Some states are pursuing waivers to expand housing-related supports.

The goals of the CI-LTSS priority program area are to: (1) increase adoption of individual tenancy sustaining services to assist Medicaid beneficiaries; (2) expand housing development opportunities for Medicaid community-based LTSS beneficiaries through facilitation of partnerships with housing agencies; and (3) increase adoption of strategies that tie together quality, cost, and outcomes in support of community-based LTSS programs. The CI-LTSS program area was launched in October, 2015.

In total, 34 states submitted EOI forms to participate in the CI-LTSS program area. The number of EOI forms submitted for CI-LTSS was the highest out of all IAP program areas, indicating that this topic is highly relevant to Medicaid programs. The CI-LTSS program area comprised two distinct components; Component A: HRSP and Component B: IQO. CMS IAP staff are also sharing the content, experiences, and best practices from the CI-LTSS Tracks with a national audience via an NDS. The first CI-LTSS national dissemination event was held in June 2017 and featured presentations by two states on their efforts to build State Medicaid-Housing Agency partnerships.

To assess the impact of the targeted support activities, the CI-LTSS evaluation team analyzed data from various primary and secondary sources (see Appendix A for greater detail on data sources). Because HRSP and IQO Components have distinct content, activities, and applications, we discuss them separately below.

Component A: HRSP

Track 1—Supporting Housing Tenancy (Supporting Tenancy Track). The focus of this track was to provide participants with strategies to support housing tenancy services for community-based LTSS Medicaid beneficiaries. This track started in February 2016 and ended in May 2016, with 30 states participating in at least one webinar.

Track 2—State Medicaid-Housing Agency Partnership (Partnership Track). The focus of this track was to provide intensive support to facilitate Medicaid collaboration with key housing partners. Through this track, the IAP promotes partnership between state Medicaid agencies, state housing finance agencies, public housing agencies, and others. To facilitate these relationships, CMS IAP staff partner with 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. The first Partnership Track cohort was launched in April 2016 and continued through December 2016. This cohort included the following states: California, Connecticut, Hawaii, Illinois, Kentucky, Nevada, New Jersey, and Oregon. A second cohort of this track is scheduled to begin in August 2017, with Alaska, Massachusetts, Michigan, Minnesota, Nebraska, Texas, Utah and Virginia participating. Exhibit 25 details the interventions of the HRSP component.

Exhibit 25. CI-LTSS HRSP Component Interventions

Intervention	Frequency	Intervention Activities[1]	Intervention Status
Supporting Housing Tenancy Track			
Webinars	Monthly	IAP staff held a three-part webinar series.	Completed
Partnership Track			
Webinars	One time	IAP staff held a mid-point check-in webinar with Cohort 1 states (held between the two in-person meetings).	Completed
In-person meeting	Varied	Cohort 1: In-person meetings were held in in May 2016 and October 2016 in Washington, DC.	Cohort 1: Completed
Coaching	Varied	Participants receive one-on-one support from their assigned coach, tailored to individual needs and aims.	Cohort 1: Completed
	One time	Participants worked with their coaches to complete a crosswalk of housing and health services programs.	Cohort 1: Completed
	One time	Partnership Track state participants developed driver diagrams and other project planning tools with their coaches to set goals and priorities.	Cohort 1: Completed
	One time	Participants received an on-site visit from their coach.[2]	Cohort 1: Completed
Discussion Groups	Varied	IAP staff convened optional peer-to-peer discussion group calls in August and September 2016 for Cohort 1.	Cohort 1: Completed
Email updates	Bi-weekly	CMS IAP staff sent participants biweekly emails detailing milestones, next steps and upcoming events, and providing resources.	Ongoing
Groupsite	N/A	Groupsite is a web-based library of materials and tools available to IAP participants. It was established to store and maintain information online.	Ongoing
NDS			
NDS Webinars	One time	IAP staff has held one NDS webinar on examples of state Medicaid housing partnerships.	Ongoing

Note. [1]Activities included as of August 2017. [2] Although site visits were available to all HRSP Partnership Track participating states, not all Cohort 1 states received a visit.

Reaction

Did the application and targeted support planning process identify the most needed targeted support, the most appropriate mode of delivering targeted support, the most appropriate target audiences, and realistic timing/sequencing for targeted support?

Thirty-two applicants indicated interest in participating in HRSP Cohort 1; all 32 indicated interest in the Supporting Tenancy Track and 29 in the Partnership Track. CMS IAP staff articulated selection criteria on the first round of CI-LTSS EOI forms to help identify applicants best positioned to benefit from work in the two tracks. The selection criteria are summarized in Exhibit 26.

Exhibit 26. CI-LTSS HRSP Cohort Selection Factors

Selection Factors
Factor 1: Commitment and Leadership of State Team • Has the state designated a Medicaid IAP lead? • Has the state designated other Medicaid staff for this work? • Is the proposed team lead well positioned within the state to marshal resources, as needed, for this work? • Does the proposed team have the right composition of members given the scope of its work, and is the Medical Director involved?
Factor 2: Expected Outcomes • Do the state's program support needs align with the IAP's proposed approach and content areas? Do the state's goals align with IAP's goals for this activity?
Factor 3: State Needs and Interest • Supporting Tenancy Track: – Has state clearly articulated its program support needs with regard to supporting housing tenancy? • Partnership Track: – Has the state clearly articulated its program support needs with regard to building a Medicaid-Housing Agency Partnership? – Has the state provided evidence of its willingness to create a Medicaid-Housing Agency Partnership from both Medicaid and the housing agency?

Source. CMS IAP document titled "Program Support for States, Promoting Community Integration – Long-Term Services and Supports State Selection Factors."

Following receipt of the EOI forms, CMS IAP staff and representatives from their federal partners held conference calls with each applicant to further discuss their applications and clarify the goals of the two CI-LTSS HRSP Tracks. Federal officials ranked states based on selection factors, affording an objective process to review and compare applicants. The same process was followed for the second Partnership cohort.

Cohort 1 state participants indicated that the application process was generally straightforward, but suggested including definitions of housing-related terms to further clarify the application template. Several Partnership Track interviewees expressed appreciation for the individual kick off calls that took place after they were selected. The kick off calls followed a standard agenda in which states introduced their teams and described their current Medicaid reform status and goals to the coaching team (coach and SME) and CMS IAP staff. The calls served to explain expectations concerning the level of commitment and program activities of the Partnership Track. All Partnership Track teams included representation from the state Medicaid and housing agencies. We found that the composition of the teams evolved over time, as individuals joined or left depending on their availability and alignment of their roles with the track goals.

How did state participants (including any stakeholder groups) experience the targeted support process? How did they engage with the targeted support providers?

CMS IAP staff designed the Supporting Tenancy Track as a three part webinar series, offering an educational opportunity with a fixed curriculum, specific to strategies for supporting tenancy (see Exhibit 27). Participation was open to all Medicaid programs who applied. All 32 states that indicated interest in participating in the Supporting Tenancy Track were invited to attend the webinar series.

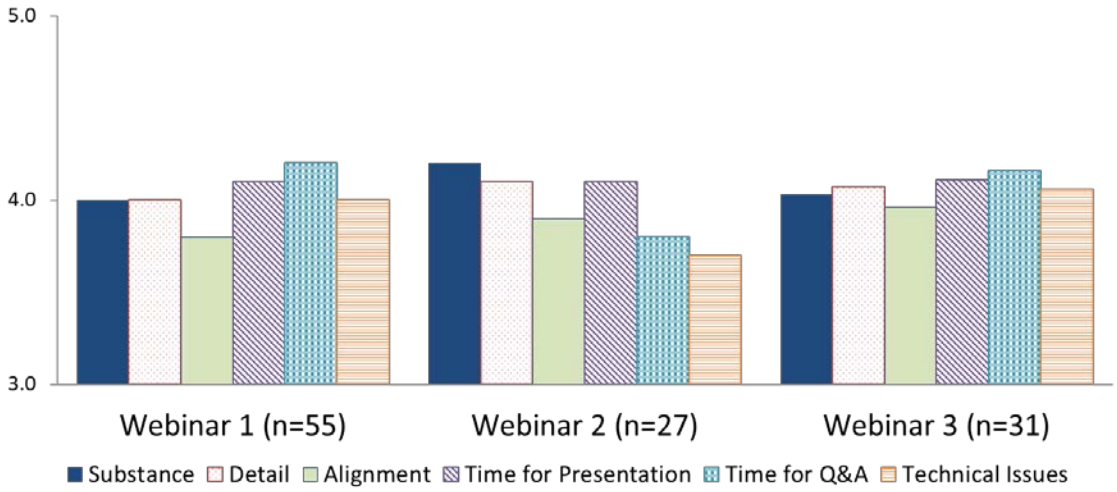
Exhibit 27. CI-LTSS HRSP Supporting Tenancy Track Webinar Topics

Webinar Number	Date	Topic
1	February 8, 2016	Description of housing-related services and Medicaid authorities that may cover some of these services
2	March 14, 2016	State examples of Medicaid coverage of housing-related services
3	April 11, 2016	Implementation planning based on lessons learned from experienced states

The Supporting Tenancy Track webinars were well-attended. Thirty states participated in at least one of the three webinars. In total, 406 individuals participated in the webinars across all three sessions, with an average of 135 individuals attending each webinar. Attendees included representatives from Medicaid, behavioral health, housing, and other agencies, as well as municipal agencies, non-profit policy and advocacy organizations (homelessness, housing, financing), universities, and consulting firms. States were encouraged to invite non-government stakeholders to Supporting Tenancy Track webinars.

There was active involvement in the webinars as indicated by the fact that more questions were consistently asked by the states than time allowed for responses. At the end of each Supporting Tenancy Track webinar, attendees were asked to rate the webinar across six areas: 1) overall substance and quality; 2) level of detail and content; 3) alignment with state's reform efforts; 4) time allotted for presentation; 5) time allotted for questions; and 6) technical issues. As shown in Exhibit 28, on average, attendees rated the webinars positively. Evaluation team members observed that presentations were well-organized, with ample opportunity for questions and answers.

Exhibit 28. Average Ratings of CI-LTSS HRSP Supporting Tenancy Track Webinars



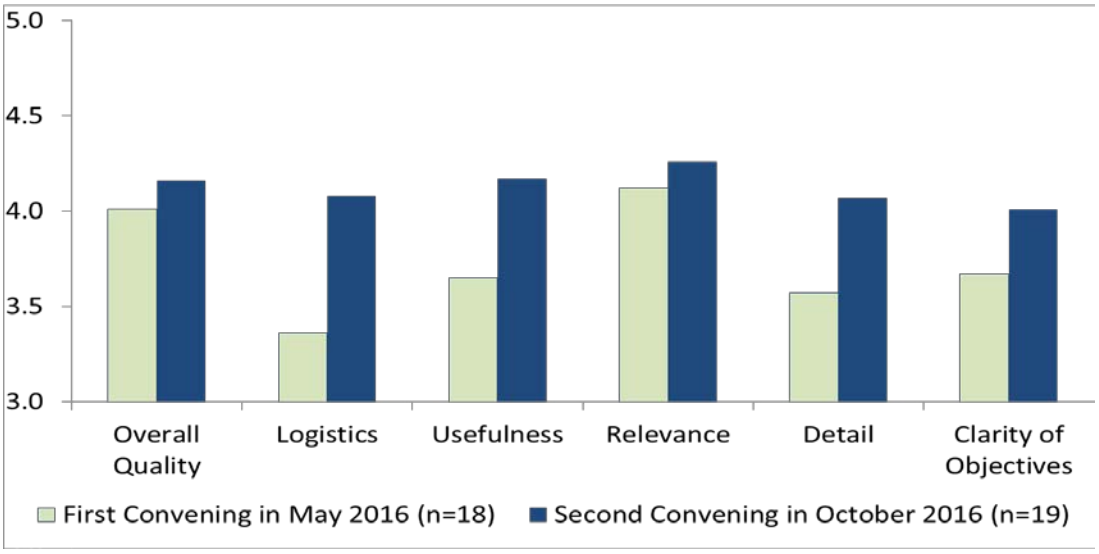
Note. The y-axis represents an average rating on a 5-point Likert scale ranging from 1 (poor) to 5 (excellent).

The Partnership Track Cohort 1 included multiple modes of targeted support, including a one-on-one support team consisting of a coach and an SME, two in-person meetings, webinars, and tools to help states profile their current resources and develop a detailed action plan. In addition, all states had the opportunity to receive an on-site visit from their support team, although not all states were able to take advantage of this option. Schedules and other barriers prevented a visit for some states, and we learned

during a focus group discussion that not all state team members were aware of the option for an on-site visit.

After each in-person meeting, Cohort 1 participants were asked to respond to an evaluation survey. Exhibit 29 presents a comparison of the average ratings by dimension between the two in-person meetings. Across all dimensions, the second in-person meeting received a higher rating than the first, with greatest perceived improvement in logistics, usefulness, and detail.

Exhibit 29. CI-LTSS HRSP Partnership Track Comparison of Average Rating by Dimension between Cohort 1 In-Person Meetings



Note. The y-axis represents an average rating on a 5-point Likert scale ranging from 1 (poor) to 5 (excellent).

Were the targeted support offerings aligned with states' needs and reform goals?

As illustrated in Exhibit 28 above, Supporting Tenancy Track Webinar participants indicated that the webinar series aligned with their states' reform efforts.

Our review of the Cohort 1 EOI forms found wide variation in current and previous collaborations between housing and Medicaid, but indicated substantial interest in the topics to be addressed in this CI-LTSS component (see Exhibit 30), suggesting that the track encompassed areas of most-needed support. Applicants mentioned interest in addressing a range of target populations including those experiencing homeless (n= 20), individuals with disabilities (n=13), SUD-impacted groups (n=8), Medicaid beneficiaries with severe mental illness (n=12), individuals with multiple chronic health conditions (n=5), and those with a history of incarceration or institutionalization (n=15).

Exhibit 30. Cohort 1 States' Interest in CI-LTSS HRSP Areas of Targeted Support (N=32)

Topic	Number of States Expressing Interest
Expanding housing opportunities for people receiving community-based LTSS	30
Providing individual tenancy sustaining services	28
Coordination with housing agencies and providers	24
Understanding federal housing policy	21

Note. Includes all EOI forms received.

In key informant interviews, focus groups, and a summative survey, Cohort 1 Partnership Track state participants expressed that the overall topic of building partnerships across health services, housing, and other agencies and organizations was extremely relevant to their needs and reform goals. Participants highlighted the value of customized targeted support according to each state's unique needs and characteristics.

Was targeted support provided in an appropriate, convenient, and minimally burdensome format?

The Supporting Tenancy Track included only one mode of support, webinars, which was appropriate for its group learning goals. As shown in Exhibit 28 above, participants gave high marks overall to the time allotted for both the presentations and the question and answer periods following.

For both cohorts of the Partnership Track, the primary mode of targeted support is individual coaching provided by coaches and SMEs. Cohort 1 states provided positive feedback on coaching, and the coaches and SMEs described working with their individual states on a schedule, and using modes of sharing information, that aligned with their needs and preferences, thus prioritizing convenience and minimizing burden.

> *"Our [targeted support] team has been really great about what's special about us … picking out the issues that our state has without having worked in the state system."*
>
> ~ HRSP participant

In addition, for Cohort 1 Partnership states, IAP staff organized four peer-to-peer webinars for the Partnership Track state participants. The topics included: (1) related services in Medicaid 1915 waiver programs, (2) incorporating housing-related services in section 1115 demonstrations, (3) housing development strategies, and (4) coordinating tenant selection/housing referrals. A range of two to six states attended each one-hour session. One state participant commented that because all peer-to-peer calls occurred within a two-week timeframe over the summer, it was difficult for some team members to attend given vacation and work schedules. Focus group participants suggested that IAP staff circulate an agenda in advance of the calls and lead a structured discussion, rather than depending on state participants to facilitate the conversation. One participant commented, "*Five minutes into the call, [the coach asked], 'Can you tell us what your state is doing?' I called in just to listen in and learn something, but I was called on to present*." Because these webinars lacked a dedicated facilitator to guide the discussion, states did not ask a lot of questions.

Was the amount of targeted support sufficient? Was it targeted to the appropriate audiences?

Supporting Tenancy Track state participants provided generally positive responses on the post-webinar evaluation survey to the range, novelty, and depth of the issues covered by the Supporting Tenancy Track webinars. More than 60 percent (n=29) of survey respondents agreed or strongly agreed that they were satisfied with the range of issues discussed, and that the webinars offered new or more in-depth information.

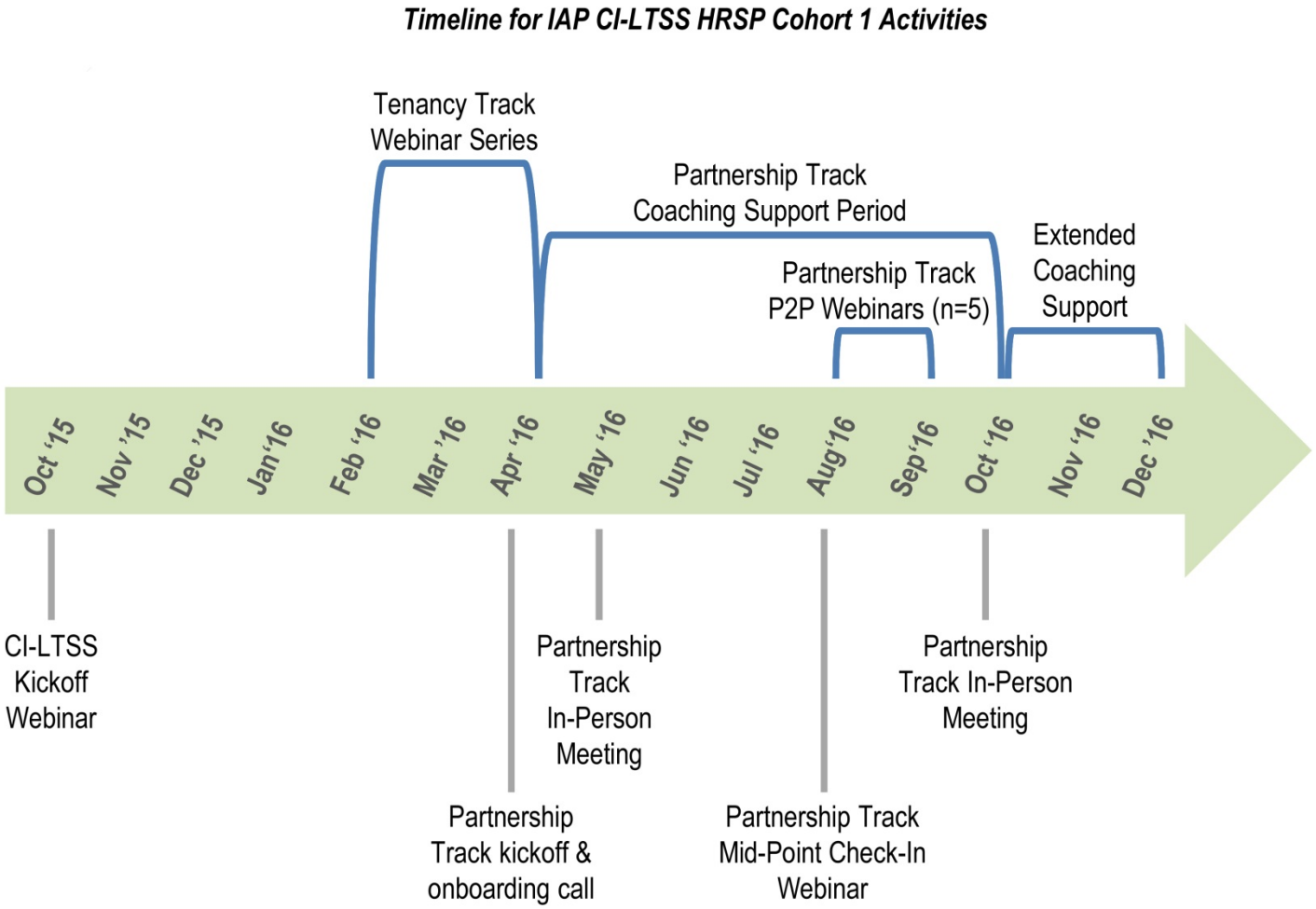
After the first in-person meeting in October 2016, the Cohort 1 Partnership Track coaches shared that more time should be allotted for state-to-state discussions during the meeting. For example, they noted that a breakfast or lunch meeting among states could offer opportunities for cross-state collaboration. Additionally, coaches shared that the in-person meeting is the best mode of communication with their states. The breakout sessions were appreciated by all the coaches as an opportunity to solidify states' action plans. To maintain the momentum of the October in-person convening, coaches emphasized the importance of next steps including: regular communication through weekly-standing meetings and emails, forming sustainable partnerships within the state teams, gaining leadership buy-in, and peer-to-peer and mid-way webinars.

The structured portion of the first Partnership Track cohort lasted six months, but based on state feedback, CMS IAP staff gave states the option of receiving continued coaching support for three additional months. During the Cohort 1 Partnership focus group discussions, state participants and coaches unanimously agreed that the original six-month timeframe for the Partnership Track targeted support was too short, and recommended that 9 to 18 months of targeted support would be more effective. One state participant shared that, "*By the time we got our act together … the [targeted support was] nearly finished. We couldn't absorb the information presented to us (earlier) until now*." One coach suggested that the length of targeted support should be tailored to each state's goals and needs, as additional time or follow-up may be needed in some states to bring about change in institutional and government programs and achieve a sustainable outcome.

Cohort 1 Partnership Track state participants were also invited to attend the Supporting Tenancy Track webinars, and some states elected to take advantage of this option. Partnership Track participants who attended reported that these webinars provided an opportunity to hear from CMS IAP staff and the targeted support providers about the direction the state should be taking, and to hear from other states about their plans and progress.

Exhibit 31 shows the timeline of targeted support provided for Supporting Tenancy and Partnership Tracks.

Exhibit 31. CI-LTSS HRSP Cohort 1 Timeline



Was the quality of targeted support adequate and sufficiently targeted to meet states' needs?

At the end of the final Supporting Tenancy Track webinar, the evaluation team conducted an online survey (post-webinar series survey) to gather feedback on the Supporting Tenancy Track webinar series as a whole. Forty-eight individuals responded, with 21 (46 percent) identifying themselves as a representative from the Medicaid agency. On average, 33 percent of the respondents indicated that the webinars were useful across the three sessions. Respondents noted they valued information on specific funding processes and concrete experiences presented by other states. The third webinar, on implementation planning, was rated least useful of the three webinars by more than half of the respondents. Respondents explained that the specific state examples presented on this webinar were *"not close to what our state plans to offer."* These findings underscore the challenge of identifying state examples that are relevant across a diversity of state participants, despite the expressed value placed by states on peer learning.

Cohort 1 Partnership Track state participants generally agreed that the quality of targeted support, including in-person meetings, coaching support, and various tools including housing assessment, crosswalk, and action plans adequately and sufficiently met their needs. At the end of each in-person meeting, participants were asked to share their feedback through a post-meeting evaluation survey. These results are shown in Exhibit 29, above.

The in-person meetings were particularly valuable for fostering the opportunity to connect with other states in person. However, some state participants noted that state presentations at the in-person meeting could have been more succinct. One participant suggested an alternative she had seen at a prior CMS meeting: "*Instead of sitting in a room watching state presentations, CMS put huge easels everywhere. … There were a lot more questions and interactions as we walked around [to hear states present]*."

