MEDICAID DEMONSTRATION EVALUATION LEARNING COLLABORATIVE FIELD GUIDE

JULY 2020

Robert Wood Johnson Foundation

AcademyHealth

INTRODUCTION

Section 1115 Medicaid demonstrations enable states to test potential innovations or alterations to Medicaid that would not otherwise be allowed under existing law. Demonstrations generally reflect evolving priorities at the federal and state level and can vary in scope in terms of populations impacted and services provided. In the last 10 years, there has been an increase in 1115 demonstration proposals and approvals. Some examples of common 1115 demonstrations are: Community Engagement; Substance Use Disorder (SUD); Institutions for Mental Disease (IMD); Behavioral Health; Delivery System Reform Incentive Payment (DSRIP); Coverage; and Expansion. Yet, with this increase brought heightened scrutiny to the quality of demonstration evaluations, particularly around the limited insights into a demonstration's effectiveness or value in informing policy decisions[1]. As 1115 demonstrations are required to have an external evaluation, the Center for Medicare & Medicaid Services (CMS) has become increasingly focused on improving the rigor of these assessments to examine their impacts on beneficiaries, providers, health plans, and states, including effects on access, quality of care, and cost as proposed in a state's plan. To support state efforts in responding to these demonstration project requirements, as of 2019, CMS has provided guidance and examples on recommended evaluation outcome measures, methods, approaches, and data resources.

AcademyHealth, through support from the Robert Wood Johnson Foundation, created a **Learning Collaborative** in the fall of 2018, comprised of nearly 60 evaluators, state agency partners, and other stakeholders from over 20 states. This 18-month project aimed to support state agency and research partners, who were proposing and/or implementing Section 1115 demonstration evaluations and were tasked with addressing the requirements for monitoring and evaluating those demonstrations. The Learning Collaborative also included state agency and university researcher members from AcademyHealth's state-based networks, the **State-University Partnership Learning Network** (SUPLN) and **Medicaid Outcomes Distributed Research Network** (MODRN).

As a pillar of the Learning Collaborative, AcademyHealth fostered peer-to-peer shared learning, creating an open dialogue between Learning Collaborative participants and CMS State Demonstrations Group colleagues with the intent to share promising practices and solutions to ongoing challenges in evaluation design and measurement. Further discussion raised thoughts on how to incorporate robust monitoring and evaluation strategies into demonstration proposals, as well as align, where applicable, the policy questions being evaluated, the data sources being used, and the study designs and methodologies employed in those efforts. In doing so, the Learning Collaborative addressed the following foundational themes and issues therein to consider when designing robust evaluations of Medicaid demonstrations originally identified in the issue brief: State Flexibility in a New Era: What are the Research Priorities for 1115 Demonstration?

- **Evaluation design and the evidence gained therein is equally important to a demonstration's success**. A robust evaluation design is essential to assess the effectiveness of the interventions, as well as the strategies used to implement them. It is a central tenet of the demonstration authorization that Section 1115 waivers produce new knowledge, regarding both the outcome of the demonstration, as well as the process by which it is to be implemented. Specifically, it is important to capture if demonstration provisions are capable of being implemented in a manner that comports with the hypotheses being tested through the original demonstration design. Implementation evaluation also allows researchers and policymakers, with some certainty, to eliminate factors unassociated with the underlying drivers of the demonstration results.

- **Demonstration design must be implementable**. In order for an evaluation to produce robust results and create usable knowledge relevant to social welfare policy, a demonstration design should be implementable—it cannot be so complex that it prevents the design from being implemented and evaluated using quasi-experimental design methods.

- **Multi-state evaluation designs can be powerful tools in assessing the impact of policy variation across states**. Aligned evaluations across states can create a more robust research environment and enrich the evaluation field. However, variability across states must be recognized from the start in order for state policymakers and evaluation researchers to create a strategy that will allow comparisons and analyses across that variation. Demonstrations that align evaluation plans, sources of data, methodological approaches, and data access across multiple states could ultimately produce stronger results than single-state evaluations. The state case studies in this Field Guide (Ohio, Michigan, West Virginia, California, Virginia, Massachusetts, and Washington) highlight examples of such efforts.

1. https://www.gao.gov/products/GAO-18-220

These foundational themes were addressed through a variety of programing opportunities that brought Learning Collaborative members together. In March 2019, AcademyHealth convened the Learning Collaborative in-person meeting to focus on evaluation priorities and a need for more rigor in demonstration evaluation design and implementation. Throughout the course of the funded project, AcademyHealth held four webinars that highlighted a variety of demonstration evaluations. Webinar presentations included:

- **Community Engagement Evaluation Challenges**
- **CMS Evaluation Design Resources**
- **Institution for Mental Disease (IMD) Evaluation Practices**
- **Substance Use Disorder (SUD) Evaluation Practices**

In addition, Learning Collaborative members published blogs highlighting their demonstration evaluation work through the AcademyHealth website to disseminate their findings and lessons learned. Further dissemination tools were also produced by the Learning Collaborative through the creation of a resource repository, in which members could share their learnings and publications.