> *"The biggest value of this TA has been to getting to meet all of you [the other state participants]. I can now pick up the phone and call you."*
>
> ~ HRSP participant

Between the two in-person meetings, CMS organized a mid-point check-in webinar for Cohort 1 Partnership states to share any updates and early accomplishments. State participants noted that this check-in webinar might have been more helpful for CMS IAP staff than for states in identifying states' needs and checking on their progress.

Cohort 1 state participants voiced mixed reactions about the coaching support they received. One participant shared that more guidance and technical support would have been helpful, as their coach "*was not receptive*" to requests for assistance with encouraging collaboration between housing developers and health services. Another participant agreed, saying that their coach was "*very hands off*" and the state "*did not get as much TA or facilitation as we thought we would*." In contrast, another participant commented favorably that their SME shared examples of Medicaid waiver applications and helped the state strategize on how to approach their waiver applications. Despite the individual kick off process that included the state participants, their coaching team, and CMS IAP staff, some discrepancies in expectations about available support seemed to persist. We learned through focus groups that evolving state team composition, and the fact that some team members joined their state's effort partway through the Cohort 1 Partnership Track, could have contributed to the misaligned expectations. Focus group participants also suggested that the varied level of support may be driven by "*the personality of the facilitator [coach],*" and suggested that states might assess their own needs, strengths, and weaknesses, and pick a coach based on resumes.

States that received a site visit by their coach expressed enthusiasm for on-site support. One participant shared that their coach and SME organized a conference-like meeting with senior leaders, Continuum of Care leads, and other stakeholders to discuss data, managed care, and stakeholder engagement. This meeting "*really galvanized what we were doing*." Another state identified the site visit as a turning point in their experience with the IAP: "*At first, I didn't find what our facilitators [coaches] were sharing with us was all that helpful; I felt like we were being bombarded with information. … Then, it all came together once we had the site visit*."

Cohort 1 Partnership Track state participants were encouraged to complete various planning tools, including a project action plan and a housing-Medicaid crosswalk that assessed housing and service options in each state. Several participants positively rated the experience of completing these assignments, stating that the work *"exposed us to what the different entities were doing and kind of unified us."* One participant observed that, *"I'm not a housing person, I'm a clinician in my career, so the crosswalks helped me find out how much I didn't know*." Another participant commented that seeing the housing assessment from the Medicaid perspective was *"very eye-opening."* However, one state shared that these assignments did not facilitate interagency conversations because each agency contributed their relevant piece independently rather than collaboratively. In addition, some participants noted that these assignments were challenging to complete due to the tight timeframe and a perceived inadequate explanation of their objectives. One state commented that applying the same tools, such as the action plan and crosswalk, to all states was less valuable than tailored materials would have been. "*Fitting in materials into the crosswalk wasn't useful. … [The] action plan was another one, where the format didn't seem that helpful for us. When we got home, we turned it into a brief form that we shared with the rest of our team*." As a result of this feedback, CMS plans to more explicitly address the goals and purpose of the various tools, including the crosswalk, with Cohort 2 participants and allow more flexibility.

Learning

What specific, actionable knowledge did participants acquire from the IAP?

While results of the Supporting Tenancy Track post-webinar series survey did not refer to specific, actionable knowledge that participants gained from the IAP, more than 60 percent (n=29) of survey respondents agreed or strongly agreed that the webinars offered new information or more in-depth information.

Cohort 1 Partnership Track state participants described specific, actionable knowledge acquired from the October in-person meeting and their plans to apply the newly-acquired information. In particular, participants reported learning about building a business case for supporting housing, inserting housing incentives into MCO contracts and mandating the presence of MCO housing coordinators, engaging stakeholders, providing training for case managers, and data sharing.

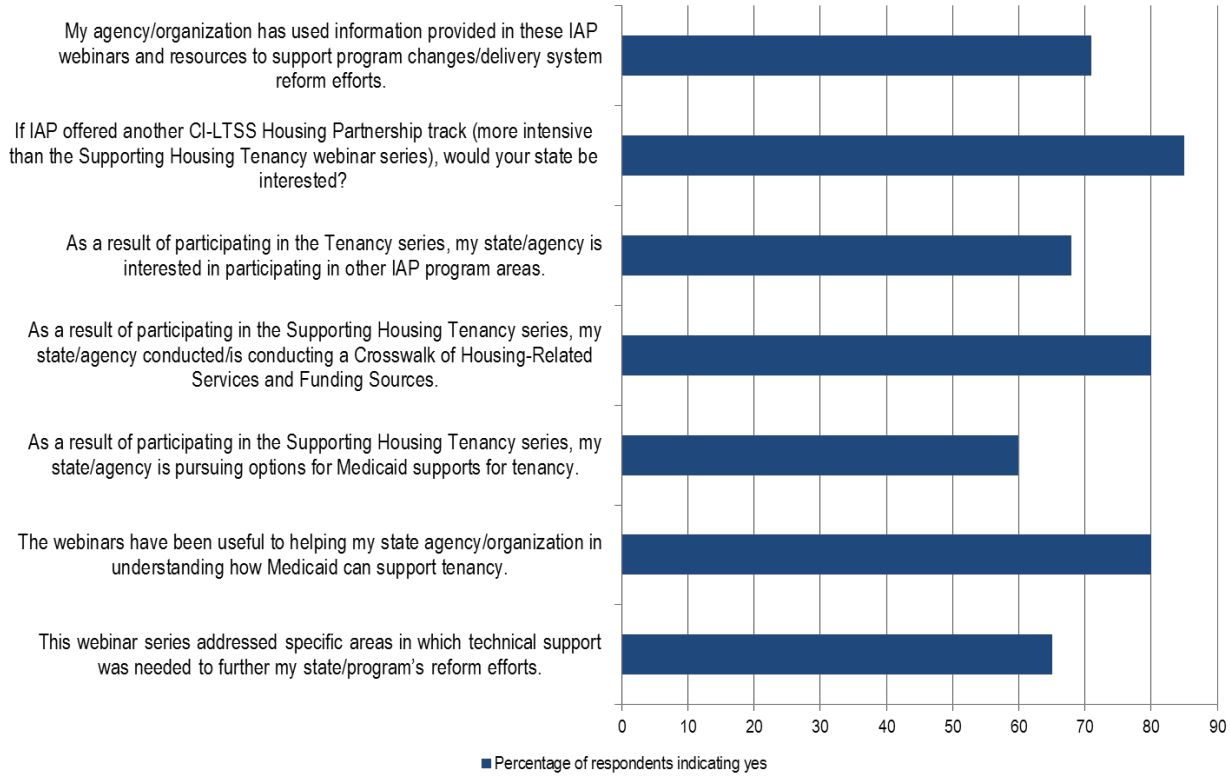
The summative survey, conducted 10 months after the second in-person meeting, provided examples of Partnership Track participants' reported areas of increased knowledge due to IAP participation. What they learned about housing-related support options and techniques for integrating housing and Medicaid supports include: the use of 1915c waivers, models of tenancy supports and evidence-based practices, implementation of housing support benefit within a managed care context, and types of housing-related services that are already billable by Medicaid. Due to data collection timeframes, full analysis of all summative survey data was not possible prior to production of this report. Future reports will include more detail.

Response

What specific activities or changes did participants undertake in their programs as a result of participating?

The Supporting Tenancy Track post-webinar series survey addressed a number of questions about specific activities or changes that participants have undertaken as a result of participating in the Supporting Tenancy Track webinar series. As Exhibit 32 shows, more than half of the respondents indicated that their participation resulted in various types of support for reform efforts.

Exhibit 32. Participants' Ratings of Results of Participating in the CI-LTSS HRSP Supporting Tenancy Track (N=48)

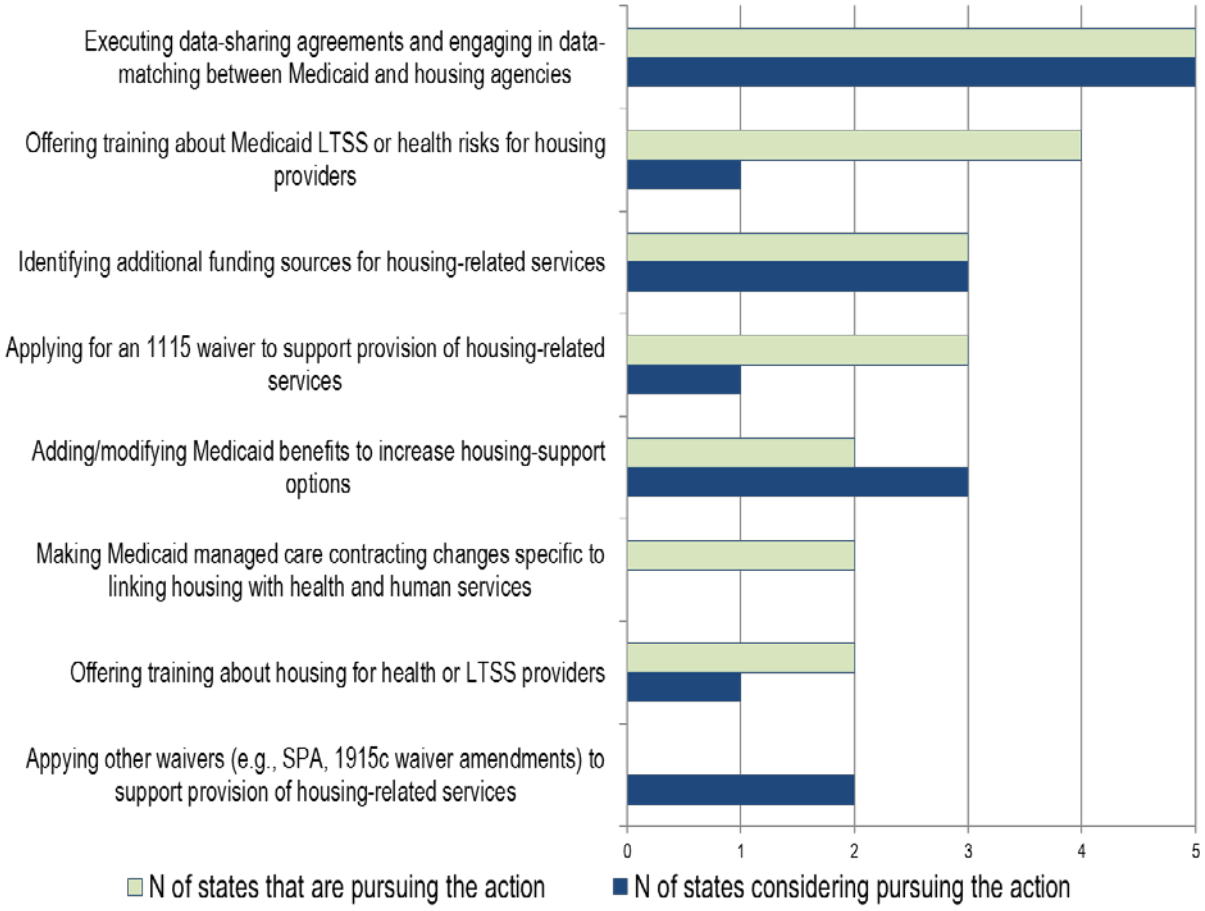


During the second in-person meeting in October 2016, Cohort 1 state participants shared their accomplishments from participation in the Partnership Track and their planned next steps. State participants discussed establishing or strengthening existing interagency relationships, mining existing data, and including housing-related services and supports in their 1115 waiver applications as a result of their participation in the IAP.

As Exhibit 33 shows, states have pursued or are considering pursuing numerous actions to enhance and expand housing-related supports in the six months following participation in the Partnership Track, as indicated in the summative survey.

As Exhibit 33 shows, states have pursued or are considering pursuing numerous actions to enhance and expand housing-related supports in the six months following participation in the Partnership Track, as indicated in the summative survey.

Exhibit 33. Activities Pursued or Planned by Cohort 1 CI-LTSS HRSP Partnership Track States Following IAP Participation (N=7)



Note. No states were pursuing other waivers as of July 2017.

Were CMS IAP staff responsive to performance improvement feedback on participant reaction and learning?

As states' goals and priorities shifted over time, IAP content had to shift accordingly. For example, peer-to-peer webinars focusing on particular areas, such as matching Medicaid data to other data sources, were added as states increasingly voiced need for more support in those areas. One of the participating states that was most advanced in data sharing and matching served as an SME on one of these webinars.

In addition, CMS IAP staff modified the support to be offered to Cohort 2 based on feedback and lessons learned in the first round of Partnership support. The refinements are summarized in Exhibit 34 and discussed below.

Exhibit 34. Comparison of Characteristics and Support Offered through CI-LTSS HRSP Partnership Track, Cohort 1 versus Cohort 2

	CI-LTSS Housing Partnerships Cohort 1	CI-LTSS Housing Partnerships Cohort 2
State Selection		
Informational webinar	Yes	Yes
Number of participating states	8	8
Topic selection on EOI	Choose as many as applicable from 4 options + "other"	Choose up to 3 from 9 options + "other"
Initial length of support	6 months	9 months
Group Learning Approaches		
Webinars	Yes	Yes
In-person meetings	2	1
Email updates	Biweekly	Yes
Peer-to-peer webinars	3	Yes
Groupsite virtual resource library	Yes	Yes
Individual Assistance Approaches		
Coaching	Yes	Yes
Site visits	Optional[1]	Expected for all states
Crosswalk	Yes	Yes
Housing assessment	Yes	Yes
Gaps analysis	Yes	Yes

Note. [1]In Cohort 1, site visits were optional for all states, although some states reported that they were unaware of this option and did not take advantage of the support.

The first cohort of eight states selected to participate in the Partnerships Track also had the option, as all states who indicated interest did, to participate in the Supporting Housing Tenancy web series. The Partnership Track began as six months (later extended to nine months) of technical support to establish or strengthen partnerships between state Medicaid and housing agencies. The planned nine-month duration of the second cohort of IAP Partnership support suggests responsiveness to states' needs.

The general approach to providing assistance—using a coaching model with assistance provided through webinars, conference calls, and in-person group meetings—is the same for both cohorts, as are the tools that will guide the states in their work. As with Cohort 1, the states selected for Cohort 2 will complete services crosswalks, a housing assessment, a gap analysis to identify gaps in housing and services resources, and a state action plan to address the gaps. CMS IAP staff are refining the tools for the second cohort based on feedback from Cohort 1 to simplify them and reinforce linkages between them. When asked, Cohort 1 states commonly mentioned that the housing partnership activities were very valuable and aligned, although time-consuming. CMS has established an expectation for staff time commitment in Cohort 2, which should help ensure that Medicaid leadership supports staff spending adequate time on IAP activities. In addition, Cohort 2 materials explicitly indicate that coaches will conduct site visits to selected states. Since CMS is not able to pay for state travel, CMS IAP staff decided to minimize burden

on states by including only one in-person meeting for Cohort 2, although both in-person meetings were well received by Cohort 1.

Other changes to the design between the first and second Partnership cohorts include:

- The site visit is being moved earlier in the track.
- The in-person meeting will have a greater focus on peer learning and networking among the states.
- Confirming and sharing basic information on housing and services will occur during the site visit instead of during the in-person meeting.
- Expectations for states regarding the site visit and tools are being communicated upon state selection, during the kick off call with states, and during the in-person meeting.
- Expectations for coaches regarding the site visit and tools are being communicated more clearly, including the use of a coaches' orientation webinar.

For both cohorts, CMS held informational webinars to describe the goals of the housing-related support and the types of assistance available prior to the EOI submission deadline. Building on the experience of Cohort 1, the Cohort 2 webinar was more specific and incorporated presentations by Cohort 1 states.

EOI forms for Cohorts 1 and 2 were generally similar. Both forms requested information on key team members, the status of current or recent housing partnerships activities, planned goals for and target populations that will benefit from the IAP assistance, and how the IAP assistance will align with the state's reform efforts. For both cohorts, the EOI form noted that state Medicaid agencies did not have to secure a written commitment from the state housing agency until after the states were selected. One difference between the Cohort 1 and 2 EOI forms is in how the types of IAP support are described and how states indicate their interests across the types. For the first cohort, the EOI form identified four general areas of support and invited states to check all the areas of interest. By contrast, the Cohort 2 EOI form asked states to select up to three areas of program support from a list of nine more-narrowly defined areas.

Results

What happened as a result of the IAP? Did the program support ongoing reform?

> *"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."*
>
> ~ HRSP participant

Cohort 1 state participants gave examples of how IAP participation supported their reform efforts, such as facilitating partnership within and across states, and leveraging new partnerships to apply for waivers. One participant shared, "*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.*" A few state participants also mentioned that being able to connect with CMS through the IAP endowed a sense of credibility and "*clout*" in being able to access resources and collaborate with other agencies.

What barriers, if any, reduced the impact of the targeted support and other resources?

Coaches for Cohort 1 underscored that competing demands and limited staff resources faced by state participants are barriers to benefiting in full from the IAP support. In particular, coaches noted that state participants faced extra burden as the first Partnership Track was rolled out concurrently with busy legislative and budgetary timelines in spring.

Interim Key Findings: CI-LTSS Incentivizing Quality Outcomes (IQO) Component

The IQO component of the CI-LTSS IQO program area aims to increase adoption of strategies that tie together quality, cost, and outcomes in support of community-based LTSS programs. The CI-LTSS IQO component advances state efforts to improve quality and outcomes for community-based LTSS.

Track: Planning
Dates of support: April 2016-October 2016
Targeted support approaches/activities: Webinars, Groupsite
Participating states: Indiana, Maryland, Mississippi, Nebraska, Nevada, North Carolina, Ohio, Pennsylvania, and Virginia

Track: Implementation
Dates of support: November 2016-April 2017 (with opportunity to extend support through Sep 2017)
Targeted support approaches/activities: Webinars, coaching (including action plans and site visits), email updates, Groupsite
Participating states: Massachusetts, New Jersey, Virginia and Washington

National Dissemination Strategy activities to date: N/A

Key Findings:

	REACTION • Case studies, specific examples of state implementation strategies, and site visits were especially valuable tools and supports. • Webinars focusing on quality and outcome measures were of significant interest. • States preferred email updates to Groupsite for accessing additional resources.
	LEARNING • Support increased understanding of quality outcome measurement generally and home and community based services (HCBS) QM specifically. • State participants learned from one another about different VBP models.
	RESPONSE • States intend to develop work plans, drive VBP strategies in managed care contracts, explore using national surveys related to HCBS QM, and engage stakeholders as part of the ongoing work in this area.
	RESULTS • States participating in strategic implementation activities plan to apply information to waiver renewals, and payment and delivery system reform strategies, including with Accountable Care Organization (ACOs) and MTLSS programs. • States identified staffing constraints, stakeholder engagement and agreement of measures, and interpretation of data as implementation challenges they expect to encounter.

Component B: IQO

Track 1—Planning an IQO Strategy. The focus of the IQO Planning Track was to provide planning support in developing a value-based payment approach for community-based LTSS. This track started in April 2016 and concluded in October 2016 with the following participating states: Indiana, Maryland, Mississippi, Nebraska, Nevada, North Carolina, Ohio, Pennsylvania, and Virginia.

Track 2—Implementation of an IQO Strategy. The focus of the IQO Implementation Track is to provide support to states undertaking early stages of IQO strategy implementation. This track launched in November 2016 with a structured period that lasted until April 2017; participating states were offered the opportunity to extend coaching support through September 2017. The following states are participating in the Implementation Track: Massachusetts, New Jersey, Virginia, and Washington.

Exhibit 35 details the interventions for both tracks within the Incentivizing Quality Outcomes component.

Exhibit 35. CI-LTSS IQO Component Interventions

Intervention	Frequency	Intervention Activities[1]	Intervention Status
IQO Planning Track			
Webinars	Monthly	IAP staff held six IQO Planning Track webinars.	Completed
Groupsite	N/A	Groupsite is a web-based library of materials and tools available to IAP participants. It was established to store and maintain information online.	Ongoing
IQO Implementation Track			
Webinars	Three times	IAP staff held IQO Implementation kick off, peer-to-peer, and conclusion webinars.	Complete
Coaching	Varies	IQO Implementation Track state participants receive one-on-one support from their assigned coach, tailored to individual needs and aims.	Ongoing
	One time	IQO Implementation Track state participants developed action plans with their coaches to set goals and priorities	Completed
	One time	IQO Implementation Track state participants received an on-site visit from their coach.	Completed
Email Updates	Biweekly	CMS IAP staff send IQO Implementation Track state participants biweekly emails detailing milestones, next steps, and upcoming events, and providing resources.	Ongoing
Groupsite	N/A	Groupsite is a web-based library of materials and tools available to IAP participants. It was established to store and maintain information online.	Ongoing

Note. [1]Activities included as of August 2017.

Reaction

Did the application and targeted support planning process identify the most needed targeted support, the most appropriate mode of delivering targeted support, the most appropriate target audiences, and realistic timing/sequencing for targeted support?

Fifteen applicants expressed interest in Component B: IQO. Of those, 13 states expressed interest in participating in Track 1: Planning an IQO Strategy, and three in Implementing IQO Strategies. Ultimately, CMS selected nine states to join the Planning Track and four states to join the Implementation Track, including two states that had applied for the Planning Track but were determined to be more appropriate for implementation support. In addition one state, Virginia, participated in both the Planning and Implementation Tracks, although these tracks were originally intended to be mutually exclusive.

Of the four selection criterion that CMS IAP staff developed for CI-LTSS applicants, one was earmarked for those interested in the IQO Track; this factor is detailed in Exhibit 36.

Exhibit 36. CI-LTSS IQO Selection Factors

Selection Factors
Factor 4: Clearly Articulated Program Needs and Experience • Planning an IQO Strategy Track – Has the state clearly articulated its program support needs with regard to planning an IQO strategy in community-based LTSS programs? • Implementation of an IQO Track: – Has the state provided evidence of current activity in designing and/or implementing an IQO strategy for community-based LTSS program?

Source. CMS IAP document titled, "Program Support for States, Promoting Community Integration – Long-Term Services and Supports State Selection Factors."

In key informant interviews, IQO Planning Track state participants described the application process as straightforward and *"not cumbersome like a grant application."* The EOI format allowed the applicants to express their specific needs related to IQO and to work collaboratively with Medicaid and other agencies to complete the application. However, three out of nine states shared that having the HRSP and IQO on one EOI form was confusing, as they are disparate components. One said that they staffed their IQO Planning team with housing coordinators as they thought *"there would be more of a tie between housing and IQO."*

> *"The simplicity of the application process was one of the determining factors for us to apply."*
>
> ~ IQO planning participant

How did state participants (including any stakeholder groups) experience the targeted support process? How did they engage with the targeted support providers?

CMS IAP staff conducted a six-part webinar series on VBP for HCBS for the nine states participating in the IQO Planning Track (see Exhibit 37).

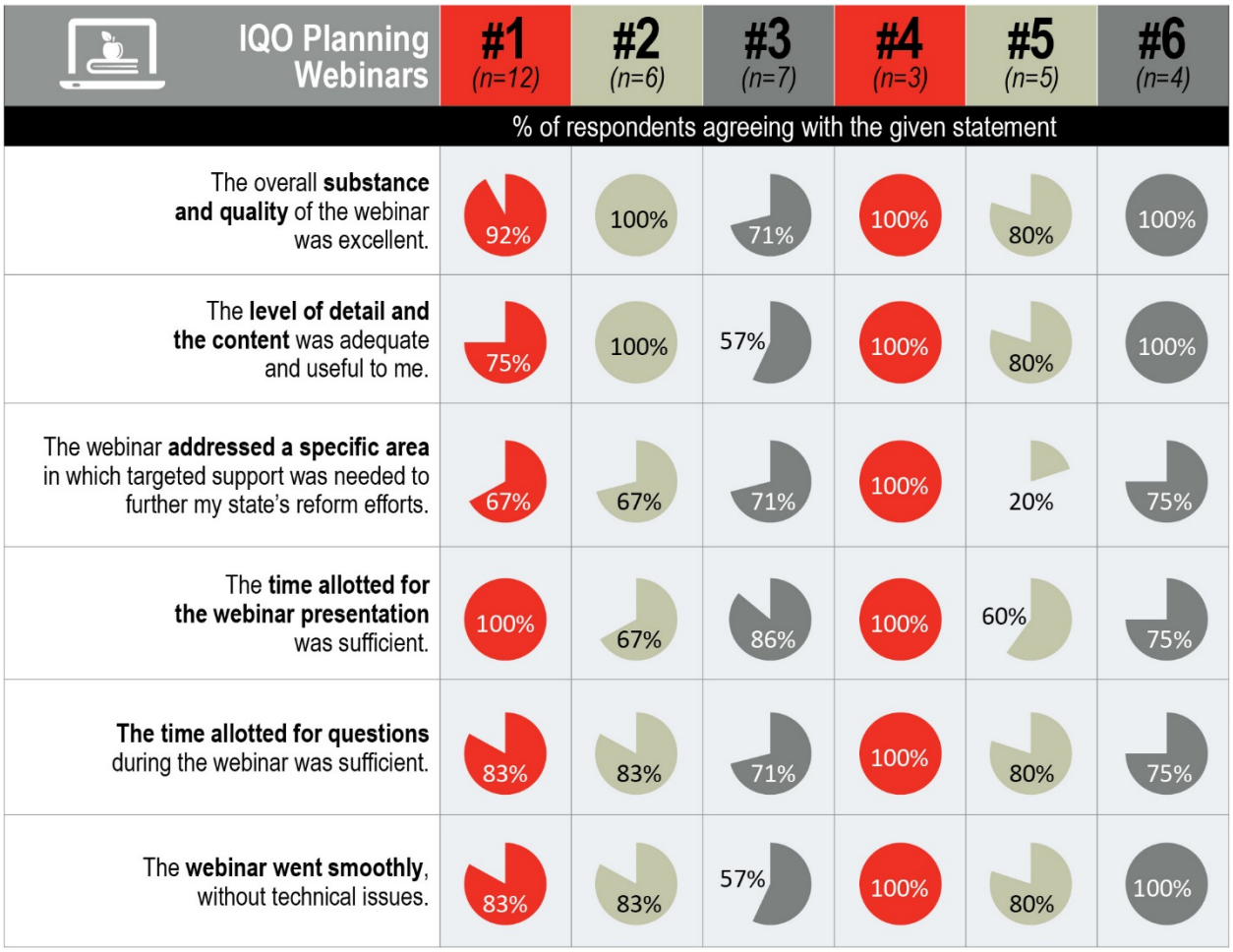
Exhibit 37. CI-LTSS IQO Planning Track Webinar Topics

Webinar Number	Date	Topic
1	April 20, 2016	IQO for HCBS
2	May 26, 2016	HCBS Quality/Outcome Measures Part I
3	June 30, 2016	HCBS Quality/Outcome Measures Part II
4	July 27, 2016	HCBS Quality/Outcome Measures Part III
5	August 17, 2016	Moving Towards Implementation of an IQO Strategy for HCBS
6	September 7, 2016	IQO Strategies in MLTSS and a Case Study of Tennessee

The most highly attended among the six webinars were the first two, with 32 attendees for each webinar. Participants appeared to be quite engaged in the webinar topics, based on the fact that more questions were asked by states than time allowed for responses. These webinars introduced the concept of value-based payment for HCBS. Based on states' requests, several later webinars discussed quality and outcome measures. On average 27 individuals attended each webinar. In total across all webinars, the highest number of attendance for any state was 44, or approximately seven individuals per webinar. The lowest number of attendance for any state was seven, or approximately one individual per webinar. These numbers are likely an underestimate of the actual number of individual attendees, as we learned during key informant interviews that many state teams gather in one room to participate in the webinar together.

Exhibit 38 presents a summary of IQO Planning Track post-webinar evaluation survey results. On average, 22.5 percent of attendees responded to the evaluation surveys.

Exhibit 38. Summary of Post-CI-LTSS IQO Planning Track Webinar Evaluations



Note. Webinar 1: IQO for HCBS; Webinar 2: HCBS Quality/Outcome Measures Part I; Webinar 3: Implementation Planning Based on Lessons Learned from Experienced States; Webinar 4: HCBS Quality/Outcome Measures Part III; Webinar 5: Moving Towards Implementation of an IQO Strategy for HCBS; Webinar 6: MLTSS and Case Study.

The IQO Implementation kick off webinar was held on November 2, 2016. Ten individuals across the four selected states attended the webinar. Following the kick off webinar, state teams developed action plans with the assistance of an on-site coaching visit. States were encouraged to modify the action plan template they were provided according to their state's specific needs and implementation status. The initial submitted action plans varied across states, with some states providing more detail and specificity than others.

Were the targeted support offerings aligned with states' needs and reform goals?

Exhibit 39 presents the findings from our analysis of the EOI forms regarding the areas of support and topics applicants identified as of interest. As shown, 14 of the 15 applicants (93 percent) identified data sets and analytics to support community-based LTSS as an area of needed assistance.

Exhibit 39. States' Interest in CI-LTSS IQO Areas of Targeted Support (N=15)

Topic	Number of States Expressing Interest
Data sets and analytics to support community-based LTSS	14
Identification of a quality measurement strategy	13
Operational aspects of implementing incentives	13
Purchasing strategy design	11
Effective stakeholder engagement during incentive design	7
Strategies to scale up successful IQO activities	6

Note. Includes all EOI forms received.

Overall, participants indicated through their first draft of action plans submitted in January 2017 that they were seeking targeted support in identifying HCBS measures, a financial model, and best practices in HCBS performance measurement strategies. Below are the specific supports that states requested:

- Support in identifying existing or proposed HCBS domains and measures from other states or environments
- More information on what other states are doing through programs like the Balancing Incentive Program, Money Follows the Person and HCBS VBP
- Strategies to fill all measure gaps for all Medicaid populations governed under managed care, including MLTSS, commercial payers, or other state Medicaid programs
- Support in completing a gap analysis to inform the final selection of performance measures

Following the first IQO Planning Track webinar, half of the respondents (n=13/26) indicated in a polling question that they did not currently understand their state's option for IQO for Medicaid community-based LTSS, underscoring the importance and relevance of the targeted support offered for this topic. During the second webinar, 53 percent (n=8/15) of attendees reported that they were just beginning to research HCBS measures, and another 33 percent (n=5/15) were weighing options for HCBS measures.

Approximately four months after the conclusion of the IQO Planning Track webinar series, participants completed a post-webinar series survey in which they were asked to provide feedback about their overall experience in the Planning Track. Ten individuals, from seven of the nine participating states, responded to the survey. Eight of the 10 respondents indicated that they are affiliated with the state Medicaid agency, one indicated affiliation with the developmental disabilities agency, and one indicated affiliation with an aging agency. When asked to describe any additional information or topics that they would have liked to learn about through the IQO Planning Track series, one respondent identified quality measurement outside of a managed care environment, and another mentioned processes that map how to transition from the fee-for-service system for states in the early stages of MLTSS implementation.

As noted above, two of the four IQO Implementation states originally applied to participate in the IQO Planning Track. However, given where these two states stood in their reform efforts, CMS IAP staff suggested that they would be better served in the Implementation Track. Both states indicated that the IQO Implementation Track better aligned with their goals than the IQO Planning Track. Overall, coaches and state participants in the Implementation Track noted that the targeted support offerings helped refine state goals. During the early stages of the coaching period, coaches provided on-site assistance and held frequent calls to help states develop an action plan. Coaches also provided the states with technical

materials, such as memos pertaining to quality measures, which the states used to advance their implementation strategy.

Was targeted support provided in an appropriate, convenient, and minimally burdensome format?

As with the Supporting Tenancy Track, the goal of the IQO Planning Track was to share content with participants to support their initial development and consideration of an IQO strategy. Group learning, through webinars, was an appropriate mode to accomplish this goal. As shown in Exhibit 38, most IQO Planning Track respondents reported satisfaction with the time allotted for questions across all webinars. To facilitate discussion, one respondent suggested that the webinar coach could provide specific case studies or examples to illustrate different scenarios, rather than asking states for reactions, "*putting [them] on the spot after learning new(er) content.*"

> *"Most helpful for us is to hear the experiences of other states and where they are in their process. It is reassuring to know that other states are at the same stage as us"*
>
> ~ IQO planning participant

IQO Implementation Track participants found most modes of targeted support offered to be appropriate. Coaches and state participants spoke highly of the on-site coaching visits that occurred shortly after the track's kick off. During the site visits, coaches helped state participants refine their goals and develop action plans. While states valued the coaches' assistance with the action plans, they were more appreciative of the opportunity to meet in person with their coach. One state participant and several coach interviewees expressed their desire to have had more site visits during the coaching support period. Another state participant suggested that having more information about the track before the site visit would have allowed the state team to take fuller advantage of the visit.

> *"The in-person nature of the site visit was meaningful. When you have the TA provider come to the agency, it sets a high bar for the quality of the work. Our expectations for the IQO team and ourselves were set high in terms of information presentation and policy development and implementation."*
>
> ~ IQO implementation participant

After the site visits, coaches provided targeted support to states through calls and emails, scheduled according to each state's preference. In the early stages of the track, most states held biweekly calls with their coaches, but as the track progressed, some states transitioned towards email communication and ad hoc calls. One state participant said he found the calls to be the most helpful mode of targeted support because the coach assisted the team in narrowing their goals. State participants indicated that overall, the coaches were flexible and the frequency of communication was appropriate.

State participants found the action plan to be less valuable than did the coaches. One state indicated that it was particularly challenging to identify dates in the action plan, given the inter-relationship of tasks. However, the coaches believed the action plans kept states accountable to a deliverable timeline and agreed it was "*an essential management tool.*" One coach recommended that a Gantt chart might be a less burdensome format for developing an action plan than the format used by the IQO Implementation Track.

During our interviews, two IQO Implementation Track states noted that the timing of their track posed some logistical challenges, as it launched immediately prior to the December holiday season and overlapped with the end of states' fiscal years.

IQO Implementation states reported that they received and read the CMS biweekly emails. Participants from two states reported that they had difficulty accessing the resources listed in the emails via links to Groupsite despite having joined; one state had not signed up for Groupsite. One state participant said that

having to log into the site acted as a barrier to accessing materials, and suggested including original source links to resources in the biweekly emails rather than links to the resource on Groupsite.

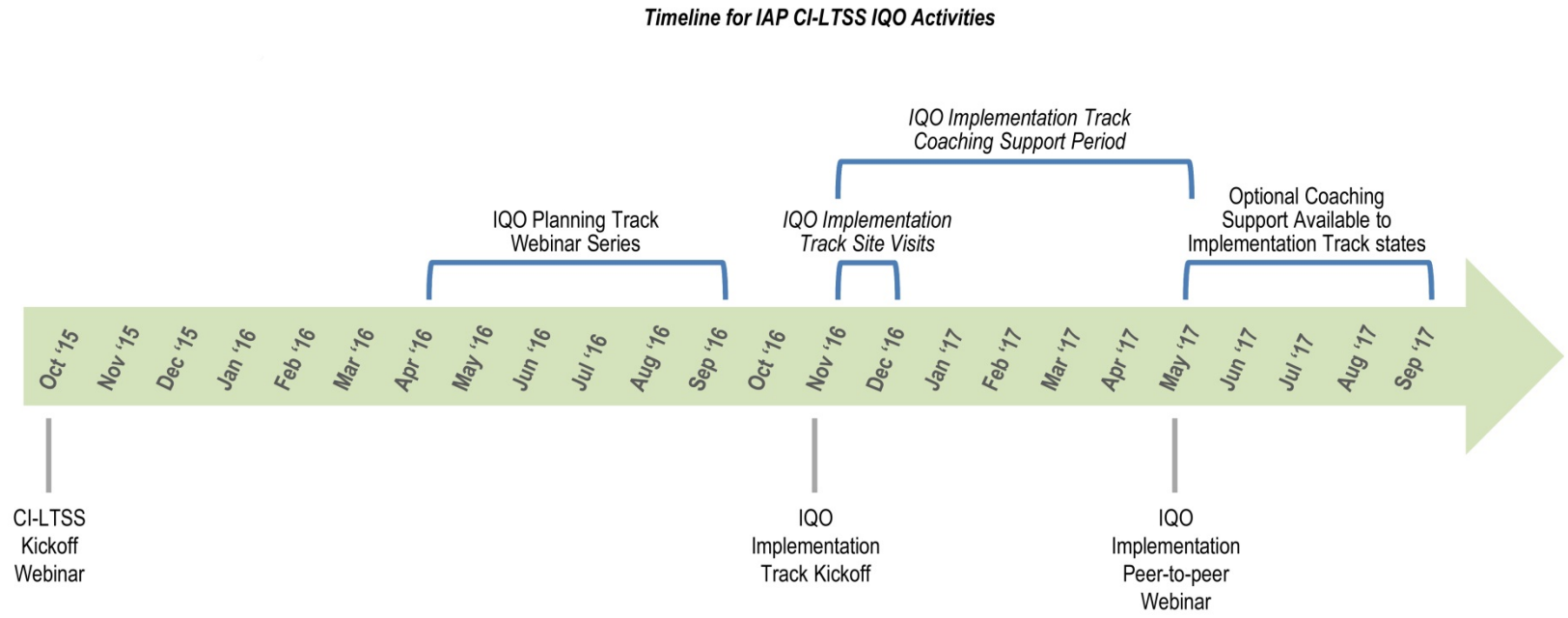
Was the amount of targeted support sufficient? Was it targeted to the appropriate audiences?

Overall the information provided via the IQO Planning Track webinars was sufficient to meet states' needs, as most participating states were in information-gathering and planning stages. States in more-advanced planning stages indicated that they would have appreciated one-on-one targeted support to learn how to apply the information specifically to their state programs. In response to the final post-webinar survey, 50 percent (n=5/10) of the state participants indicated an interest in participating in a more intensive CI-LTSS IQO Planning opportunity if one were to be offered by the IAP. In contrast, another state admitted to not yet feeling ready for more-intensive support, stating that while *"an individually tailored approach sounds nice, because of the newness of this topic [IQO], there are way too many questions to ask and we wouldn't know what to request.*"

IOQ Implementation Track state participants and coaches agreed that the initial six-month period of targeted support was insufficient. Coaches indicated that most states' goals involved long-term initiatives that would take longer than six months to accomplish. One coach noted that the track should not encourage just establishing reform, but also the continual improvement of reform: "*You don't just get the plane off the runway … It's about how it's flying … not 'did we get it out the gate.'*" Coaches and state participants appreciated the extension of optional coaching support following the end of the initial six-month targeted support period.

Exhibit 40 presents the timeline of targeted support provided for IQO Planning and Implementation Tracks.

Exhibit 40. CI-LTSS IQO Timeline



Was the quality of targeted support adequate and sufficiently targeted to meet states' needs?

Overall, the IQO Implementation Track state participants were satisfied with the quality of targeted support. All of the state participants expressed positive feedback about their coach's ability to help them select quality measures. One state participant remarked that their coach offered *"detailed comments on individual measures,"* and others noted that they found the written materials their coaches provided useful. However, state participants wished the coaches' support could have gone further. One state suggested that the scope of the IAP model limited coaches' ability to provide relevant information from other IAP program and functional areas.

> *"There were things [the coaches] were not allowed to do as part of the support they provided to us during the [IQO] Implementation Track … Identifying domains, potential measures, testing the measures … and evaluating what makes the most sense is a process, so some of these tasks should happen simultaneously. However, you cannot get that support to happen simultaneously if the [IAP] services are provided in multiple places and at different times."*

It should be noted that some IQO Implementation Track states later also joined the VBPFS functional area once that IAP opportunity became available.

As shown in Exhibit 38, IQO Planning Track post-webinar survey respondents indicated the highest scores on the HCBS Quality and Outcomes Measures Part III webinar, and expressed appreciation for the CMS presentation on developing quality measures. One respondent commented, "*The presentations provided more in-depth explanations of concepts that we can start to tie back to our current work and discussions. As good educational opportunities do, this webinar [Moving towards Implementation of an IQO Strategy for HCBS] raised more questions than answers*."

Learning

What specific, actionable knowledge did participants acquire from the IAP?

In response to the IQO Planning Track post-webinar series survey, seven out of the 10 respondents expressed that the webinars offered new or more in-depth information, and six indicated that their state had gained a better understanding of quality outcome measurement as a result of participating in the IQO Planning Track. In particular, respondents pointed to the specific quality measures for HCBS, and information on implementing VBP to providers for the HCBS population, as the most useful information discussed in the series.

Following an IQO Implementation peer-to-peer webinar, survey respondents (n=6) indicated that they learned valuable information from other states that they hope to apply to their own delivery reform efforts. Respondents reported learning about different models of reform and approaches to incentives. One respondent noted that while she found the peer-learning opportunity useful, she needed more context: "*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."*

Response

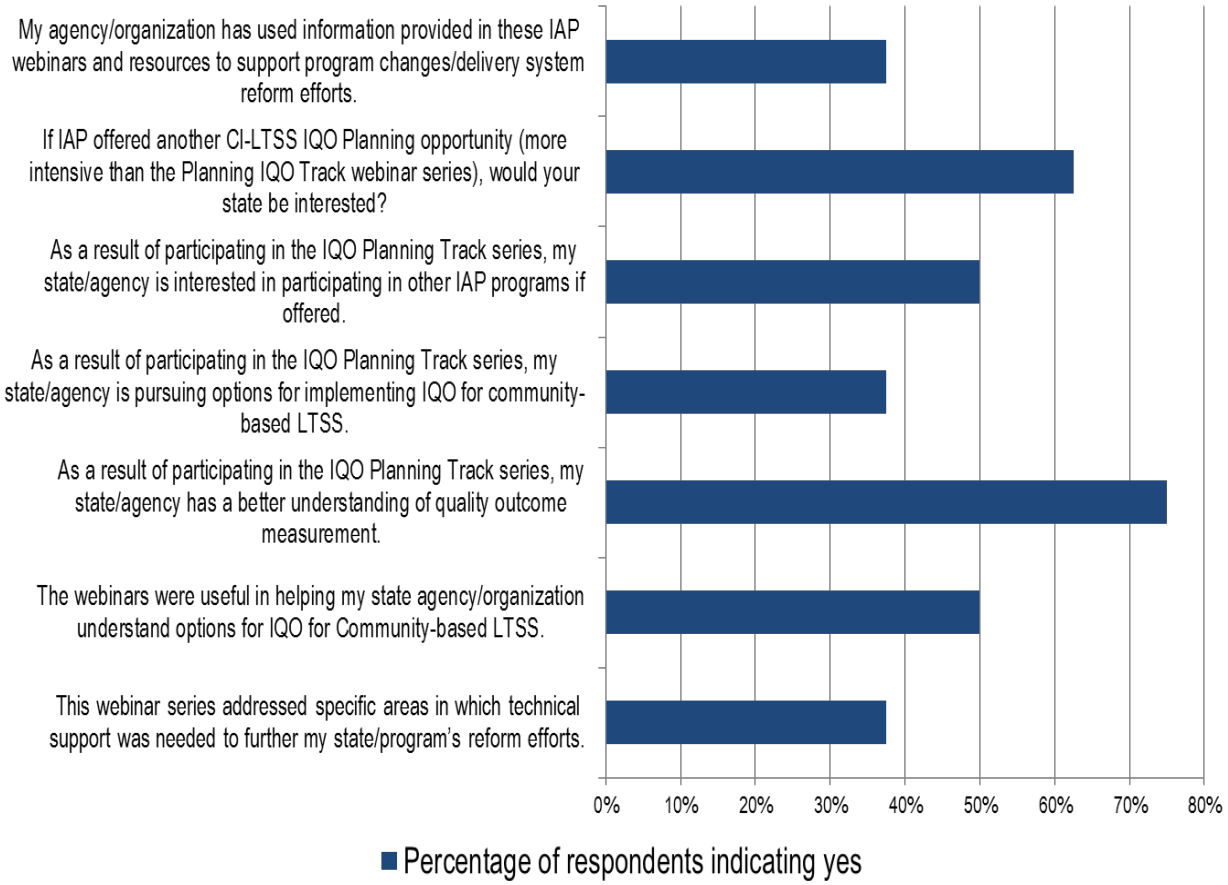
What specific activities or changes did participants undertake in their programs as a result of participating?

On average, across all six Planning Track post-webinar surveys, participants indicated that they intend to apply the information learned from the session (range from 57 percent to 100 percent), in the following ways:

- Developing an IQO work plan (IQO for HCBS webinar)
- Supporting VBP in MCO contracts (IQO for HCBS webinar)
- Exploring use of the National Core Indicators-Aging and Disabilities as part of sustainability plans for their state's Money Follows the Person program (Implementation Planning Based on Lessons Learned from Experienced States webinar)
- Getting more stakeholders' buy-in to VBP methodology (MLTSS and Case Study webinar).

As Exhibit 41 illustrates, 75 percent of the respondents indicated that their participation in the IQO Planning Track resulted in a better understanding of quality outcome measurement.

Exhibit 41. Participants' Ratings of Results of Participating in the CI-LTSS IQO Planning Track (N=8)



Partway through the track, IQO Implementation Track state participants reported that they had more-refined goals and IQO strategies from participating in the IAP. As one state participant said, *"We are clear on how we're trying to pursue goals and what we're looking to do."* All of the states indicated that the coaches helped identify which quality measures to implement. For example, one state applied to the track hoping to learn about person-centered measures for the HCBS population. The state's team members confirmed that their coach taught them about measures specific for this population as part of their participation in the IAP.

Were CMS IAP staff responsive to performance improvement feedback on participant reaction and learning?

IQO Implementation Track state participants and coaches agreed that the track was initially too short for states to implement an effective IQO strategy. Coaches shared this feedback with CMS IAP staff, who responded by offering optional coaching for four additional months after the end of the structured period. Three states elected to continue working with their coach during the optional period.

Results

What happened as a result of the IAP? Did the program support ongoing reform?

Thirty-three percent (n=3/10) of post webinar-series survey respondents participating in the IQO Planning Track noted that they were pursuing options for implementing IQO for community-based LTSS and that their state has used information provided in the webinars to support program changes and delivery system reform efforts. Given the low response rate for the summative survey, it is difficult to assess whether knowledge change and specific initiatives have occurred as a result of states' participation in the IQO Planning webinar series.