The Learning Collaborative concluded with a convening in March 2020. The purpose of this meeting was to engage the Learning Collaborative and related state and federal stakeholders to reflect on federal guidance to date, noting what is most valuable and what gaps remain. Stakeholders also discussed effective strategies for measuring and disseminating demonstration impact on the health and long-term wellbeing of Medicaid beneficiaries, and the nation's Medicaid program as a whole. The second half of the convening was dedicated to a "Field Guide" exercise, which focused on capturing real world lessons from evaluators. Participants were divided into small groups based on their current demonstration focus, as described in the case studies further below. They were asked to reflect on their evaluation process, considering how the current guidance assisted them in their design and share what additional support, resources, and direction could be useful. Information from these independent field guides were collected and summarized to create this report. We intended this resource to expand learnings from the federal guidance, as referenced by evaluators for the benefit of future demonstration evaluators.

Since this Field Guide was produced during the COVID-19 pandemic, it does not consider or reflect temporary changes made to Medicaid policies during this global health crisis, nor address the immediate concerns or guidance needs potentially impacting demonstration evaluations at this time.

ACKNOWLEDGEMENTS:

CASE STUDIES
1115 Community Engagement Demonstration

Executive Summary:

1115 Community Engagement (CE) demonstrations are designed to support states in their efforts to strengthen the Medicaid program by requiring work and community engagement among non-disabled, working-age Medicaid beneficiaries to help them improve health and wellbeing and achieve economic self-sufficiency. Primarily implemented through work requirements, CE demonstrations have faced swift legal challenges. With most states' demonstrations on hold or in court, and with additional uncertainties as a result of the impact of the COVID-19 virus on unemployment, state researchers are awaiting future guidance.

Michigan's 1115 CE Demonstration:

Description of the State's Demonstration: The demonstration's work reporting requirements mandate that beneficiaries complete 80 hours a month of work, training, school, or volunteer activities. Pregnant women and individuals who are disabled, or older than 61, or were recently incarcerated are exempt from these requirements. Furthermore, beneficiaries with incomes greater than 100% of the federal poverty level and on Medicaid for 48 months or more, cumulatively, must complete healthy behavior requirements and pay monthly premiums to maintain coverage.

The Demonstration's Research Questions:

1. Does the new requirement for work/CE lead to changes in employment, health, access to care, insurance coverage, and financial well-being?

2. Do the new requirements for premiums and health behaviors lead to changes in health, health behaviors, access to care, insurance coverage, or financial well-being?

Where is the Demonstration in its Evaluation Process? A federal judge struck down the demonstration on March 5, 2020. The demonstration is currently on hold.

Ohio's 1115 CE Demonstration:

Description of the State's Demonstration: This demonstration requires that non-exempt individuals participate in community engagement activities for an average of at least 80 hours a month as a condition to maintain eligibility unless they have a good-cause exception.

The Demonstration's Research Questions:

1. Does the requirement have an effect on employment?

2. Does the requirement increase income?

3. Does the requirement increase commercial health insurance?

4. Does the requirement increase health outcomes?

Where is the Demonstration in its Evaluation Process? Ohio researchers are assisting the Ohio Department of Medicaid with updates to the evaluation design to re-submit to CMS. The Ohio Department of Medicaid has asked CMS for an extension in order to better assess how COVID-19 affects the study design.

Impact of Federal Guidance

Researchers from Ohio and Michigan both noted the importance of federal guidance in their CE demonstration evaluations. In Michigan, researchers developed a randomized control trial approach for their CE demonstration. Researchers noted that in order to justify this study design, they needed comparators to adhere to federal guidance. In Ohio, researchers found the 1115 evaluation federal guidance valuable. Specifically, researchers found that the study design guidance was very helpful for thinking through the options given data availability and hypotheses considerations. With their multi-disciplinary team, the study design guidance gave them a common language to discuss options. In addition, they consulted the technical assistance guidance throughout the process along with feedback from CMS.

Successes/Challenges in Evaluating CE Demonstrations:

Process: Researchers were asked to provide the successes and challenges of their state's CE demonstration evaluation process.

- Workforce and Infrastructure: Other projects that were pertinent to the CE project were engaged by the Ohio State University's Government Resource Center (GRC) that enabled a planned transition to the waiver questions and development of the waiver design. Michigan noted access to Medicaid administrative data, American Community Surveys, and Current Population Surveys helped formulate their CE demonstration evaluation. In comparison, Michigan lacked access to other state data, such as unemployment income data, tax records, and corrections to strengthen the CE demonstration evaluation.

- Design and Methodology: Researchers from Ohio noted that they were able to identify a control group in their evaluation design, while Michigan was able to include a randomized control group in their evaluation design. In regards to challenges, Ohio researchers had difficulty in fulfilling cross state comparisons due to lack of out-of-state data availability. In this area, Michigan researchers noted that while they tried to share measures with other states for surveys, they were answered with limited success.