IQO Implementation Track state participants suggested that the targeted support they received through the IAP had supported ongoing reforms in their respective states. Participants pointed to waiver renewals, pursuing ACO waivers, and MLTSS finance restructuring activities as examples, noting that the information they had gleaned from the IQO Implementation support had informed that continued work.

What barriers, if any, reduced the impact of the targeted support and other resources?

Results of the six post-webinar surveys indicate that, on average, 65 percent of respondents anticipated that they would face challenges in implementing the lessons learned in the IQO Planning Track, because of resource constraints, especially those related to staffing, and difficulty in ensuring that stakeholders agree with the selected measures.

Five out of six IQO Implementation Track state participants similarly stated they anticipated challenges when attempting to apply what they learned through the IAP. The Implementation Track state participants noted operational challenges, rather than resource constraints, as potential barriers. In particular, one anticipated operational challenges related to the relevance and interpretation of MLTSS data when developing quality measures.

Interim Key Findings: PMH Integration

The PMH Integration program area aims to improve behavioral and physical health outcomes and care experiences for Medicaid beneficiaries with mental health conditions by expanding and/or improving existing Physical and Mental Health (PMH) integration efforts. .

Track: Physical-Mental Health (PMH) Integration Group
Dates of support: April 2016-April 2017 (with ongoing unstructured support)
Targeted support approaches/activities: Webinars, coaching (including driver diagrams and work plans), email updates, discussion groups, Groupsite
Participating states: Nevada, New Hampshire, New Jersey, Puerto Rico, Washington

Track: Integration Strategy Workgroup (ISW)
Dates of support: April 2016-February 2017
Modes of targeted support offered: Webinars, participant post-webinar calls, email updates, Groupsite, targeted support summary memos
Participating states: Hawaii, Idaho, Illinois, Massachusetts

National Dissemination Strategy activities to date: Webinars

Key Findings:

	REACTION • PMH Group and ISW participants found the EOI application process straightforward and minimally burdensome. • PMH Group and ISW participants reported that targeted support was high-quality and customized to meet their specific needs and goals, especially the support from PMH Group coaches and the ISW facilitator. • PMH Group and ISW participants noted that webinar content was useful but did not always align with their specific PMH goals and was sometimes too general for them to apply in their specific context.
	LEARNING • PMH Group participants acquired actionable knowledge and of alternative payment methodologies, quality measurement for high-need populations, and integration of telemedicine into children's behavioral health settings. • Peer-learning was identified as especially valuable in understanding how states are implementing different models and strategies and lessons learned. • ISW participants reported learning about various integration models, value-based purchasing strategies, and quality metrics, and indicated an interest in diving deeper into those topics.
	RESPONSE • PMH Group participants organized and assessed PMH priorities, collaborated with CMS and other Medicaid agencies, and leveraged support to inform policies, processes, and activities related to PI, QM, VBP, and system reforms. • ISW participants planned to use the information acquired to begin discussions with agency colleagues, examine performance measures for managed care, identify gaps in quality measures, and connect with other states to learn from their experiences. Participation facilitated and strengthened cross-agency partnerships.
	RESULTS • PMH Group participants implemented changes in their state's care programs, processes, and delivery systems. Examples include drafting a white paper for the state legislature and implementing a reverse co-located primary care and behavioral health care model. • Both PMH Group and ISW participants noted that competing state priorities and resource constraints made it challenging to implement changes. • PMH Group and ISW participants disseminated information and resources they obtained through IAP to other state agency staff and stakeholder groups.

In December 2015, CMS IAP staff launched PMH, the fourth IAP priority program area. CMS IAP staff identified and refined goals for the PMH priority program area, based in part, on feedback from a technical expert panel that included representatives from state Medicaid agencies, other federal agencies, and national experts that had convened in summer 2015. At the session, panel members discussed the types and modalities of targeted support that would be most useful to Medicaid agencies, as well as considerations for identifying and prioritizing subpopulations (e.g., individuals with developmental disabilities, individuals with severe mental illness, racial and ethnic minorities). The feedback informed the following PMH IAP area goals:

- Improve the behavioral and physical health outcomes and experience of care of individuals with a mental health condition(s);
- Create opportunities for states to link payments with improved outcomes for Medicaid beneficiaries with these co-morbid conditions; and
- Expand or enhance existing state physical and mental health integration efforts to customize for specific populations and/or spread integration efforts to new areas of the state or to new types of health professionals.
- Identify and spread innovations to the field that improve and expand physical and mental health integration initiatives in various settings and for various populations.

The PMH priority program area offered support to two groups of participants.

Five participating teams from Nevada, New Hampshire, New Jersey, Puerto Rico, and Washington received one-on-one targeted coaching support, and will be referred to as the PMH Group in this report. The PMH Group started in April 2016 with one-on-one team calls, and the kick off webinar for PMH Group participants occurred in May 2016. The PMH program area initially allotted 10 months of targeted support for PMH Group participants (called the structured period). However, CMS IAP staff extended the structured period through April 2017 in response to requests for additional time from coaches and participants. Ongoing support has been available to PMH Group participants on an ad hoc basis after April 2017 (called the unstructured period).

Four additional states (Hawaii, Idaho, Illinois, and Massachusetts) participated in a virtual learning series called the ISW. The ISW began in April 2016 with one-on-one team calls, and a kick off webinar occurred in June 2016; the ISW group concluded in February 2017. Information gathered from participant EOI forms and discussions with state participants informed the development of content for the learning activities.

IAP staff kicked off the PMH NDS webinar series in July 2017 to share insights and key learnings from the PMH program with state Medicaid officials and other stakeholders around the country.

Exhibit 42 outlines the status of ongoing and completed activities for PMH Group and ISW state participants as of July 2017.

Exhibit 42. PMH Program Area Interventions

Intervention	Frequency	Intervention Activities[1]	Intervention Status
PMH Group			
Coaching	Varies	PMH Group participants received one-on-one support from their assigned coach, tailored to individual needs and aims. Ongoing support is available on an ad hoc basis.	Ongoing
	Ongoing	The PMH Group participants completed work plans, which they continued to reference while working with their coach.	Completed
Webinars	Five times	IAP staff hosted five webinars.	Completed
Discussion groups	Four	IAP staff facilitated virtual discussion groups between SMEs and PMH Group participants.	Completed
Email updates	Biweekly	CMS IAP staff sent PMH Group and ISW participants' biweekly emails detailing milestones, next steps upcoming events, and relevant resources.	Completed
Groupsite	Ongoing	Groupsite is a web-based library of materials and tools available to IAP participants. It was established to store and maintain information online.	Ongoing
ISW			
Webinars	Three times	IAP staff held a three-part webinar series.	Completed
Participant post-webinar calls	Three times	An ISW facilitator led three post-webinar calls with each participant.	Completed
Targeted support summary memos	Twice	An ISW facilitator provided each ISW participant with two customized memos and an annotated resource list after the ISW participant post-webinar calls.	Completed
Email updates	Biweekly	CMS IAP staff sent PMH Group and ISW participants, biweekly emails detailing milestones and next steps and upcoming events, and providing resources.	Completed
Groupsite	Ongoing	Groupsite is a web-based library of materials and tools available to IAP participants. It was established to store and maintain information online.	Ongoing
NDS			
NDS Webinars	One time	IAP staff held one NDS webinar for Medicaid agencies and stakeholders.	Ongoing

Note. [1] Activities included as of July 2017.

To assess the targeted support activities listed above, the PMH evaluation team analyzed data from various primary and secondary sources (see Appendix A for detail on data sources).

Reaction

Did the application and targeted support planning process identify the most needed targeted support, the most appropriate mode of delivering targeted support, the most appropriate target audiences, and realistic timing/sequencing for targeted support?

IAP staff invited Medicaid agencies interested in the PMH program area to attend an IAP informational webinar in December 2015 and encouraged interested agencies to submit an EOI form. CMS IAP staff, in collaboration with the targeted support providers, reviewed each of the 11 submitted EOI forms and conducted conference calls with applicant teams to identify areas of interest and answer program-specific questions. Exhibit 43 details the initial selection factors for the PMH program area.

The detailed information requested in the PMH program area EOI forms reflected lessons learned from less structured applications in earlier IAP program areas. Though PMH integration efforts target a range of services, providers, and patient types, applicants were asked to explain how their existing program's objectives aligned with the broader IAP goals for the PMH program area.

CMS IAP staff consulted with the targeted support provider to discuss crosscutting themes and needs identified in the EOI letters and conference calls. Information on the submitted EOI forms suggests that applicants were most interested in targeted support to facilitate coordination across physical and mental health providers and health systems, and in identifying PMH quality measures. Additionally, four out of five PMH Group teams indicated on EOI forms that they planned to use targeted support to guide their Medicaid section 1115 waiver applications related to physical and mental health integration.

After reviewing EOI applications and meeting with all applicants, CMS IAP staff created two groups to meet states where they were in developing/implementing PMH integration efforts: the PMH Group and the ISW. ISW was designed to help participants enhance strategic planning and prepare for future program implementation. One state opted to participate in IAP under the impression they would receive PMH Group support, but only later understood that they would be participating in ISW activities. Another ISW participant indicated that "*the application process could help states define their goals a little bit better … to make sure states get the most out of the [IAP].*"

Participating teams in both groups were composed primarily of state Medicaid directors and staff from Departments of Public Health or Departments of Mental and Behavioral Health. However, a few states included team members from other state agencies. For example, one state team included the Department of Corrections to better address the needs of a specific population of interest. Once states were selected, the targeted support provider matched each of the five PMH Group Medicaid program teams with a coach. Whenever possible, CMS IAP staff indicated that matching was based on the coach's knowledge of a state's Medicaid program, and his/her expertise that aligned with the participating team's goals. One coach explained that the matching process helped her feel like she was not *"starting from scratch"* with her team. While IAP staff reported that all the PMH coaches had experience working with state Medicaid programs, they also noted that they were experienced coaches and had expertise in PMH-related topics.

Exhibit 43. PMH Selection Factors

Selection Factors
Factor 1: State team composition reflects commitment and requisite state leadership • Is the proposed team lead well positioned within the state to marshal resources, as needed, for its PMH work? • Does the proposed team have the right composition of members given the scope of its work and is the Medicaid Director involved?
Factor 2: State team composition reflects the goals of its proposed PMH work • Does the team include the relevant staff charged with directing the integration efforts in the state? • Does the team include members from the relevant state agency partners, including, at a minimum, the state behavioral health authority (ies), and align with the scope, focus, and target population of the work?
Factor 3: The state has a current, operational integrated care initiative • Does the state have a Medicaid authority under which it can pay for its PMH initiative? • Does the state have an initial provider network or identified set of providers that are engaging in this work? • Is the state seeking to expand, enhance, or improve this initiative?
Factor 4: Current or proposed state PMH integrated care approach falls within the broad IAP PMH definition • Does the state's current or proposed integrated care approach include primary care and behavioral health providers working together (may be within primary care, in community mental health or other settings; may be via co-location or virtually through ongoing communication or care coordination)? • Is the state's current or proposed integrated care approach directed at an identified population or subpopulation (e.g., general adult population, individuals with certain conditions or diagnoses, people with serious mental illness, other)? • Is the state's current or proposed integrated care approach systematic (i.e., patients are identified and engaged; providers share a care plan or problem list and communicate about identified patients)? • Does the state's proposed approach allow the use of or modifications to existing Medicaid authority (ies) as opposed to seeking new authorities? • Does the state's proposed approach link payment with improved outcomes for beneficiaries in the target population?
Factor 5: Proposed PMH work aligns with IAP goals, and will benefit from IAP approach • Does the state's PMH work target the improvement, expansion, or refinement of current state physical and mental health integration initiatives? • Would the state's PMH work benefit from the PMH IAP support strategies, including state-specific support to improve or expand existing models, program support on existing Medicaid funding vehicles to support integrated care, the use of data and data analytics, performance improvement, and program support on targeting specific populations within the timeline of the IPA-PMH initiative? • Is the state team willing to help spread innovations (within its state) that improve and expand physical and mental health integration initiatives?
Factor 6: State can participate in IAP PMH quality measurement and reporting • Does the state explain how metrics will be used to support payment strategies and/or to target integration strategies to the appropriate population, geographic area, or professionals?
Factor 7: State can gather and analyze data needed for its IAP PMH initiative • Does the state's existing data analytics work demonstrate a capacity and willingness to use data analytics to drive its PMH integration efforts? • Does the state have the infrastructure and staff to gather and analyze data needed to participate in IAP performance improvement activities?

Source. CMS IAP website.

How did state participants (including any stakeholder groups) experience the targeted support process? How did they engage with the targeted support providers?

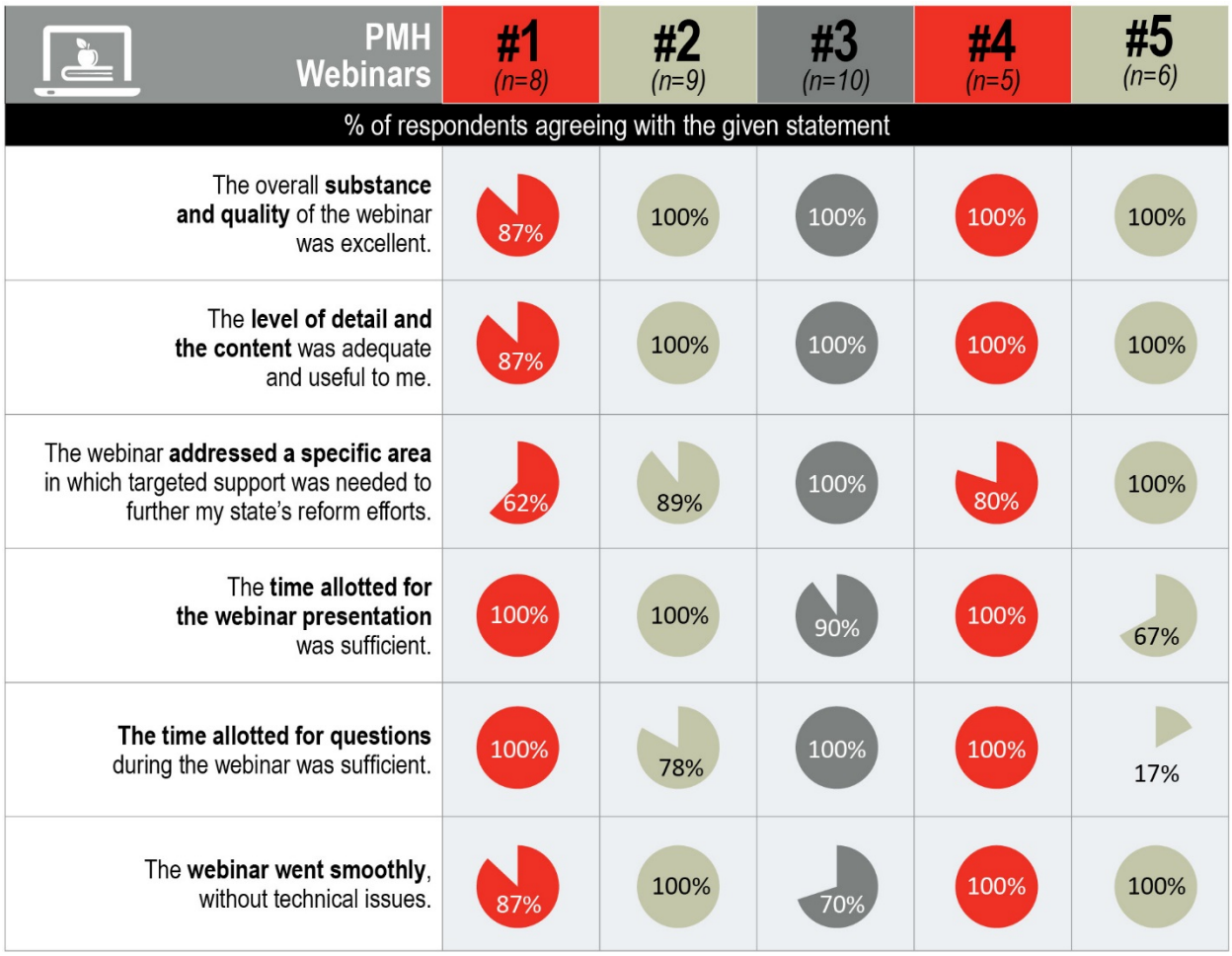
Participants described both positive experiences and challenges, but overall spoke highly of the targeted support they received through the IAP. All five PMH Group state teams engaged with their coaches on a routine basis during the structured period of the initiative. The majority of participant teams established standing calls with their coach, which the coaches supplemented with ongoing, ad hoc email communication. Coaches allowed the state teams to drive the frequency, mode, and duration of meetings. One participant explained that conference calls were at times difficult to arrange due to competing priorities, but they felt that their coach tried to be flexible and accommodating. Another team spoke positively about their coach's flexibility and willingness to *"talk by phone or give us 30 or 15 minutes wherever she can."* Coaches provided PMH Group states with resources and materials that were relevant to each state's goals and priorities. One participant noted that their team pulled together a list of requests, and in response, their coach compiled reference materials and resources from other states working on the same issues. Participants emphasized that this type of support was one of the reasons they wanted to take part in the IAP. One individual explained that the IAP "*provides the opportunity to have someone become the master librarian who gathers all of the information and feeds it to you."*

Coaches described the type of support they provided to PMH Group participants as both process and content support, guided by each state team's work plan and the other tools that coaches developed to support the team's needs. Participant teams indicated that having guidance from their coach and a state work plan template was helpful to guide them through the process. Participating teams and coaches reported using their work plans throughout the duration of the IAP targeted support, with one coach referring to it as a living document that allows flexibility for updating the plan when needed. One team described initially feeling *"lost about where to go,"* but said the coach developed a template to help them organize all of their relevant initiatives and policies. The team noted that this tool from their coach helped them identify initiatives in their state, crosswalk the initiatives with existing policies, list team members responsible for oversight, and note areas for potential change.

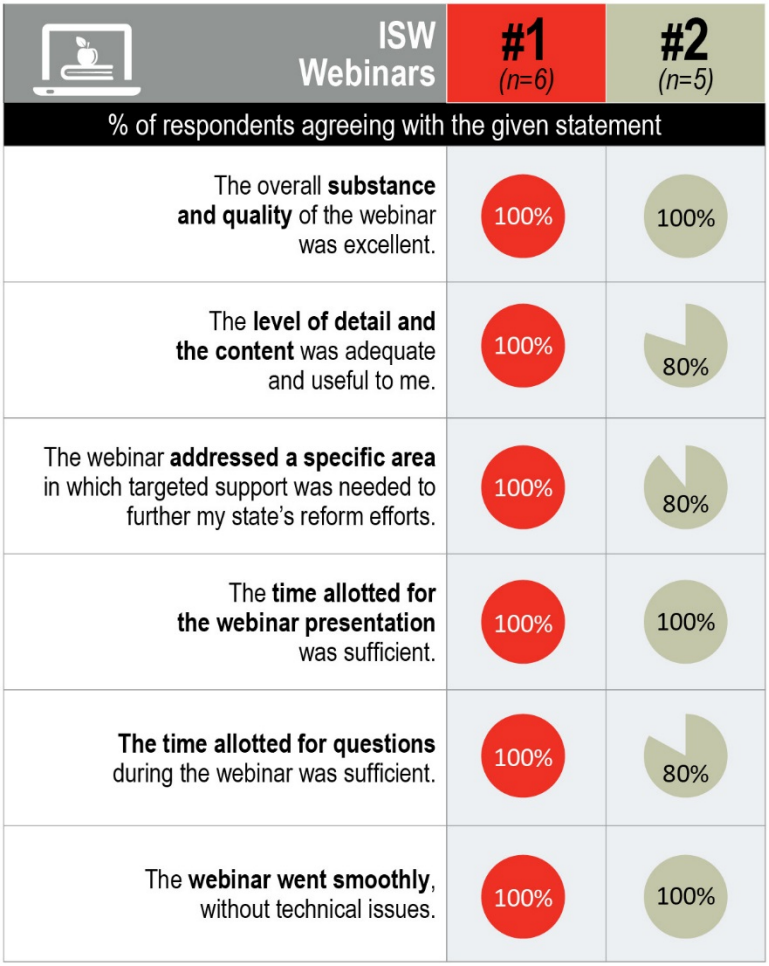
PMH Group coaches and participants suggested they would have benefitted from an in-person meeting at which all coaches and participants could convene, share their PMH program objectives, and troubleshoot common challenges they encountered. One state participant noted that, *"It always helps to get face to face with peers, coaches, and other support teams to kick off organic conversations. Innovation sparks in these settings and that's where you make those connections to other states."*

CMS IAP staff convened five webinars for the PMH Group and three webinars for the ISW Track that covered the topics listed in Exhibit 44. On average, PMH Group participants agreed that the webinars addressed a specific area in which targeted support was needed. However, PMH Group participants reported that they had a hard time recalling the content of the webinars because *"they attend so many webinars that all blend together."* One participant said the PMH Group webinars were *"hit or miss"* based on the topic, while another participant indicated that hearing about integration activities other states were working on during the kick off webinar was interesting and motivating. She noted, *"You don't want to be the one state that hasn't made any progress, but at the same time, you want to listen to other states' issues and goals and deliverables because we are all experiencing the same problems. Hearing how other states solved issues around privacy, data sharing, or working with stakeholders that provided messaging helps us re-engage our thinking."* Learning from the experiences of other teams was one of the reported highlights for participants of the webinars.

Exhibit 44. Summary of Post-PMH Group and ISW Webinar Evaluations



Note. Webinar 1: PMH Kick-Off Webinar for Selected States; Webinar 2: Performance Improvement Overview: Key Methods & Tools; Webinar 3: Overview of the Two Common IAP PMH Quality Metrics; Webinar 4: Physical and Mental Health Integration Measurement Webinar; Webinar 5: Physical and Mental Health (PMH) Integration Closing Webinar.



Note. Webinar 1: PMH Kick-Off Webinar for Selected States; Webinar 2: Integrated Care Measures for Quality Improvement and Payment – Opportunities and Challenges; Webinar 3: Building Provider Capacity for Integration (data not shown due to low response rate).

IAP staff coordinated four discussion groups for the PMH Group that focused on VBP strategies and administrative alignment (i.e., aligning state licensing and regulation to promote PMH integration). The topics were selected based on feedback from states who shared it with their coaches, and from information included in participant work plans. The discussion groups also served as a venue for participants to continue conversations on challenges and to discuss examples of innovative strategies. The discussion groups followed a similar format to the webinars, but provided more opportunity for state participants to ask questions. Participants found the discussion groups to be most helpful when the topic was of interest and when the information was presented in a way that was relatable to the state. One participant shared that *"in order to actively participate in a discussion group, [one needed] to have some basic knowledge of an area."* From her perspective, webinars were more helpful than discussion groups if the state's main objective was to learn.

> *I think in some ways [the follow-up calls] were some of the most useful pieces, since we could tailor [the conversation] to address our particular interests.*
>
> ~ ISW participant

In addition to leading webinars for ISW participants, the ISW facilitator scheduled post-webinar calls with participating teams. Participants found the calls provided directed, targeted support that addressed the individual needs of the state. One

participant shared that the ISW facilitator made helpful connections between webinar content and specific activities within the state. The targeted support provider offered ISW state teams with two customized memos and annotated resource lists after the post-webinar calls. ISW participants found these memos with embedded links and annotations helpful. An ISW participant said that they *"looked forward to this resource."* Participants reported sharing specific resources in the memos with colleagues and also distributing the memos widely across agencies and with external partner organizations. One ISW participant would have liked to also receive copies of the webinar slides directly (in addition to them being posted on Groupsite) in order to share these across their agency and with partner agencies more rapidly.

Overall, participants and facilitators perceived ISW as more structured and less tailored than the PMH Group in meeting the evolving needs of participants. Interviews and webinar observations suggest that more-direct communication between the ISW facilitator and participants might have fostered greater customization of ISW webinar content and targeted support. ISW participants recommended creating discussion groups with subgroups of states by areas of interest to help establish a learning community and tailor webinar content. In addition to the information provided at the kick-off, another suggestion was for CMS IAP staff to provide supplemental contextual information about initiatives under way in each state related to physical and mental health integration. These resources could provide valuable background for the targeted support provider and help states leverage existing resources.

Were the targeted support offerings aligned with states' needs and reform goals?

Throughout the structured period for the PMH Group and ISW, CMS IAP staff engaged in ongoing program planning and development activities, conducted one-on-one calls with PMH Group participants to solicit ongoing feedback about their experience, met regularly with PMH Group coaches and the ISW facilitator, and attended webinars to adapt the program technical support opportunities to align with evolving participant needs.

PMH Group and ISW state participants indicated that their initial goals for the PMH program area were either too broad or not well defined, but PMH Group participants noted that coaches helped them to identify and narrow their focus to more precise topics, priorities, and goals. Exhibit 45 outlines the areas of targeted support that PMH program area applicants identified on their EOI forms. Participants appreciated the effort of CMS IAP staff and coaches to customize the targeted support to meet their targeted support interests for the PMH Group.

Exhibit 45. States' Interest in PMH Areas of Targeted Support (N=11)

Topic	Number of States Expressing Interest
Quality measurement and quality/performance improvement	10
Coordination across providers and systems	10
Data and data analytics	8
Payment reform strategies	7
Clinical models	5
Identifying and targeting discrete populations	4
Other	2

Note. Includes all EOI forms received.

At the conclusion of the ISW kick off webinar, state participants were asked to provide input on future presentations. An ISW participant noted that relying on participants to generate ideas for webinar topics *"was a little hard because if we knew what to focus on, we wouldn't need so much assistance."* Participants and facilitators had mixed feedback about the ISW webinar topics that were chosen. The ISW facilitator reported it was challenging to find common webinar topics that remained relevant and aligned with ISW participant needs throughout the initiative. The time lag between developing webinar content and the actual webinar dates at the beginning of ISW resulted in less flexibility for speakers to address recent changes in the policy landscape. As one interviewee described, a prescriptive curriculum is difficult to modify if determined early in the process. She emphasized the importance of flexibility in the targeted support offerings to accommodate state needs and the rapidly changing climate as a state may "*suddenly veer off because of [other] things going on that affect their initiative, [it could] make a webinar irrelevant … [you need] the flexibility to make real-time modifications."* Despite challenges described, three of the four ISW participants indicated that the content of the targeted support aligned with their IAP goals and existing reform efforts (i.e., state innovation model initiatives, patient-centered medical home initiatives, ACOs).

PMH Group participants similarly thought that the targeted support aligned with and served to inform other ongoing policy reform efforts, such as co-location of mental and physical health providers, rate setting for individuals who are dually eligible for Medicare and Medicaid services, and substance use crises. One team explained how learning best practices and approaches from other Medicaid programs and CMS IAP staff informed their integration efforts. As one state participant said, *"Some of the most valuable information [was] presentations and information from other states on what they are doing. It is always easier to use another state's examples instead of creating something out of nothing."*

Was targeted support provided in an appropriate, convenient, and minimally burdensome format?

PMH Group participants and coaches reported that varying levels and frequency of coaching support were appropriate and convenient for different teams. One coach explained, *"I try to make [targeted support] individualized. It depends on both the level and bandwidth of the state team, whether [that team] has worked in a group before or are new to working together,[and] the size and scope of the team."* For example, during the work plan development process, coaches paced their collaboration according to the teams' preference and stage in the integration reform process. While one coach noted that her state was self-directed in completing the work plan, other coaches described taking a larger role in the process. State participants valued their coaches' flexibility and general responsiveness to their needs. A participant noted, "*The coach was helpful in giving some directions when we found ourselves going in circles."* Another state team suggested that the targeted support could have been even more convenient had the coach sent materials, such as agendas, a few days in advance of meetings to have a chance to review. Additionally, some teams said that they appreciated the connections that their coaches facilitated with other states. One coach noted, "*When we put states on the phone with another state, they devour them. It's noticeable if it's a one-on-one call, they are so energized and it seems like they get so much out of it."*

While PMH Group participants and coaches benefited from the process of developing the work plans, some described the process as more intensive and complex than initially anticipated. One participant suggested additional time and support for goal setting and work plan development be provided to participants at the onset of the program. A coach suggested reframing the work plan as a *"program deliverable"* and for it to serve as a mechanism to document important decisions about goals and objectives, as opposed to using it as a project management tool. In this way, participants might feel a sense of accomplishment when updating the plan. In response, CMS IAP staff and coaches reframed the work plan as a living document to provide ongoing tailored support and document participant progress.

CMS IAP staff and the targeted support contractor aimed to design webinars that were both instructive and participatory. In both PMH Group and ISW webinars, presenters used a variety of approaches to deliver webinar content, including tables that conveyed overarching themes in integration, diagrams with contextual background information, a strategic framework, policy levers, and examples from the field. State participants indicated that supporting concepts with specific case examples or stories from the field in this way facilitated their ability to apply the concepts to their unique contexts. Participants noted that the peer-to-peer engagement was one of the most useful aspects of the webinars. The interaction with other participants and discussion of lessons learned allowed participants to collectively process and consider factors that impact implementation.

Three PMH Group teams found the discussion groups useful, but all three noted that in certain cases the content was not directly applicable their work. One participant felt the content was too far behind the progress they had already made, while another felt it was too advanced. One state noted, *"If the examples [during the discussion groups] are talking about services that aren't provided in the same way you provide them [in your state], it can get a little bit off pace."* Three ISW state participants found the facilitated post-webinar calls helpful, and one noted that the support was directed and targeted. However, one state thought the time lag between the webinars and follow-up calls was challenging because it was difficult to remember the content of the webinar when too much time had elapsed.

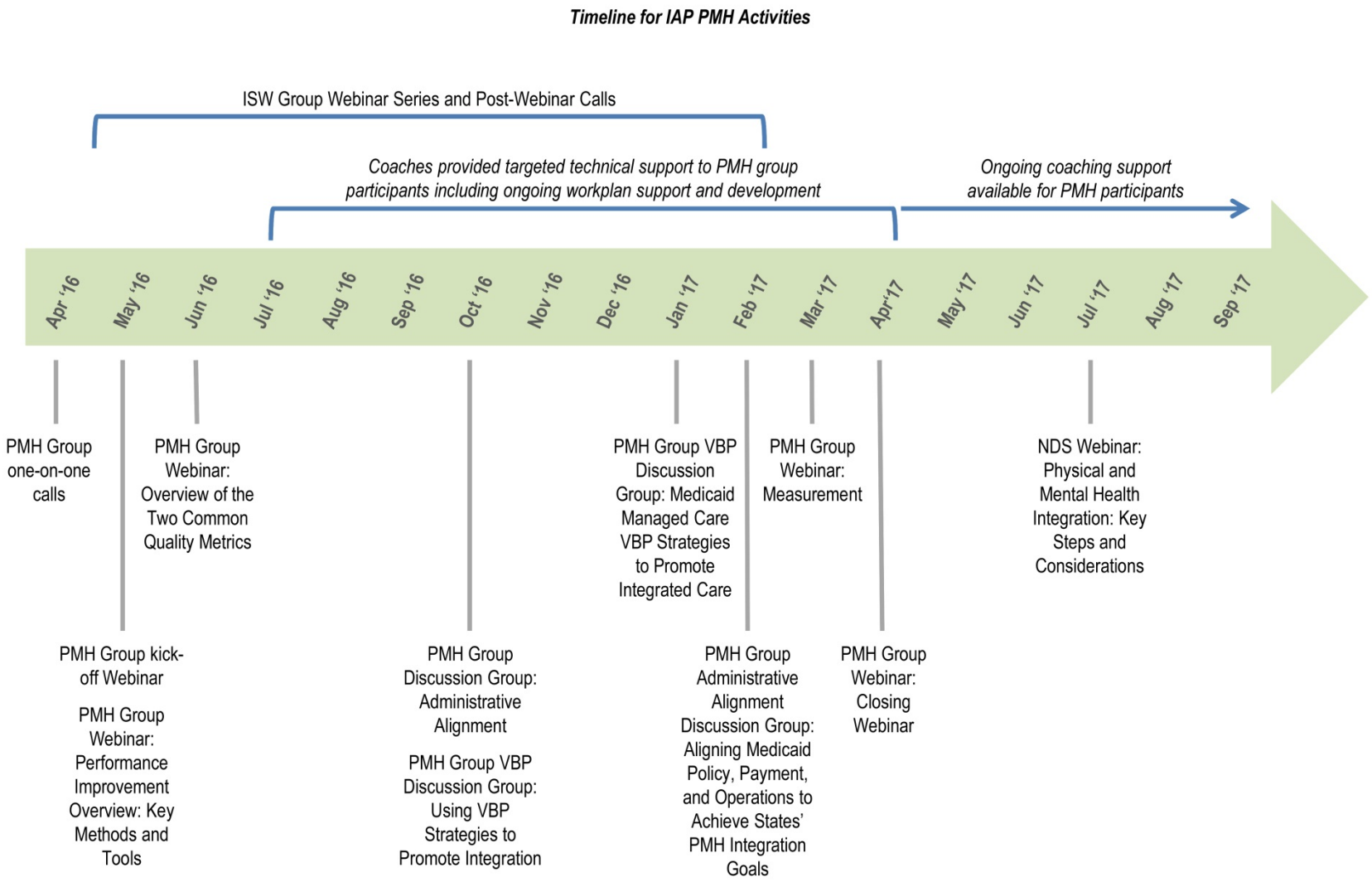
CMS IAP staff sent biweekly emails to participants in both the PMH Group and the ISW to provide program updates and disseminate resources related to physical and mental health integration. One participant reported that these email digests were not only interesting and informative, but they also *"help[ed] us feel more connected to CMS."* Participants and coaches agreed that these summary emails alleviated burden on participants to sift through materials and resources each week to find what could be applicable to their PMH goals. One PMH Group participant felt the biweekly emails were less valuable because they were not tailored to their specific needs "*because the emails were generalized and shared with all the states."* An ISW participant also noted that although they felt the content of the emails could be helpful, it became burdensome for them to log in to Groupsite to view the articles.

Was the amount of targeted support sufficient? Was it targeted to the appropriate audiences?

The structured period for the PMH Group was originally designed to be 10 months, from April 2016 to January 2017. However, based on state feedback, CMS IAP staff extended the timeline through April 2017. Coaches underscored that this extension of the PMH Group timeline was both necessary and helpful, as the process of developing participant work plans early on in the initiative took longer than expected. One coach noted that, "*every state has bandwidth issues. It takes time to develop the work plan, get everything up and running, and understand how the states could use TA … I think a year is sufficient time and is more realistic for what is expected [of the PMH Group participants]."* ISW received support over the course of eight months. Exhibit 46 illustrates the timeline of targeted support provided for both the PMH Group and ISW.

The amount of PMH Group targeted support varied according to participant preferences. In general, coaches indicated that more-frequent communication with teams resulted in faster progress on participant work plan goals. One team noted the regular meetings were necessary to keep everyone focused and on point. Another PMH Group team reported feeling overwhelmed by the amount of targeted support opportunities available, especially when they were asked to present on webinars or calls. This team suggested there should be more of a *"balance of what we receive versus give"* when considering targeted support opportunities and need to prepare presentations about their IAP projects.

Exhibit 46. PMH Timeline



ISW participants expressed mixed views about the amount of targeted support they received. One interviewee noted that individual coaching "*would have been amazing*," but she acknowledged that it was not within the scope of the ISW. Another participant felt that the amount of support was appropriate for their team given that they "*did not really have well-defined goals*," but the ISW support helped them "*find a path forward*" towards improving behavioral health integration in their state. Two ISW participating teams noted that they had reallocated internal resources to other priorities once they had learned that the ISW would provide more-limited support than the PMH Group.

Was the quality of targeted support adequate and sufficiently targeted to meet states' needs?

PMH Group participants were generally pleased with the quality of targeted support they received. In particular, they felt the coaching was of high quality, and all PMH Group teams interviewed expressed interest in reaching out to their coach during the unstructured period should they need additional support. However, despite overall positive feedback on the webinar presentations, two PMH Group teams described the content as not detailed enough for them to operationalize. One of these teams was further along in the integration process than the other participants, and because the webinar content focused on preliminary information, it was no longer applicable to them. As the participant said, *"States are very similar, but also very different in how they implement things … it's hard to pull what's relevant for you."*

Similarly, ISW participants were satisfied with the overall quality of the program, with one participant noting that *"ISW exceeded [my] expectations."* One participant indicated that the targeted support providers listened to their team needs and effectively tailored webinars. Another participant noted that offering state-specific content and solutions was the most beneficial component and that activities were happening "*in tandem with other work that we were doing [in the state]. It was like the fire was lit, and these other opportunities were just oxygen."*

Participants offered suggestions about how to improve the targeted support they were offered. PMH Group coaches and teams from both the PMH Group and ISW suggested that an in-person meeting would have been beneficial to enhance peer-to-peer learning. Participants and coaches suggested that the approaches available to build relationships, particularly virtual meetings with coaches, allowed them to build relationships over the course of the targeted support period, but it was limited in terms of participant interactions and building peer-to-peer relationships. One PMH Group participant expressed the need for more time to ask questions and engage with other participants on webinars. Many coaches and participants suggested that a site visit or in-person kick-off meeting between participants and coaching staff could be a more efficient and effective way to build relationships from the onset of the targeted support period. Another PMH Group participant suggested that it would be helpful to receive strategic planning support at the beginning of the initiative to prepare the team for the work ahead. They suggested that, "*It may have been helpful as part of the application process for CMS to provide some more general information and case studies or other examples of where states have already undertaken similar activities."*

An ISW participant noted that monthly check-in calls with the targeted support provider, in addition to the post-webinar calls, would have helped the team focus and move their work along. Another ISW team suggested that coaching support would be a helpful addition to the ISW targeted support. They appreciated the follow-up calls after the webinars and suggested more time interacting directly with the targeted support provider. Participants recognized that this type of one-on-one coaching support may not have been feasible for a lighter touch track.

Learning

What specific, actionable knowledge did participants acquire from the IAP?

PMH Group participants indicated that they gained actionable knowledge through their participation in the webinars. Across all five webinars, approximately 87 percent of post-webinar evaluation survey respondents indicated that they learned new information and intended to apply it in their states and agencies. For example, following the Quality Metrics webinar, respondents indicated they had learned and planned to apply measure calculation standards. Similarly, following the PI webinar one respondent indicated that the state planned to use the information they had gleaned from the presentation to draft their driver diagram and aim statement. The closing PMH webinar provided an opportunity for PMH Group participants to share accomplishments and lessons learned from participating in the IAP. All of the post-webinar survey respondents (n=6) indicated they gained actionable knowledge from their peers, and noted the following specific areas of increased knowledge:

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

Three PMH Group teams further noted that peer-learning opportunities, often facilitated by the coaches, provided some of the most valuable information obtained from the IAP. Coaches also set up opportunities for states to communicate directly with each other.

> *"These [peer-to-peer] interactions worked well because they were focused on us. We could ask questions specific to [our state], and the state could respond directly with information about how they dealt with the issue."*
>
> ~PMH group participant

ISW participants from two states said learning about various models of integration enabled them to make informed decisions about which model to pursue in their state. Participants also indicated they gained substantial knowledge about VBP and quality metrics, which they planned to apply to current reform initiatives, such as ACO development or telehealth implementation. While participants found the webinar content useful, they noted that they would have benefited from a deeper dive into the information.

Response

What specific activities or changes did participants undertake in their programs as a result of participating?

PMH Group participants viewed the IAP as an opportunity to organize and assess priorities concerning PMH issues and to learn about models and best practices from other Medicaid programs. One participant described the highlight of the IAP as an opportunity for participants to innovate, connect, and interact with CMS and other Medicaid programs, noting "*We are trying to move forward with more up-to-date philosophies in providing services and want to be more efficient and effective.*"

> *"These types of opportunities have helped us improve infrastructure, re-think how we're doing things, improve how we provide service delivery to citizens."*
>
> ~PMH group participant

PMH Group participants also provided examples of how they had applied knowledge to their current Medicaid program's policies, processes, and activities. For example, one team described how the targeted support enabled them to better leverage the capabilities of federally qualified health centers to coordinate the delivery of mental health services. Another team mentioned that guidance they received regarding

billing and coding regulations for PMH service integration was later used to draft state legislation on PMH payment guidelines.

Webinar feedback from ISW participants revealed that 90 percent (n=5) of respondents used the information presented to improve programs and policies in their states. Respondents noted that they planned to use the information to begin discussions with colleagues in their state, examine performance measures for managed care plans, identify gaps in quality measures, and to connect with other states to learn from their experiences.

One team described how cross-agency participation in the ISW taught their "*sister agencies*" (e.g., behavioral health) more about the role of Medicaid. The partner agencies 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 targeted support ended. Similarly, as previously noted, a PMH Group participant reported that they created a new working relationship with the Department of Corrections in their state to work on a prisoner reintegration project.

As a result of their participation in the IAP, PMH Group participants also demonstrated success across PI, quality measurement, and VBP. Exhibit 47 includes highlights from the perspective of PMH Group states at the end of the structured period in April 2017.

Exhibit 47. Select Activities of PMH Participating States

Area of Activity	Select Activities of PMH States
Performance Improvement	• Developed specific, measurable, achievable, relevant and time bound (SMART) goals and driver diagram • Established statewide consensus on PMH goals • Developed a timeline for implementation • Executed statewide core standardized assessment gaps analysis with Integrated Delivery Networks • Developed a work plan to strengthen the integrated care model using pay-for-performance incentives
Quality Measurement	• Collaborated with multiple divisions to determine consistent and efficient measures • Selected 10 quality measures that meet adult and adolescent needs • Met six-month goal of testing 40 percent of the Metro North region's serious mental illness population with the A1C test to screen for diabetes
Value-Based Payment and Financial Simulation	• Launched Integrated Managed Care successfully in first region in April 2016 • MCOs, Practice Transformation Hub, and Accountable Communities of Health began work to transform delivery systems with new integration models and innovative financing • Received technical support on alternative payment models • Received approval for state Medicaid section 1115 demonstration waiver

Source. Data derived from state interviews and PMH Group Closing Webinar held in April 2017.

Were CMS IAP staff responsive to performance improvement feedback on participant reaction and learning?

Analysis of discussions with the PMH Group and ISW participants, coaches, and our observations during webinars, all confirm that the CMS IAP staff have been responsive to participant feedback.

PMH Group participants and coaches reported that the initial timeline for the PMH Group was too short. CMS IAP staff addressed this issue by extending the PMH Group by three months to April 2017. Coaches and participants agreed that the extension helped their teams make substantive progress.

Due to the variation in state team goals and early feedback from ISW participants, CMS IAP staff added post-webinar calls to the roster of targeted support activities for ISW. These post-webinar calls were designed to provide more customized, specific one-on-one support for participants and to help them apply content to reform efforts in their states.

Results

What happened as a result of the IAP? Did the program support ongoing reform?

One PMH Group participant reported that the state incorporated a reverse co-location model in one region, where "behavioral health professionals are [located] in primary care settings and primary care providers are [located] in behavioral health settings." They planned to continue to monitor and evaluate the initiative using tools and quality metrics gained through IAP targeted support, and discussed expanding the model to other regions. Another team drafted a white paper for state Medicaid leadership to use and discuss during an upcoming legislative session. The white paper included data from the follow-up after hospitalization for mental illness measure, which was one of two measures for which PMH Group participants were required to submit baseline data to CMS as part of their work in the PMH program area. One ISW state used the targeted support they received to assist with the implementation of a five-year SBIRT grant.

> *"[Our team was able to] adjust some of the original implementation plans for our [SBIRT] project to lay the groundwork for sustainability and integration."*
>
> ~ISW participant

What barriers, if any, reduced the impact of the targeted support and other resources?

Three teams in the PMH Group identified competing interests and priorities as a barrier to engaging in activities offered through the PMH IAP program area. One team experienced internal logistical challenges in getting their team to prioritize work, given competing demands, and noted that this was especially difficult in the "*condensed timeframe*." Another state echoed this sentiment but said they were able to keep the team moving forward once they began holding internal weekly meetings and biweekly coaching calls. Another state team felt they were not as engaged as they wanted to be, due to competing interests, noting that "*a different world, in a different time, we could have taken more advantage of what IAP [PMH Group] had to offer*." Coaches agreed that some team members did not have adequate time to commit to the PMH work, leading to cancelled meetings and delayed timelines. Coaches emphasized the need for participant teams to be able to attend meetings and devote the time necessary to complete important project milestones.

Coaches also reported that the PMH Group teams did not always include members with the appropriate skills or level of commitment. For example, one coach noted that the team lead did not have the appropriate expertise to move the work forward autonomously, without consulting members of her team at each stage. Instead, the state team lead served as a liaison between the coach and the state SMEs, creating an added layer of communication that the coach found challenging to navigate. The coach believed it would have been more efficient for the appropriate state SME to attend project team meetings.

PMH Group participants described two barriers related to the design of the PMH program area. At the start of the program, participants were confused about the roles of various IAP staff, the targeted support providers, the coaches, and other types of coaching staff such as the PI SME who consulted with

participants about work plans and goals. Participants and coaches thought that defining expectations and roles at the inception of the program would have helped participants to more appropriately direct questions, requests, and concerns. Second, participants and coaches emphasized the importance of having a coach with a strong understanding of the state's health policy landscape. One team suggested that a coach's understanding of these unique contextual factors builds trust early in the coach-participant relationship. To aid with this, one interviewee recommended that CMS IAP staff keep coaches informed of other ongoing Medicaid initiatives that impact participating teams (e.g., section 1115 waiver demonstrations, or state innovation model grants).

As noted previously, coaches and CMS IAP staff found that variation among ISW participant goals and interests made the selection of webinar topics challenging. Some ISW participants mentioned that they would have benefited from a "deeper dive" into the information than the group webinars could provide in order to learn how to apply the material presented on the webinars. The follow-up discussions with the ISW facilitators helped in part to address this need.

Interim Key Findings: DA

The DA functional area provides states with tools that will expand their technical capacity to improve data-driven programmatic decision-making to support delivery system reform. States receive individual support in integrating Medicare with Medicaid data (including data transfer protocols and beneficiary matching).

Track: Medicare and Medicaid Data Integration
Dates of Support: October 2015-October 2016 (with ongoing support as needed)
Targeted support approaches/activities: Webinars, post-webinar discussions, use cases, coaching including site visits
Participating states: Alabama, District of Columbia, New Hampshire, New Jersey, Pennsylvania
National Dissemination Strategy activities to date: None

Key Findings:

	REACTION • Support was targeted but states needed help earlier in the process than was anticipated. • Site visits and recorded webinars were helpful. • Having a coach as a single point of contact to additional SMEs was a streamlined way to communicate.
	LEARNING • States learned the structural, historical, and analytic difference between various Medicare data sources. • States learned about the process and details necessary to request Medicare data.
	RESPONSE • States submitted requests for Medicare data. • States participated in development of use cases.
	RESULTS (Data not yet available.)

The MMDI Track launched in October, 2015 with targeted support to six Medicaid programs (Alabama, New Hampshire, New Jersey, Pennsylvania, Tennessee, and the District of Columbia). It should be noted there is a second DA Track, Data Analytics Technical Support (DA Technical Support); however, findings for this track are not included in this report because it had launched shorty before the close of data collection activities for inclusion in this report. The first six states that submitted EOI forms met the selection criteria and accepted participation in the program. However, one of the six states experienced a change in Medicaid leadership and has not continued to engage in this activity; targeted support to five states continues. The DA Technical Support Track launched in May, 2017 but due to very limited evaluation results to date, the results are not included in this report.

MMDI provides individual targeted support from a team of technical experts to help state participants use Medicare data in conjunction with Medicaid data to improve care coordination for Medicare-Medicaid dually eligible beneficiaries. Each participating state receives a site visit from the targeted support providers, followed by a tailored report describing the state's Medicaid data systems and outlining how the state can approach data integration. In addition, each state receives one or more use cases, which describe the technical approach to integrating a specific component of Medicare data with Medicaid data to address a policy question. The targeted support provider developed a set of generic use cases to help state participants select a specific way to apply the newly integrated data. Exhibit 48 presents completed and planned MMDI activities.

Exhibit 48. MMDI Functional Area Interventions

Intervention	Frequency	Intervention Activities[1]	Intervention Status
MMDI Track			
Webinars	Multiple	IAP staff held webinars, which were also recorded for repeated online viewing.	Ongoing
Development of Use Cases[2]	One time	Technical support staff developed generic use cases and provided assistance in developing state-specific use cases.	Ongoing
Coaching	Varies	All states received one-on-one support from their assigned coach team, tailored to individual needs and aims. One state received intensive support, for three months (primarily on site) from a data architect assigned to assist with the use case.[2]	Ongoing
	One time (potentially more, if needed)	Technical support providers held site visits at all five MMDI states between December 2015 and July 2016. One state had a second site visit in April 2017.	Completed

Note. [1]Activities included as of July 18, 2017. [2]A use case is a list of actions or event steps, typically defining the interactions between a role and a system, to achieve a goal.

To assess the DA targeted support activities the evaluation team examined data from primary and secondary sources (see Appendix A for detail on data sources).

Reaction

Did the application and targeted support planning process identify the most needed targeted support, the most appropriate mode of delivering targeted support, the most appropriate target audiences, and realistic timing/sequencing for targeted support?

States we interviewed expressed a long-standing desire to better understand their Medicaid populations, in particular dually eligible beneficiaries, in order to develop population health programs, to identify individuals who would most benefit from those programs, and to assess the care provided by managed care organizations. The IAP staff found that states need targeted support in three areas: understanding the various formats and uses of Medicare data, preparing a formal request for Medicare data, and integrating the data once they acquired it. Providing support in these three areas added months to the originally anticipated support timeline.

MMDI teams are headed by Medicaid agency leadership staff, such as a chief medical officer or policy director. MMDI teams will require skilled technical staff to implement the programs resulting from the use case. While all five MMDI states included technical staff, changing priorities often claimed their time and energy, leaving them with little for MMDI.

The criteria for selecting states for the MMDI Track focused on the states' needs and planned outcomes, as defined in their EOI (see Exhibit 49). States were asked to indicate their progress in submitting quarterly files of Medicaid and CHIP (Transformed Medicaid Statistical Information System, TMSIS) eligibility and claims data to CMS to ensure selected states were up to date with TMSIS submission requirements. However, applicants were not asked about their level of experience in creating data use agreements with CMS to obtain Medicare data.

> *Where we're at now is feeling like we're kind of left out in the wind without assistance [submitting a data request to the SDRC], trying to figure out the right way to answer questions, which is where we were before we started the whole IAP process, and the reason we didn't move forward with it is we didn't know how to answer all of these questions.*
>
> ~ MMDI participant

The role of the State Data Resource Center (SDRC) is to "facilitate state access to, and use of, Medicare data for Medicare-Medicaid data coordination and program integrity."[9] However, the SDRC only places a facilitation role for states Medicaid agencies, it does not approve data requests or provide actual data. The MMDI coaches could arrange telephone conversations between states and the SDRC, direct the states to specific SDRC resources about the process for requesting Medicare data, and review materials the states related to Medicare access and use. However, only states are permitted to prepare the Information Exchange Agreement or data request package, so IAP coaches were limited in how they worked with states during the development of the data request package.

Some states had difficulty understanding the difference between the support they could get from the coach and that which they could receive from the SDRC. While one state participant demonstrated accurate understanding, stating that *"We think of [SDRC] as part of this project but I know it's not*

[9] "About the State Data Resource Center," SDRC. http://www.statedataresourcecenter.com/about.html, accessed 9/19/2016.

technically part of the project," another wished for *"someone who has been there and done it to walk through [it with us]."* One state realized that, due to an anomalous set of circumstances, it already had Medicare data in the necessary format but needed to work with SDRC to update its DUA to sanction the use of these data for care coordination. Another state participant, describing how his coach *"triages"* his questions, explained that the coach *"kicks it to CMS, or [lets me know] whether I need to kick the question to SDRC."*

Exhibit 49. DA MMDI Track Selection Factors

Selection Factors
Factor 1: Expected Outcomes • States committed to sharing results of linked information with CMS and to publicly disseminating their approach and findings so other states and stakeholders can learn from it.
Factor 2: State Needs and Interest • State can articulate a use case in which the availability to link Medicare data to Medicaid data will support planning or implementation of care coordination for Medicaid and Medicare dual eligible beneficiaries. • States propose to use the linked Medicaid-Medicare data to evaluate State Plan Amendments or waiver programs (excluding Financial Alignment Demonstrations).
Factor 3: Clearly Articulated Program Needs and Experience • States are making progress with submitting Transformed Medicaid Statistical Information System data to CMCS.

Source. IAP Program Support to State Medicaid Agencies: Medicare-Medicaid Data Integration.

How did state participants (including any stakeholder groups) experience the targeted support process? How did they engage with the targeted support providers?

State participants in the MMDI received help from a team of subject matter and technical experts, reflecting each state's data needs and project timeline. A single point of contact for the targeted support team provided a consistent source of information and resources as well as coordinating the project, organizing meetings, and managing documentation.

MMDI Track targeted support officially began with a site visit by the coach to each state during which state teams met with their coach and a full complement of SMEs to learn about Medicare data and the process of selecting a use case. All five state participants interviewed felt the appropriate state officials attended the site visit—technical, policy, planning, and leadership—in part due to the preparation provided by the targeted support provider. However, one respondent suggested that if the coach had asked "*Can you envision any downstream users even six months from now you'd like to bring in?,*" they might have recognized that the process would benefit from also inviting Medicaid MCO staff to attend. Four of five MMDI Track state teams found the site visit helpful. In particular, one state participant found that after the site visit, all stakeholders were *"on the same page in terms of understanding where our data limitations were and where [the targeted support provider] could fill in and help us."* In contrast, one state participant said that while they enjoyed the opportunity to meet people, they "*did not understand the necessity for the site visit before, during or after it. It seemed like a lot of energy for something that wasn't real helpful,*" as they felt they did not discuss new information.

The MMDI Track targeted support provider offered webinars to help state participants understand the Medicare data options (see Exhibit 50). The two webinars broadcast so far were recorded and posted on the CMS IAP website so state participants could access the technically complex information repeatedly, if necessary. At least one state participant listened to a recording rather than attending the live session, and listened multiple times together with the targeted support provider.

Exhibit 50. Data Analytics Webinar Topics

Webinar Number	Topic
MMDI Webinars	
1	Coordination of Benefits Agreement (COBA) Mapping and Recommended Data Structures. Part 1: Overview & Data Source Comparison
2	COBA Mapping and Recommended Data Structures. Part 2: Data Element Mapping

Note. Webinars posted to CMS's Medicaid IAP website as of July 2017.

MMDI Track state participants generally found the webinars to be useful. One state participant reported that they did not receive an answer to a question posed during the live webinar. The presenter did reply that the question was too detailed to be addressed on the webinar. It is unclear whether the question was addressed separately. (Note that a post-webinar survey was not conducted).

> *"I have no doubt that when I walk away I'm going to be able to use that data and to use that software and if I have any questions about it, I can call them up or email them and say I need some help on something."*
>
> ~MMDI participant

Some MMDI states developed one or more of their own use cases. One state proposed 21 possible use cases at the site visit. To help the state choose the most appropriate use cases to start with, their coach created a matrix to help the multiple state agencies involved review the state's priorities, potential data sources, and timing requirements. Other states selected a use case from a repository of customizable, generic use cases created by the coaching teams. Access to a variety of use cases helps state participants understand the range of applications of integrated data. One state participant chose its use case very quickly from that set, "*We looked at the options, looked at each other, and said, boy, that [choice] is about as obvious as the nose on your face.*" At least two MMDI Track states will receive additional direct support in the form of software code. One state was assigned a data architect to work primarily on the state's use case for three months on site, which the state participant found to be the most effective assistance provided. Another state participant indicated that the most valuable aspect of the targeted support was "*extra people to do the work*" because the state staff didn't have "*an infinite amount of time.*"

Some MMDI Track state participants' prior experience with Medicare data actually made the MMDI process more complicated. All states used Medicare data to ensure that Medicare pays for services for the dually eligible when possible, but the data format is not approved for use in improving care coordination. It took many months for one state team and its coach to fully understand the implications of their situation. The team discovered that their use of the Coordination of Benefits Agreement (COBA) data had never been documented correctly, and thus they needed to file new DUAs, which the state participant interpreted as having to *"back up four steps, back to square one."* This setback affected their perception of the project as a whole.

In general, MMDI Track state participants felt the timing of targeted support was reasonable. For example, one participant stated that "*[The coach] moved us along but it wasn't like they would have rushed us.*" When asked whether the targeted support met the state's needs, another state participant gave an overall score of eight on a scale of one to 10, with timeliness and responsiveness earning a 10.

State participants universally reported on their coaches' professionalism and organization. Most state participants reported that the coaches asked good questions and understood their needs. The state that

received the first site visit felt the visit was a bit awkward, while a state that received a later site visit reported that the targeted support provider brought an understanding gained through prior visits. One respondent spoke highly of the emotional safety of working with their coach, and of being able to *"freely communicate with folks without fear that you're stepping out of bounds … that kind of oil helps the process along immeasurably."*

Were the targeted support offerings aligned with states' needs and reform goals?

The MMDI Track is well aligned with state participants' fundamental need to better understand their dual eligible populations in order to achieve the reform goal of improving care, and controlling cost of care, for this population. As one respondent pointed out, *"You can't get to the truth, and be as objective as you can, without having comprehensive data."* The state participants we interviewed reported a long-standing desire to integrate Medicare data in their respective states, and told us that the IAP MMDI targeted support opportunity prompted their action on applying for those Medicare data.

The MMDI Track EOI forms identified the policy topics states sought to address using combined Medicare and Medicaid data. All participating states planned to use the data to assess the dual eligible population's health care utilization patterns and needs, and to evaluate and develop programs for subpopulations of the dually eligible such as homeless or severely mentally ill individuals. Two of the five selected states noted that they will first use the data to identify their dual eligible population (see Exhibit 51).

Exhibit 51. States' Interest in DA MMDI Track Areas of Targeted Support (N=5)

Topic	Number of States Expressing Interest[1]
Policy and analytic topics to be addressed with integrated data	
Understand the health care utilization patterns of the dually eligible population.	5
Evaluate and improve payment models and programs for subpopulations of the dually eligible population.	5
Identify the dually eligible population.	2
Develop health risk algorithms and plot geographic distribution of dually eligible population.	1

Note. Includes EOI forms for participating states only.

It became clear during the coaches' initial site visits that the state participants were earlier in their MMDI process than IAP staff had expected. State teams needed to learn about their own Medicaid data management structures as well as about Medicare data in order to request appropriate and useful data elements and formats. The targeted support provider adapted to the states' needs, and spent considerable time educating state participants and directing them to the State Data Resource Center which plays a role in helping states understand the DUA process and requirements for accessing Medicare data from CMS.

Was targeted support provided in an appropriate, convenient, and minimally burdensome format?

In general, MMDI Track state participants appreciated the effort taken by the coaches to make sure they understand the states' goals for using the data. Having a single coach as the primary contact and having that coach engage other SMEs as necessary helped streamline communication between state participants and the targeted support team. On the other hand, addressing miscommunication can be more challenging with a single point of contact. Two state participants expressed that they felt the coach misunderstood their status. In one case, the misunderstanding was cleared up on a webinar, when a third party recognized

that the state had an unusual situation which could be addressed on a separate telephone call with multiple entities.

> *"In listening to us and taking our complaints or feeling our pain, they handled it really well and understood exactly what we were talking about."*
>
> ~MMDI participant

State participants told us that meetings with their coaches are executed efficiently, and email helps to maintain communication between meetings. One respondent noted timely communications; their coach typically responds to email within an hour. They also appreciated the efficient and transparent transition from one coach to another when one state coach was replaced by another. Another explained that, "[The coach] *tested us when we needed to be tested and they backed off when they needed to back off. It felt like the right level of interaction.*" Further, one coach reported that during the 2017 Health Datapalooza, a state participant comment about being happy with the *"level of engagement with the MMDI team."*

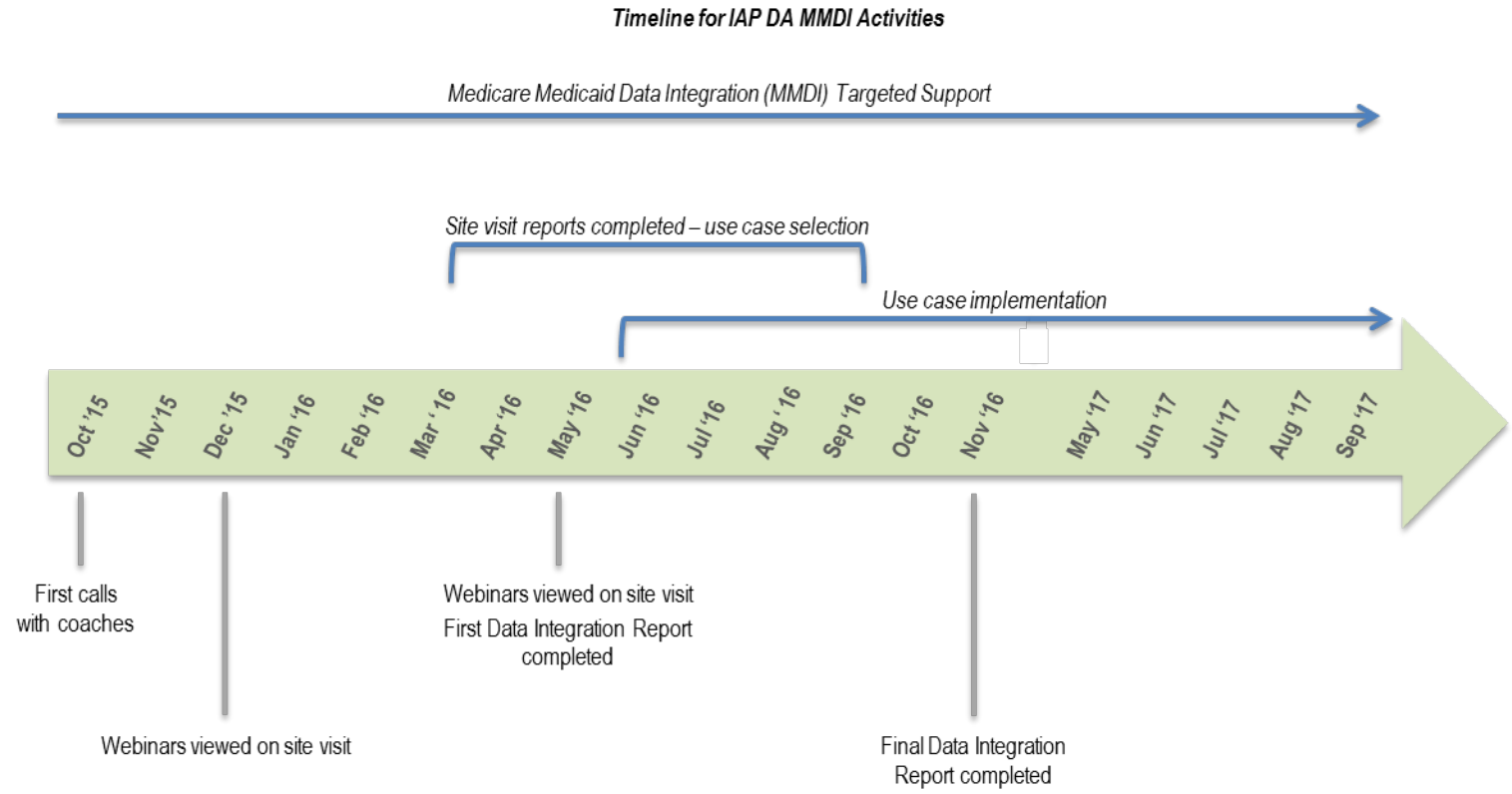
Was the amount of targeted support sufficient? Was it targeted to the appropriate audiences?

To a large extent, the MMDI Track state participants determine the amount of targeted support they need and receive from the targeted support providers. Many state participants described temporary disruptions to their involvement due to changing priorities and then re-engaging with the coach. In turn, the coaches describe the process as *"really collaborative and iterative with the states we're super involved with."* One state participant reported a lack of responsiveness on the part of the coaches; however, it is evident that the state made a particular request that was outside of the scope of the targeted support available through the IAP. Nonetheless, the state's coach facilitated a telephone call with the appropriate resource to assist the state participant in getting appropriate help outside of the IAP.

The targeted support involves more hands-on work by SMEs than was initially expected. In two states, coaches have enlisted technical expertswrite software code and teach Medicaid agency staff how to implement that code. One state participant described the support as *"being taught to fish,"* meaning that the targeted support allowed him to develop the skills to perform the work himself in the future. That state has made so much progress on its use case that the state is in the process of selecting a second use case.

Exhibit 52 show the timeline of targeted support provided for MMDI.

Exhibit 52. DA MMDI Timeline



Was the quality of targeted support adequate and sufficiently targeted to meet states' needs?

The MMDI Track state participants' varying responses to the questions on targeted support speak to the challenge of developing a model that is appropriate for states with vastly different backgrounds and levels of experience. The assistance provided by the coaches would have been more helpful if they had had a better initial understanding of each state's Medicaid data structure. One state participant expressed an understanding of the coach's initial confusion over the complexity of their systems, and two state participants described the site visit as being an important opportunity for the targeted support team to understand the states' systems. Face-to-face conversations have "*a certain efficiency, [allowing] a creative process*" that is hard to achieve in a telephone conversation One state participant expressed admiration for the speed with which the support team understood the data, *"thinking to myself, boy they're catching on to this faster than I did."*

Three of the MMDI Track states reported having biweekly meetings (in-person when geography allows, or by telephone) with the coach and relevant SMEs. Another state corresponded with the coaching team primarily by email and, when a data architect was onsite, held weekly meetings with him and monthly meetings with the project management staff. The state participants universally reported that these meetings were well-organized, with agendas sent ahead of time, and that they included outstanding documentation. However, one felt that they had the same conversation repeatedly: "*biweekly meetings to know how the project is moving along is a great concept… the same issues keep getting brought up and we just don't seem to move on them."*

Learning

What specific, actionable knowledge did participants acquire from the IAP?

Through their participation in the MMDI IAP, state participants learned specific, technical details about requesting and using Medicare data in conjunction with their Medicaid data. Medicare data are available to states in three different formats: (1) Chronic Condition Data Warehouse (CCW) data, which are available no less than four months after the service to allow time for payment to be completed;[10] (2) COBA data, which states can receive within two weeks of the claim being submitted to CMS, so the healthcare services data are current. COBA data can be used for financial analysis, with preliminary claims being replaced as payment is determined: (3) Enhanced COBA data, which includes claims that are excluded from standard COBA data. When merged with Medicaid data, the enhanced COBA data yield a more complete, current clinical profile of dually eligible beneficiaries.

Only enhanced COBA data can appropriately be used to inform care management or program integrity, per CMS policy. This was initially confusing to some state participants, who were familiar only with using Medicare data for financial analysis. Through their participation in the IAP MMDI Track, they learned how and why the data formats differ and technical reasons why enhanced COBA data are appropriate for use in care management. In addition, all state participants learned the requirements for

[10] Claims go through a process called adjudication which involves the payer determining whether to pay the entire billed amount or a portion of the billed amount, and the provider possibly contesting the decision. The process may take months before the claim is "fully adjudicated," with an agreed-upon amount paid. During that time, claims may be replaced by newer claims with updated payment information.

requesting data from CMS, which include detailed requirements, such as specifying for which analytic purpose each data element will be used. As one state participant explained, *"our technology side was very capable, but our understanding of the [available] data was not."*

State participants also faced a steep data learning curve regarding activities that state personnel must complete with regard to writing and signing DUAs with CMS. Participants learned the importance of understanding how the data will be used to address specific policy needs as well as ensuring proper data management.

Response

What specific activities or changes did participants undertake in their programs as a result of participating?

All MMDI participants submitted or are in the process of submitting a DUA through the SDRC to use Medicare data for their state. State participants refer to the application process as "*complicated*" and "*complex*." One participant, with more technical than policy background, noted the difficulty in providing a detailed explanation of how the state will use each data element without having prior experience with the data: *"I'm just a data geek and I want to get the data so I can play with it."*

Results

What happened as a result of the IAP? Did the program support ongoing reform?

One MMDI Track state has nearly completed its first use case, but it is too early to report results.

What barriers, if any, reduced the impact of the targeted support and other resources?

Two types of barriers impacted MMDI targeted support. State participants' perceived level of experience may have been a barrier to communication. The two state participants who felt they had significant miscommunication or redundant conversations with their coaches also report being *"ahead of the curve in terms of the information they were trying to give us"* and *"pretty far ahead in the process"* of acquiring and using Medicare data, so that "*we were beyond what was being discussed on the webinar.*" Despite this perception, these two states were slow to initiate MMDI. Their coach site visits took place four to five months after the introductory call, and they were slow to select a use case.

Other barriers were structural. First, leadership changes, whether at the gubernatorial or agency head level, distracted from current initiatives and resulted in changing priorities and in staff being unavailable. Second, as reported by at least three of the five MMDI coaches, most states' Medicaid Management Information Systems (MMIS) are managed by vendors, increasing the cost and timeline associated with implementing changes. Third, some MMIS systems were in flux, either being upgraded or in the process of a re-procurement. State participants sometimes requested a delay in MMDI so they could focus on the system change first, then integrate Medicare data into the new structure. Finally, states with Medicaid MCOs receive data from the MCOs and merge it to create a single Medicaid data repository, rather than collecting the data on health care services directly as in a fee-for-service payment system. This extra step delays integration of Medicare data.

When the coaches began working with MMDI Track state participants, every state participant struggled to understand the variety of Medicare data sources, structures, and valid uses. It also became clear that accessing the appropriate Medicare data presented a hurdle. Medicare rules require that state participants complete the data applications themselves, in order to ensure that they understand the data and security

requirements. The coach can direct the state participant to resources, including State Data Resource Center staff and a generic use case, but only states can complete the form.

The Medicaid data are also complex, and state participants had to understand their state's Medicaid data systems before deciding what Medicare data to request. The targeted support provider learned that each state has at least two different Medicaid data platforms into which the Medicare data will be integrated. The first platform is the MMIS, and the second is typically a data warehouse of quality results or containing data from multiple state agencies. Each platform has unique characteristics and requirements. The second platform is often managed by a state agency other than the agency in which Medicaid is housed, requiring that second agency's cooperation. Working through these technical issues can slow the progress of MMDI Track participants towards their IAP DA goals.

Synthesis of Key Findings

The IAP is testing various modes of targeted support and their effectiveness in supporting states in their Medicaid reforms. Each IAP program and functional area offers a unique combination of support modes that are summarized in Exhibit 53.

This section presents a synthesis of interim key findings across the four IAP program areas and one IAP functional area that have actively engaged states since the inception of the IAP in 2014. Specific challenges and suggestions for program improvement have emerged from the evaluation data gathered from state participants, coaches, targeted support provider organizations, and CMS IAP staff. In a rapid-cycle feedback process, these lessons learned have been shared with CMS IAP staff and, at times, directly with targeted support providers. Using a continuous quality improvement approach, CMS IAP staff have refined program elements based on the suggestions received and the learning styles of program participants. At this mid-point in the implementation of the IAP, the interim findings provide a window into the IAP's early successes and suggest possible directions for future program modifications. In keeping with its purpose to test various modes of targeted support to states, the IAP offerings are expected to continue to evolve to address challenge as they arise and to incorporate additional lessons learned.

Key findings, including lessons learned and resulting program adaptations, are summarized below. First, this chapter describes key findings related to the design of a targeted support program for state officials. Second, this chapter examines key findings related to each of the group and individual targeted support modes included in the IAP. The chapter concludes with a brief discussion of barriers to the impact of targeted support.

Exhibit 53. Summary of Modes of Targeted Support Offered In Each IAP Program and Functional Area Active to Date

	SUD HILC	SUD TLO	SUD 1115 Strategic Design Support	BCN	CI-LTSS HRSP Supporting Tenancy	CI-LTSS HRSP Partnership Cohort 1	CI-LTSS IQO Planning	CI-LTSS IQO Implementation	PMH Group	PMH ISW	DA MMDI
Webinars	X	X		X	X	X	X	X	X	X	X
Post-webinar discussions		X								X	X
In-person meetings	X			X		X					
Email updates	X			X		X	X	X	X	X	
Discussion groups			X	X		X			X		
Targeted support summary memos										X	
Groupsite virtual resource library	X			X		X	X	X	X	X	
Individual Assistance											
Coaching	X		X	X		X		X	X		X
Driver diagrams	X			X		X					
Use cases											X
Work plans or action plans								X	X		
Crosswalks						X					
Site visits				X		X		X			X
Check-in calls with CMS staff	X		X	X					X		

Key Findings Regarding the Design of Targeted Support to States

At approximately the midpoint of this evaluation, we have had the opportunity to observe the start-up of work in three IAP program areas (SUD launched prior to the onset of the evaluation) and one IAP functional area. Through interviews, focus groups, and surveys, our evaluation sought feedback from state participants and IAP coaches about their experiences learning about and starting work in the IAP areas. Below, we present some of the key findings about setting up a targeted support program and communicating with applicants and participants.

IAP topic areas align with states' needs and reform goals

The selection of the IAP's priority program and functional areas was a deliberate process. CMS IAP staff gathered quantitative and qualitative feedback about possible areas for support from stakeholders including Medicaid leaders, other state officials, providers, associations, and advocates. CMS IAP staff sought input at three one-day open-door sessions held in Baltimore, Maryland, Chicago, Illinois, and Denver, Colorado, and one virtual listening session. Attendees were asked to prioritize topics by importance and need. Altogether, nearly 400 people representing 20 states participated in these sessions. The participation of states in all of the IAP areas offered thus far suggests that Medicaid programs see the program and functional areas that emerged from this process as important. In most, though not all, program and functional areas, the number of applicants has equaled or exceeded the available opportunities for participation. Several state participants identified functional area topics—namely using data and quality measurement—as areas of need within the program areas where they sought support. This aligns with CMS IAP staff intent that all IAP program areas include opportunities to receive support in performance improvement, quality measurement, VBP, and data analytics.

Detailed applicant information is needed to optimize state selection

Generally, across the IAP program and functional areas, participants reported that the targeted support they were offered aligned with their needs and reform goals. However, in some of the IAP program and functional areas there were challenges in matching the Medicaid programs' readiness to make reforms with the targeted support provided. For some programs, IAP support may have come too late, as they had already enacted significant reforms. In other areas, coaches found that the participating states were not as advanced in certain technical areas as had been expected, and adapted their support accordingly. Finally, a few state teams lacked the decision-making authority or resources to implement changes identified through the targeted support opportunity.

To indicate interest in each IAP program and functional area, states submitted a short application, known as an EOI. The selection process employed by CMS IAP staff was iterative from one IAP area to the next, and evolved over time to include more-detailed EOI forms and explicit team composition criteria. The refinements that led to the current EOI form through iterations from one IAP area to the next are outlined in Exhibit 54.

The process now employed is as follows: The completed EOI provides information about a state's IAP project team, lists the state's goals for participation in IAP, and identifies the state's needs for targeted support. CMS holds a one-hour conference call with each state that submits an EOI to discuss the state's goals and targeted support needs and to answer the state's questions about the IAP area. Using the information gleaned from the EOI forms and conference calls, CMS then selects states for participation based on criteria specific to each IAP opportunity.

This highly structured approach to the EOI and state selection process may help set realistic expectations among state applicants and allow them to narrow their goals for IAP participation to align with available

support and realistic timeframes. Nonetheless, the IAP exists in the context of multiple federal initiatives that overlay state-specific programs, concerns, and other financial and policy factors, which makes it difficult to judge the readiness of an individual state for IAP participation in a single area at any given time.

Exhibit 54. Comparison of EOI Forms

Requested information	SUD	DA MMDI	BCN	CI-LTSS HRSP Cohort 1 and IQO	PMH
	Nov 2014	*Jul 2015*	*Aug 2015*	*Dec 2015*	*Jan 2016*
State team information	Identify Medicaid lead, data lead, single state agency for SUD lead, other potential stakeholders	Identify Medicaid agency team lead; describe team composition	Identify Medicaid team lead and agency; list state agency or provider partners	Identify Medicaid team lead and agency, other team members; list state agency partners	Identify Medicaid team lead and agency, other team members; list state agency partners
States goals for participation	What states would like to achieve through the program (i.e., specific topic areas or types of data analysis)	Goals and partners	How state's BCN work would align with IAP BCN goals	How state's CI-LTSS work would align with IAP CI-LTSS goals	How state's PMH work would align with IAP PMH goals; how state's goals and program support relate to data analytics, incentivizing integration, and quality measurement
Most helpful areas of program support	Not addressed	Not addressed	Choose most helpful areas of program support from eight options including "other" write-in	Choose most helpful areas of program support from five options (IQO) or seven options (Partnerships) including "other" write-in	Choose most helpful areas of program support from seven options including "other" write-in

Source. EOI forms, information session slides, fact sheets, state selection factors documents, and overview documents, as available for each program and functional area.

States need clear expectations regarding time commitment and level of effort

CMS IAP staff provided information about the structure and goals of each IAP program and functional area to potential participants through the application materials, conference calls with applicants, and in some cases, informational webinars. Despite these efforts, some state participants found that the IAP targeted support they were offered did not match their expectations. In particular, some states were surprised by the emphasis on performance improvement in certain IAP tracks. A few states made requests of coaches that went beyond the support coaches were able to offer within the IAP's parameters. Expectations about level of effort, what assistance participants will receive, and what time and experience participants must offer should be clear and explicit. Our review of the EOI forms, information session slides, and other materials available online found that CMS IAP staff provided information on the expected value of IAP participation for every program and functional area. The information sessions

presented the types of targeted support participants would be offered. However, the application materials did not explicitly address level of effort expected from state teams. It is possible that some state participants did not understand the timing or sequencing of targeted support, or the time commitment required for productive participation.

State teams must include staff experts and key decision makers

The participants in the targeted support provided by the IAP were self-selected. In shorter IAP tracks, such as SUD TLO, CI-LTSS Supporting Tenancy, and CI-LTSS IQO Planning, state participants were assembled ad hoc to join webinars. In longer IAP tracks, states determined their teams' composition based on the project and on information provided by CMS IAP staff during the EOI review period. In general, this self-selection approach led states to choose staff to participate in the IAP who were appropriate audiences for the support being offered. However, a few challenges related to team composition surfaced as state teams continued work on their projects.

In keeping with the theory that adults learn best when content is organized around tasks,[11] the IAP asks each state team to design a project that applies IAP content to a state-specific policy or program. In order to apply what they learn, state teams need the ability to make decisions and act on those decisions to carry out the projects they have designed. Across IAP program areas, some state teams lacked the authority or resources to carry out their proposed IAP projects. As a result, progress was slow while IAP teams sought buy-in or resources from appropriate state officials. On the other hand, very senior Medicaid officials may not be the most appropriate team members for day-to-day activities. Some state teams struggled to meet CMS's initial expectations (since revised) for Medicaid agency leadership participation in IAP targeted support (e.g., webinars, calls with coaches). It is more efficient for state participants in IAP program areas to brief Medicaid leadership on progress, as appropriate.

In some IAP program areas, a few states grappled with determining which agencies to involve in their IAP projects. State participants appreciated that the IAP gives them the opportunity for more focused and intentional collaborative efforts among state agencies. However, it was not always initially clear to state participants which IAP activities would be directed primarily to Medicaid staff or when other agency employees should be actively engaged.

To facilitate optimal state team configurations, CMS now more explicitly articulates the expectations regarding team composition, including requiring Medicaid leadership sign-off on EOI forms. A tailored discussion with each state team about how to ensure that team members have the expertise, authority, and resources to further Medicaid reforms could also be incorporated into the IAP's solicitation, orientation and onboarding activities. In addition, CMS IAP staff could consider holding specific, limited IAP activities to which senior agency leaders are invited and that they are encouraged to attend.

The ideal length of targeted support is difficult to determine a priori

The amount of targeted support offered in different IAP tracks within the four program areas and one functional area described in this report varied according to the goals of the track. The shortest period of support offered was in the Supporting Housing Tenancy Track, which consisted of a series of three

[11] Knowles, M. (1984). *Andragogy in action: Applying modern principles of adult learning.* San Francisco: Jossey-Bass.

webinars over three months. The longest-running support is offered in the functional area, where participating states will receive individual coaching for at least 12 months, with extensions possible.

Throughout our evaluation, we heard differing views on the ideal length of targeted support periods for the IAP program areas. Some state participants felt they needed more time to complete their IAP project activities. Similarly, several states reported difficulty carving out time to focus on their IAP projects in the face of competing priorities. In contrast, other states expressed that a compressed timeline created a positive sense of urgency and focused attention on the IAP project. In all four program areas, state participants wanted a longer period of targeted support than was initially offered, and CMS IAP staff accommodated these requests. State participants across the program areas said that the program and policy changes they were attempting took longer than the initial support periods and that the start-up phase was often slower than had been anticipated. As additional IAP areas begin, CMS IAP staff are responding to this feedback by designing longer initial periods of support.

The ideal length of targeted support for a specific state in a particular IAP program or functional area can be difficult to determine *a priori*. CMS has extended the targeted support period for several program areas to offer states ongoing coaching assistance if needed, beyond the original program timeline. These program extensions have been well received, and are a reasonable option for CMS IAP staff to retain in future IAP cohorts.

Key Findings Regarding the Effectiveness of Group and Individual Targeted Support Modes

The IAP program and functional areas offer a range of targeted support modes, in different timeframes and combinations, to deliver targeted support to participating state teams. Overall, state participants across the priority program and functional areas reported a positive experience with the IAP targeted support. State participants interacted with the targeted support providers primarily through individual coaching, in program and functional areas that included the coaching intervention, and through webinars in those areas that emphasized group learning. The majority of participants in more concentrated targeted support tracks described active interactions with their assigned coach, consisting of regular meetings and ad hoc email exchanges. In more than one case, a state participant described the strong sense of trust that the state team developed in the state's coach. Our observations of group learning program area webinars and NDS webinars also revealed active engagement of participants. State participants at these events engaged with targeted support providers through virtual means, as gauged by the number and content of participant questions available to our evaluators. In addition, participants at group learning program area webinars expressed a desire to continue the learning opportunities, and sometimes requested additional, more tailored support.

Below, we present key findings about different group and individual targeted support modes, and their perceived effectiveness.

Effectiveness of Group Targeted Support Modes

States bring different levels of prior knowledge, experience, and technical skills to their IAP work. This variation can lead to challenges in designing and delivering both group targeted support. Among a diverse group of states, it can be difficult for participants or coaches to readily identify areas where states can learn from one another. In some cases, one state may be more advanced than the others, and thus always be thrust into the role of teacher; conversely, a state may feel they are lagging behind and be reluctant to ask questions that appear too basic. Skillful facilitation of peer learning activities can help overcome these disparities, but they pose unique challenges for fostering group unity. One coach observed that when

states are working on similar projects, there is more flexibility for coaches to tailor individual support while maintaining group cohesion; conversely, when states are working on diverse projects, coaches may need to identify less obvious common issues to create group cohesion. Findings specific to in person meetings, webinars, and other virtual peer-to-peer learning activities are summarized, below.

In-person meetings

Some IAP program areas (i.e., SUD, BCN and CI-LTSS) have included in-person meetings as a means of delivering targeted support to states. State participants continue to express a strong preference for in-person meetings as a means to build connections across states and provide momentum within state teams. Participants from the SUD, BCN and CI-LTSS priority program areas rated these events as both useful and relevant on post-event evaluation surveys. Participants and coaches in the PMH area, which did not include an in-person meeting, expressed a desire for such a meeting as an opportunity to build relationships and a sense of cohesion among participants. They felt that in-person meetings are the best way to foster connections among state teams, across states, between state teams and coaches, and with CMS IAP staff. Further, 44 percent of respondents to the CI-LTSS IQO Planning Track post-webinar series survey selected in-person meetings with states as a desired mode for additional support to states that want to pursue an IQO initiative for HCBS.

CMS IAP staff structured in-person meeting agendas to allow both formal peer learning and peer-to-peer networking among state participants. While meeting time is often scarce, networking opportunities are highly valued by participants and are less likely to occur outside of the face-to-face setting. Formal peer learning was fostered in facilitated roundtable discussion sessions. Less-formal peer-to-peer networking was encouraged at meal times, with lunches often set aside for networking. One meeting also included a short break dedicated to networking. These opportunities were well received by participants. On the other hand, optional networking dinners were not well attended. One suggestion made by a state participant for an in-person peer learning activity is a “gallery walk,” a poster session at which attendees circulate and ask questions of one another.

Given broad federal limitations on in-person meetings, other approaches to building relationships could include a virtual meeting via video conference at the inception of the program or an in-person kick off meeting between participants and coaching staff (i.e., a coach site visit to the participant’s state, or a small-group in-person meeting in a central location with multiple participants and coaches).

Webinars

All four IAP program areas included webinars on which experts provided information and examples. Participants’ judgements of webinar quality varied. Commonly expressed criticisms included: that webinar topics were not relevant to issues a state was working on, that the examples provided in webinars were not applicable to a state watching that webinar, and that webinar content was not detailed enough. Given that webinars overall were rated as high-quality in post-webinar surveys, these specific criticisms may speak to the difficulty in developing content for a diverse group audience that can meet the needs of all participants. It should also be noted that, in some IAP areas, including SUD, BCN, PMH, and MMDI, CMS IAP staff selected webinar topics based on suggestions or expressed preferences from participating states.

Over time, CMS IAP staff made adaptations to some IAP area webinars to enhance their utility for participating states. For example, CMS IAP staff added polling questions to make webinars more interactive. In addition, as states’ IAP projects matured, CMS IAP staff invited participating states to share their experiences as webinar speakers. Finally, CMS IAP staff added to some tracks an option for

post-webinar discussions between a state team and the webinar presenters. These discussions allow more in-depth, tailored consideration of topics addressed on the webinars. PMH ISW state participants noted that the post-webinar calls were targeted to specific state needs, which they found particularly helpful. In contrast, post-webinar calls involving only IAP state participants were not successful in stimulating conversation among BCN participants.

Although early SUD and BCN webinars were not recorded, CMS now consistently records webinars so that states can readily access their content and share webinars with colleagues. These recordings enable greater IAP reach and promote sustainability within Medicaid programs as new staff join a state IAP project team.

Virtual peer-to-peer learning

As noted throughout the program and functional area specific chapters, state participants highly value peer-to-peer learning as an element of IAP targeted support. Across program areas, state participants reported that they benefit from hearing from one another and appreciate having peers provide feedback and suggestions on their own approaches. The IAP program areas have offered various virtual peer sharing opportunities, in addition to presentations by state participants at in-person meetings and on webinars. These have generally been well received.

How best to facilitate activities to optimize peer sharing remains a challenge, however. Our observation of peer learning opportunities noted that, despite their stated enthusiasm for this mode of support, state participants did not always actively engage with the virtual peer learning events that the IAP offered. For example, a peer-to-peer call series offered to the CI-LTSS Partnership Track mustered only moderate engagement by the state officials who attended.

State participants told us in interviews that they appreciate having agendas, thought questions, or other probes in advance of peer discussions so that they can prepare their questions for one another and examples to share with their peers. This comports with Malcolm Knowles's adult learning theory,[12] which postulates that adults should be involved in planning their own educational experiences. Focus group discussions also revealed that participants value informal peer learning opportunities as much as structured settings for peer sharing. IAP coaches can continue to encourage participating states to reach out to one another for peer learning.

[12] Knowles, M. (1975). *Self-directed learning: A guide for learners and teachers.* Chicago: Follett Publishing Company.

Effectiveness of Individual Targeted Support Modes

The different IAP program and functional areas place varying emphasis on individual versus group support. Generally, functional areas place more emphasis on individual support relative to group learning than do program areas. Individual support is facilitated by a targeted support provider identified as a coach. In some IAP program areas, a single coach works with the state IAP project team; in other program and functional areas, the coach acts as a liaison between the state IAP project team and a larger team of SMEs ready to work with states as their needs are defined. In both cases, individual support helps states develop concrete action steps based on information they learn through their IAP participation.

Coaching

State participants across program and functional areas provided positive feedback regarding the individual coaching offered by the IAP. Across all IAP program and functional areas, participants reported that coaching was one of the most valuable aspects of program participation. In the few instances in which individual participants in the BCN program area, CI-LTSS Partnership Track, and DA MMDI Track expressed dissatisfaction with the quality of coaching, it appears there may have been a misunderstanding by participants about the type of support coaches could offer.

Early in the implementation of the IAP, both program participants and coaches reported initial difficulty understanding the role of an IAP program area coach. Some states were disappointed when they were informed that their requests for coaching assistance went beyond the targeted support envisioned for a given IAP area. Others were frustrated when individual coaching was delayed while states completed strategic planning and goal setting. For their part, coaches wrestled with what they perceived to be their dual roles as a program overseer—ensuring participants completed project planning tools—and as an expert advisor or mentor, offering advice and resources. The CMS coaching orientation calls were valuable in orienting coaches to their roles, and a similar orientation for program participants on what to expect from the coaching role could help participants take best advantage of this resource.

In response to state feedback regarding the desirability of one-on-one support, CMS IAP staff added individual support in select program areas. For example, the PMH ISW participants expressed a need for more individual support, leading the CMS IAP team to add post-webinar discussions with SMEs to the menu of targeted support offerings. In multiple IAP program and functional areas, CMS IAP staff extended the timeline for coaching support beyond that for group activities so that states could continue to draw on coaching resources.

Project planning tools

IAP program and functional areas introduced state participants to a variety of project planning tools, including driver diagrams that illustrate causal pathways to allow for performance improvement, use cases that define IT requirements, crosswalks that compare Medicaid and housing resources, and work plans that specify project responsibilities and timelines. These tools were applied early in an IAP program or functional area's timeline to help states focus their goals and conduct strategic action planning.

Participants' reviews of these IAP tools were mixed. While most participants found the tools helpful, a few described them as "*busywork*." In particular, the driver diagrams posed challenges to state teams, who were often in the early stages of program planning and unable to apply the performance improvement steps embodied in the driver diagram tool. Other frustrations state participants voiced regarding project planning tools included: the time required to complete crosswalks and perceived rigidity regarding the structure of work plans. Some participants did note, however, that the full value of the tools became clear to them only in retrospect. This underscores the importance of making clear at the outset the application

of any tool to a state's IAP project implementation of the targeted support engagement, as adult learners are task-oriented.[13]

Site visits

Three IAP program area tracks (i.e., BCN, CI-LTSS Housing Partnerships and CI-LTSS IQO Planning) and one functional area track (i.e., DA MMDI) included site visits where coaches traveled to spend time with participating state teams. It should be noted that although all states in the CI-LTSS Housing Partnerships Track had access to coach site visits, not all states used this support. Although CMS IAP staff articulated the availability of site visits during early webinars, some states were unaware of the option. In contrast, all CI-LTSS IQO Implementation Track and DA MMDI Track states did take advantage of coach site visits.

In the priority program and functional areas that included site visits, the majority of state participants we spoke with told us they found the site visits useful. For example, several participants in the CI-LTSS Partnership Track described the in-state meetings facilitated by the site visits as important to advancing their project activities. In the DA MMDI functional area, one participant specifically noted the creativity that flourished at the face-to-face meetings enabled by the site visit.

Barriers to the Impact of Targeted Support

Three specific barriers were reported by program participants as impeding the impact of the targeted support they received through the IAP. First, IAP participating states within each program and functional area were at disparate points along the continuum of their Medicaid delivery system reform efforts. Some programs had already implemented many of the concepts addressed by IAP, and thus reported that they gained little new knowledge; other programs were in the earliest stages of Medicaid reforms and found that the information provided through IAP support was beyond their current level of capacity to incorporate. Second, states across IAP program and functional areas pointed to competing demands, limited resources, and staffing constraints as hindering the implementation of tools and knowledge obtained through IAP participation. In some cases, state teams lacked participation from key decision-makers needed for project implementation. Finally, one state participant felt that an assigned coach's lack of state-specific contextual knowledge hampered the coach's ability to proactively address state needs. Despite these challenges, states overall assessed their participation in the IAP as having a positive impact on ongoing reforms.

Summary

The Medicaid IAP targeted support staff engaged directly with state Medicaid officials and their partners on areas identified by states as priorities for payment and delivery system reform, providing a combination of individual support and cross-state group learning opportunities. Our findings suggest that this blend of group learning and individual support modes is appropriate. While state participants appreciate group learning as a means to learn new information and share ideas, they also want an opportunity for tailored discussion about how the information they have received relates to their own, specific circumstances. In some instances, participants told us that the various modes of targeted support

[13] Merriam, S.B. and Caffarella, R.S. (1999). *Learning in adulthood: A comprehensive guide.* San Francisco, California: Jossey-Bass Inc.

complemented or even reinforced one another. For example, ideas presented in a webinar could be further discussed with peers or explored more deeply with coaches. In this way, learning through one mode reinforced or built on information first gained from another mode. One state said that the *"IAP is valuable in helping to look for that innovation, and as you come up with an idea, IAP can connect you with someone who can assist you. Without that service, you'll lose innovation at the state level because there are a lot of conflicting priorities."*

State participants welcomed the range of targeted support offered across program and functional area tracks, which allows them to engage at a level that is feasible and productive given their unique state circumstances. As one participate stated, *"It's important that you have the intensive [track] and this [lighter] model as well. … it's a great resource for us and for our staff."* State participants also appreciate the mix of targeted support modes within a program or functional area, finding differing modes of support most useful at different points in the design and implementation stages of their IAP projects.

IAP interview, survey, and focus group respondents reported that they are applying the targeted support that was offered and can identify specific new knowledge that they have gained. Participants, particularly in the IAP program areas that have been active longest, were able to cite specific, actionable knowledge they have gained through IAP.

As initial IAP program areas draw their structured support periods to a close, early findings are beginning to emerge regarding the ways in which the IAP supports reform in participating states. Some IAP areas or tracks are explicitly targeted for states in the planning stage; other IAP areas and tracks select state participants already implementing relevant Medicaid delivery system or payment reforms. In addition, some tracks offer longer, more dense engagement than others. As a result, the activities and changes that participants undertake in response to their IAP participation range widely. In general, IAP program area tracks that included one-on-one coaching as one mode of targeted support had more concrete results to share than did tracks that received only virtual, group support. However, it would be premature to draw any firm conclusions regarding which areas of IAP best supported ongoing reform. Although the structured support periods for some of the program areas have concluded, enough time has not yet elapsed to fully assess state Medicaid reform outcomes.

Some challenges arose throughout the implementation of IAP targeted support in the different program and functional areas. CMS IAP staff have been responsive to feedback from state participants and coaches, and to recommendations provided through rapid-cycle evaluation feedback, and have made modifications to program and functional area targeted support offerings accordingly. Across the IAP program areas, state participants indicated that being involved in the IAP has helped to raise their state's awareness of ongoing Medicaid reforms, and they have begun to implement some of the lessons learned through the IAP to further their intended health systems reforms.

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Appendix A: Evaluation Methodology

Introduction

The goal of the IAP is to offer states resources to support ongoing Medicaid reform initiatives; the goal of the evaluation is to provide an independent assessment of the IAP intervention. With the exception of SUD, an initiative that launched prior to the evaluation award, the timing of the evaluation has been simultaneous with the sequenced roll-out of targeted support across the program areas. That approach has enabled the evaluation to address both the implementation and impact of states' processes and outcomes, as well as provide the CMS with rapid-cycle feedback to inform real-time modifications to the IAP.

This document presents the evaluation research questions, evaluation framework, data sources, data collection strategy, and analytic approach used to conduct an independent assessment of states' experiences with, and the efficacy of, the IAP, and to provide CMS with rapid-cycle feedback. CMS has articulated four primary research questions for the evaluation:

- How do states experience the IAP targeted support?
- Did the IAP support ongoing reform?
- Are there aspects of the IAP that can be improved?
- Should CMS replicate the IAP model in the future?

To address these questions, Abt's evaluation is:

- Assessing the **processes** employed in providing targeted support and other resources for their alignment and responsiveness to state needs and the IAP objectives
- Assessing the **intermediate outcomes** of the IAP relative to the aim of supporting ongoing reform efforts
- Providing CMS with rapid-cycle performance improvement feedback on these processes, to allow ongoing refinement and **continuous performance improvement** during the implementation period
- Supporting a determination of the **appropriateness of the IAP model** of targeted support and resources for future CMS use

Research Questions and Evaluation Framework

Research Questions

From a conceptual perspective, we designed an evaluation plan where we consider the targeted support and other IAP resources as the intervention to be evaluated. Our specific research questions align with the scope of the cross-setting questions articulated by CMS. Exhibit A1 delineates these questions by type (process or outcomes).

Exhibit A1. Primary Research Questions, by Type

Process Questions
What themes emerge regarding states' experience with the targeted support, including successes and barriers?
How useful was the targeted support to the states?
Did the participating states feel that the four program areas (i.e., SUD, BCN, CI-LTSS, and PMH) and the functional areas were consistent with their current efforts to reform the delivery system?
Did the states feel that the level of targeted support and engagement was sufficient to spur actual change in their health care delivery system?
Were the targeted support and other resources based on and aligned with a comprehensive assessment of participants' needs?
Was the targeted support provided using evidence-based approaches?
How were the targeted support and other resources delivered? How were the support and other resources experienced?
Was the content perceived as useful, relevant and adequate?
Outcome Questions
What type of plans did states develop as a result of participation in the IAP? Were any new programs implemented or being planned as a result of the IAP?
Was CMS successful in addressing the targeted support needs identified by states to support their delivery and payment reforms?
Did participation in the IAP targeted support produce any changes in the launch and implementation of state-level health care delivery reform efforts in the IAP program areas?
Are the HILC states more prepared to produce delivery system reforms in the IAP program areas compared to the TLO states? What factors were associated with the successfulness of these two groups?
Did knowledge change as a result of IAP participation? Was this knowledge sustained throughout staffing changes?
Was new knowledge applied/implemented and what were the challenges to implementation?

Evaluation Framework

Our evaluation framework is based on the Kirkpatrick model[14] for evaluating training and technical assistance (i.e., targeted support), adapted to our research design. Exhibit A2 shows detailed research questions and related qualitative analytics, along with the descriptive information that will complement these qualitative analyses. The specific research questions are categorized by the four domains of the Kirkpatrick model: Reaction, Learning, Response, and Results. This evaluation framework is being applied to each of the four program areas as well as the functional areas, as appropriate. Data sources and analyses are described in greater detail in subsequent sections.

Exhibit A2. Methodological Approach Using the Kirkpatrick Framework

Model Domain	Detailed Research Questions	Data Sources	Qualitative Analyses	Descriptive Data
Reaction	Did the EOI forms and targeted support planning process identify the most needed technical support, the most appropriate mode of delivering technical support, the most appropriate target audiences, and realistic timing/sequencing for technical support?	Expression of Interest forms, interviews with staff providing targeted support and with state participants; driver diagrams; published and unpublished state materials; and other resources	Summary of EOI responses and design activities	Number of states reporting that the planning process reflected their suggestions/requests/ input
	How did state participants (including any stakeholder groups) experience the targeted support process? How did they engage with the targeted support providers?	Direct observation of targeted support activities such as in-person meetings and webinars; post-event surveys; in-person and telephone key stakeholder interviews; in-person and virtual participant focus groups	Description of states participating in each program area and their level and mode of engagement; additional information from analysis of post-event surveys	Number of states and number of state staff participating in each type of targeted support activity
	Were the targeted support offerings *aligned* with states' needs and reform goals?	In-person and telephone key stakeholder interviews; in-person and virtual participant focus groups; post-event surveys	Summary of state participant feedback on alignment with reform goals, including analysis of needs met and unmet, by topic; analysis of post-event surveys	Number of states reporting alignment with reform goals

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

Model Domain	Detailed Research Questions	Data Sources	Qualitative Analyses	Descriptive Data
	Was targeted support provided in an *appropriate, convenient, and minimally burdensome* format?	In-person and telephone key stakeholder interviews; in-person and virtual participant focus groups; observation of in-person meetings; post-event surveys	Summary of state participant feedback on appropriateness and convenience of targeted support activities, including any emergent themes on barriers to participation, perceived burden, and recommended changes in targeted support offerings; analysis of post-event surveys	Number of states reporting that targeted support activities, such as webinars and one-on-one coaching/ facilitating, were convenient to access
	Was the amount of targeted support *sufficient*? Was support targeted to the appropriate audiences?	In-person and telephone key stakeholder interviews; in-person and virtual participant focus groups; summative, post-event surveys	Summary of state participant feedback on the amount of targeted support received, and exploration of themes related to perceived inadequate or excessive targeted support activities; narrative stratified by high and low intensity users; analysis of post-event surveys	Number of states reporting receiving "enough" targeted support to meet their needs/expectations
	Was the *quality* of the targeted support adequate and was the support sufficiently targeted to meet states' needs?	In-person and telephone key stakeholder interviews; in-person and virtual participant focus groups; post-event surveys	Summary of state participant descriptions of satisfaction with targeted support; analysis of post-event surveys	Number of states reporting that they have applied information gained from participating in the IAP to their reform efforts. Number of states reporting that the targeted support received through the IAP impacted their ability to make progress toward their reform goals
Learning	What *specific, actionable* 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 feedback on new knowledge acquired from specific targeted support activities and about their perceived ability to act on this knowledge; barriers to actionability; analyses of survey data	Number of states reporting increased knowledge related to evidence-based practices for treating SUDs, etc.

Model Domain	Detailed Research Questions	Data Sources	Qualitative Analyses	Descriptive Data
Response	What specific *activities or changes* did participants undertake in their programs as a result of participating?	In-person and telephone key stakeholder interviews; in-person and virtual participant focus groups; post-event surveys; summative survey; review of administrative state materials	Summary of state reported activities and initiatives stemming from participation in technical support activities; analyses of survey data	Number of states that increased use of data analytics to identify beneficiaries with complex medical needs (considering baseline status); number of states promoting medication-assisted treatment for Medicaid recipients with SUDs; number of states adopting new Medicaid quality metrics, etc.
	Were CMS IAP staff *responsive to performance improvement feedback* on participant reaction and learning?	CMS interviews; direct observation of targeted support activities; summative survey	Description of changes or modifications to targeted support implementation, and stakeholder feedback on how performance improvement feedback was used; analysis of summative survey	Number of changes to targeted support mode or timing; new targeted support topics
Results	What happened as the result of the IAP: did the program support ongoing reform?	In-person and telephone key informant interviews; summative survey; review of administrative state materials	Narrative summary of state responses to questions about changes in the timeline and intensity of planned reform efforts, including why ongoing efforts were or were not supported; analysis of summative survey	Number of states reporting they implement planned reforms ahead of original schedule; number of states proposing/pursuing new reforms
	What barriers, if any, intervened to reduce the impact of the targeted support and other resources?	In-person and telephone key informant interviews; in-person and virtual participant focus groups; summative survey	Narrative summary of targeted support-driven behavior change goals, and barriers to achieving those goals; analysis of summative survey	Number of states unable to implement some/all targeted support-driven behavior or programmatic change due to specific barriers (funding, staffing and turnover, political climate, competing initiatives, etc.)

Data Sources and Data Collection Strategy

Given CMS's goals to understand states' experiences with and response to IAP targeted support, and the need for real-time performance improvement feedback, our evaluation uses a qualitative research approach, supplemented with descriptive statistics obtained through web-based surveys.

To minimize state burden, we conducted calls with the CMS IAP staff program and functional area leads, and the targeted support contractors. These calls helped to facilitate the coordination of state contact by reducing the number of individual contacts necessary to conduct the evaluation. To introduce the Abt evaluation team, CMS IAP staff sent emails to state participants before the evaluation team reached out to them. In the following sections we describe the population of interest and the types of stakeholders included in our sample. We then describe our approach to secondary and primary data collection, and our strategy for analyzing these data.

Sample

The target population included in this report is state stakeholders (e.g., Medicaid, housing agencies) who received targeted support and/or access to resources under one or more of the IAP program or functional areas inclusive of:

- SUD
- BCN
- CI-LTSS
- PMH
- DA

The sample of interviewees also includes relevant IAP CMS staff and targeted support providers, including the targeted support coaches. In addition, we interviewed state Medicaid directors and other state officials to understand how the IAP is supporting system reform in their states, and to understand the contextual factors that may facilitate or hinder the success of the program in meeting its goals.

We are not using comparison groups for this evaluation, given the timing of the rollout of program areas and the difficulty in controlling for all contextual factors that may confound true program effects. Also, there is no consistent model across program or functional areas. As a result, rather than testing program effectiveness relative to non-participants, the evaluation will provide 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. Exhibit A3 illustrates the type of data source utilized, by track, within each program and functional area evaluated in this interim report.

Given the evolving nature of the IAP program and functional areas, routine area-specific calls with CMS IAP lead staff were conducted throughout program implementation. Although information from these calls was not included in the evaluation per se, they were essential to the evaluation team's understanding of real-time implementation decisions. The calls began as monthly check-ins, but became less frequent as the programs were implemented. Participants generally included two area-specific leads from CMS, the full area-specific evaluation team, and one or two members of the Abt IAP evaluation management team.

Exhibit A3. Matrix of Data Source by Program and Functional Area Track

	SUD			BCN	CI-LTSS				PMH		DA
	HILC	TLO	1115 Waiver Strategic Design Support	BCN	HRSP Partnership	HRSP Supporting Tenancy	IQO Planning	IQO Implementation	PMH Group	ISW	MMDI
Secondary Data Source											
Expression of interest form	X			X	X	X	X	X	X	X	X
Post-webinar feedback (e.g., attendance, polling, evaluation results)	X	X		X		X	X	X	X	X	
Materials generated for or by IAP (e.g., crosswalks, action plans)	X	X	X	X	X	X		X			X
Website materials (environmental scan)	X	X	X	X	X	X	X	X	X	X	X
Primary Data Source											
Initial state participant telephone interview				X	X		X	X	X	X	X
Initial state participant in-person interview											
Follow-up state participant telephone interview	X		X	X					X		X
Initial coach telephone interview				X	X			X	X		X
Initial coach in-person interview									X	X	
Follow-up coach telephone interview	X			X							X
Initial state participant virtual focus group											
Initial state participant in-person focus group				X	X						
Follow-up state participant telephone focus group											

	SUD			BCN	CI-LTSS				PMH		DA
	HILC	TLO	1115 Waiver Strategic Design Support	BCN	HRSP Partnership	HRSP Supporting Tenancy	IQO Planning	IQO Implementation	PMH Group	ISW	MMDI
Initial coach virtual focus group											
Initial coach in-person focus group									X	X	
Follow-up coach virtual focus group				X	X						
CMS IAP lead exit interview	X	X			X						
Support contractor interview	X	X		X							
Webinar observations	X	X		X	X	X	X	X	X	X	X
In-person meeting observations	X			X	X						
In-person meeting evaluation	X			X	X						
Post-webinar series survey		X		X		X	X				
Summative survey	X				X						
CMS IAP staff conference calls	X	X	X	X	X	X	X	X	X	X	

Secondary Data

Our approach to secondary data collection was driven by the goal of minimizing the burden on state IAP participants. We obtained IAP documents through CMS IAP staff, and data-mined relevant online resources for current information on the overall state health policy context, to help inform our engagement with states across the four IAP areas. Secondary data sources we used include:

- ***Program overview documents***. CMS IAP staff developed program overview documents and informational webinar slides to describe each IAP program and functional area to potential applicants.
- ***EOI forms.*** All states interested in participating in an IAP priority program or functional area submitted an EOI form.
- ***Webinar and in-person meeting materials***. These include agendas, slide decks, and any other handouts provided to IAP participants through webinar or in-person learning events.
- ***Post-webinar materials including attendance, responses to polling questions, and evaluation results.*** The targeted support provider tracked webinar registration and attendance information, and analyzed responses to polling questions and webinar evaluations and forwarded the results to the evaluation team.
- ***Materials generated for or by the IAP.*** These include materials that participants had used in a program or in functional areas (e.g., the crosswalk developed for the CI-LTSS Supporting Tenancy Track participants; and reports drafted by the MMDI DA targeted support provider), as well as tools created for the NDS (e.g., the Medication-Assisted Treatment Clinical Pathway and Rate Design Tool developed in the SUD program area).

Primary Data

One-on-one interviews and focus group discussions were conducted with state participants, coaches, CMS IAP leads, and targeted support providers. To address the research questions, the evaluation team drafted a standard set of generic qualitative protocols for each type of respondent (available from CMS upon request) that align with cross-cutting issues, as well as topic-specific areas of inquiry and tracking. We submitted all the generic protocols to CMS for review and approval. Abt Associates' Institutional Review Board also reviewed and approved the protocols. We modified these generic protocols for each program and functional area based on the timing of the interview (i.e., initial interview versus follow-up interview) and our understanding of the area to date. For all interviews and 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 used as a reference to check content and coding of interview notes. The majority of the interviews were led by senior staff with assistance from a junior staff note-taker. A few interviews were led by seasoned junior staff with senior staff taking the notes and providing guidance if needed.

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
- CMS IAP lead staff exit interviews
- Targeted support provider lead staff exit interviews
- Focus groups with state participants
- Focus groups with coaches
- Webinar and in-person meeting observations

- In-person meeting participant evaluation surveys
- Post-webinar series surveys
- Summative surveys

Interviews

In most cases, interviews and focus groups were conducted by telephone. Exceptions are noted, below.

Telephone interviews with state participants. Program and functional area-specific evaluation teams conducted 60- to 90-minute interviews with key staff from each IAP state at various points that had been determined in collaboration with CMS IAP staff and chosen to minimize burden on state participants relative to their ongoing IAP activities. The number of interviews per state varied with the length of the IAP program or functional area engagement.

The interviews were designed to gather information on states' goals for IAP participation, their reaction to the targeted support received to that point, and whether or not they believe that the program met their needs. Given the overlapping nature of the program area populations, some respondents participated in multiple evaluations. Interviewers review state profiles in advance of each call and modify the interview guides accordingly.

Prior to our conducting interviews with state participants, CMS IAP staff sent an introductory email to them that was followed by a second email message from the evaluation team. CMS IAP staff emails included a description of the evaluation and a request for voluntary participation. The evaluation team sent its outreach message approximately one week after the CMS IAP staff email was sent, requesting a time to interview the participants.

Telephone interviews with coaches. Sixty-minute telephone interviews were conducted with coaches who had provided targeted support to state participants. The coach interviews were designed to obtain their perspective on the effectiveness of the IAP overall, and the appropriateness of the modes, level, and amount of targeted support provided to states.

In-person interviews with coaches. The evaluation team was able to conduct two in-person interviews with coaches; one with two PMH group coaches and one with the ISW coach. The interviews lasted between 30 and 60 minutes and were arranged in advance by telephone and email.

Exit interviews with CMS IAP leads. A comprehensive evaluation of the Medicaid IAP targeted support must include the perspective of the CMS program sponsors. Therefore, the evaluation team conducted semi-structured interviews with CMS IAP lead staff at the end of each program area's structured period to obtain their perception of the effectiveness and responsiveness of the Medicaid IAP targeted support and resources relative to the agency's goals. These interviews were also intended to gather information on best practices and lessons learned in providing targeted support to teams of state officials. The CMS IAP lead interviews were approximately 60 minutes in length.

Exit interviews with targeted support provider leads. The evaluation team conducted semi-structured interviews with targeted support provider lead staff to gather information on the IAP targeted support design, successes in delivering targeted support, opportunities for improvement, and modifications over time. The 60-minute interviews were conducted with relevant targeted support provider staff at the end of each program area's structured period.

Focus Groups

When appropriate, we conducted focus group interviews with state participants or coaches for each IAP that included direct support. Focus groups allow 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 Housing Partnership meeting. However, as was the case with the one-on-one interviews, the predominant mode of convening focus groups was virtual.

A seasoned Abt focus group moderator led the focus groups, whether in-person or virtual, 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.

Surveys

Brief paper-and-pencil or online in-person meeting evaluation surveys. During the CI-LTSS Housing Partnership meetings in May and October 2016, we administered a pencil and paper evaluation survey.[15] The post-event surveys take no more than 10 to 15 minutes to complete, and provide participant feedback on the logistics and content of the in-person meetings.

Summative survey of IAP participants. We conducted a comprehensive survey with SUD HILC and CI-LTSS Housing Partnership participants about six months after the completion of the structured period of the IAP. We expect to conduct summative surveys with additional program and functional areas after the end of their structured periods. The main themes for the survey are experience with the full array of targeted support, program and behavioral changes related to the support received, and the ongoing impact of the targeted support following conclusion of structured period activities.

Post-webinar series surveys. For IAP program area tracks that did not include coaching, we administered web-based surveys after the end of program area-specific webinar series. The surveys were designed to take five minutes to complete, and to obtain respondents' thoughts on how well the webinar series met its program area-specific goals.

Event Observations

The evaluation team was a silent participant at in-person and virtual (e.g., webinars) group events. Data such as state participant engagement (number of questions asked; comments made), technical issues (audio or visual), and adequate time allotted for questions were collected and recorded on an observational matrix.

Analytic Approach

Secondary Data

The evaluation team reviewed the documents obtained during the environmental scan, as well materials obtained during the course of IAP implementation, using content analysis. Information gathered was aggregated by state and compiled into state profiles for easy reference when writing semi-annual and annual reports.

[15] After the May convening we followed up the in-person paper and pencil version of the evaluation with a web-based version. However, given the low response rate, we decided (in collaboration with CMS IAP staff) not to repeat the web-based version following the October convening.

Primary Data

As described above, primary data includes virtual (WebEx) and in-person interviews and focus groups as well as responses to web-based surveys. Below we describe our approach to analyzing these data.

Interview and Focus Group Data

We analyzed interview, focus group, and observation data using the NVivo software package. After interviews and focus groups had been conducted, and interview notes had been cleaned, the data management lead, in collaboration with the program and functional area evaluation team, defined common themes that became the structure of coding using the NVivo qualitative data software package. The coding scheme aligns with the topics addressed during the interviews and focus groups, and is tailored to each program and functional area. Specific comments recorded during the interviews and focus groups could have been coded in more than one theme, but all comments were coded by the most specific theme. The data management lead, and one or more team members who conducted the focus groups or interviews, met to review the content of the themes in NVivo to identify inconsistencies, redundancies or imprecisions. The coding scheme was then shared with other program area teams, and revised as needed to support consistent coding across program areas.

Analysts were trained by Abt evaluation staff experienced in the use of NVivo to implement the coding structure for all interview and focus group notes. They analyzed the data by aggregating at the theme level and by type of participant. Because the interviews and focus groups are designed to illuminate experiences unique to each program area, and for individual respondents, analyses were largely limited to "within"-program area comparisons, although some cross-program area themes were evaluated via the use of select standardized questions within each of the evaluation domains.

Survey Data

Abt conducted analyses of data collected from three sets of surveys. Two were fielded during program implementation (i.e., the in-person meeting evaluation survey and post-webinar series surveys); the summative surveys were conducted within six months after the end of structured targeted support. Most surveys were administered via a web-based platform (e.g., SurveyMonkey, FluidSurvey), although, as described above, some post-event surveys were administered by paper and pencil (i.e., in-person meeting evaluation survey). Team members analyzed all survey data using Excel or Stata software. The analyses were limited to descriptive statistics (e.g., frequencies and cross-tabs). When appropriate, we present survey findings as graphics exhibits.

Although the statistics are descriptive in nature, where appropriate, we documented changes in states' responses over time as revealed through information collected during in-person or virtual interviews and the final summative surveys.