Outcome: Researchers were asked to provide the successes and challenges of their state's CE demonstration evaluation outcome. As stated prior, Michigan's CE demonstration was struck down by a federal judge on March 5, 2020. As of June 2020, Ohio does not currently have any outcomes to report.

1115 Institutions for Mental Disease Demonstration

Executive Summary:

1115 Institutions for Mental Disease (IMD) demonstrations allow states to pay for substance use disorder (SUD) treatment services in "institutions for mental disease" for Medicaid beneficiaries. States can utilize this demonstration type as an important tool to help expand the availability of SUD treatment.

Virginia's 1115 IMD Demonstration:

Description of the State's Demonstration: Virginia combined a Section 1115 demonstration with a comprehensive reform to their Medicaid SUD treatment services. On April 1, 2017, Virginia implemented the Addiction Recovery and Treatment Services program (ARTS) to increase access to the full continuum of evidence-based addiction treatment services for over one million Virginia Medicaid members. In addition to the demonstration that permits federal Medicaid payments to IMD facilities for short-term residential and inpatient SUD treatment, ARTS included provisions designed to transform the delivery system based on the American Society of Addiction Medicine (ASAM) criteria and increase coverage of and access to Medications for Opioid Use Disorder (MOUD). The ARTS program also significantly increased reimbursement rates for addiction treatment services (by 400% in some cases), "carved-in" behavioral health services to managed care organizations to facilitate coordination with physical health services, added coverage for peer recovery supports, and implemented Centers for Disease Control and Prevention (CDC) prescribing guidelines for opioid selection, dosage, and duration. To increase access to MOUD, ARTS enhanced payment rates for Opioid Treatment Programs and Preferred Office-Based Opioid Treatment providers with co-located buprenorphine prescribers and behavioral health clinicians to encourage the delivery of integrated pharmacotherapy and counseling services.

The Demonstration's Research Questions:

1. How do the new ARTS benefit and demonstration affect clinician ARTS training and ARTS service provision?

2. How do the new ARTS benefit and demonstration affect Medicaid members' access to and utilization of ARTS services?

3. How do the new ARTS benefit and demonstration affect patient outcomes and quality of care?

4. How is the new ARTS benefit and demonstration related to broader efforts in local communities to address SUD, especially the surge in opioid addiction?

5. Does the ARTS demonstration achieve the demonstration goals, objectives, hypotheses, and metrics approved by CMS in the demonstration application evaluation plan?

Where is the Demonstration in its Evaluation Process? Virginia's IMD demonstration has been recently renewed through December 2024 and they are working on an updated evaluation plan that not only looks at the influence of ARTS on the delivery system and patient outcomes, but also the influence of Medicaid expansion, which was passed in Virginia after ARTS, on the delivery system and patient outcomes. The evaluation design will likely include data from claims, qualitative interviews with providers and patients, member survey data, national survey data, and data from the MODRN project.

Impact of Federal Guidance

Researchers from Virginia noted the importance of monitoring federal guidance in their IMD demonstration evaluation. Virginia's IMD demonstration evaluation design predated the formal CMS guidance on IMD demonstration evaluations, though their design is broadly consistent with the more recent guidelines.

Successes/Challenges in Evaluating IMD Demonstrations:

Process: Researchers were asked to provide the successes and challenges of their state's IMD demonstration evaluation process.

- Workforce and Infrastructure: For Virginia researchers, the biggest success has been the number of trainees they have been able to involve in their evaluation projects. They have been able to include at least six doctoral students, which has enhanced the research capacity for Virginia Department of Medical Assistance Services and their demonstration research partners. In regards to challenges in this process measure, Virginia researchers faced barriers when working with raw claims data from Virginia Medicaid. They also experienced challenges linking claims data to other state data sets, such as birth and death records.

- Design and Methodology: Virginia researchers were able to utilize in-state comparison groups and propensity score weights to measure changes in hospitalization related to the ARTS evaluation. They have been challenged to find out-of-state comparison groups and also, given the complexity of the demonstration, to disentangle what components are potentially driving various changes they observe.

Outcome: Researchers were asked to provide the successes and shortcomings of their state's IMD demonstration evaluation.

- Impact and Results: Virginia researchers reported positive findings as a result of the demonstration, recording emergency department (ED) visits and inpatient utilization declined for members with OUD compared to those without SUD post-ARTS

implementation. In regards to challenges, Virginia researchers reported particular concerns with recorded disparities in diagnosed prevalence and treatment rates of SUDs by race/ethnicity.

- Interpretation and Dissemination: Virginia researchers successfully published findings in a recent Health Affairs issue examining changes in hospitalization related to the ARTS evaluation. In regards to challenges, Virginia researchers noted some initial issues in aligning the communication plans of the university, as the researchers' employer, as well as the Medicaid agency, and governor's office press relations teams. However, with coordination, communications have been greatly improved.

CASE STUDIES
1115 Substance Use Disorder Demonstration

Executive Summary:

1115 Substance Use Disorder (SUD) demonstrations allow states to improve access to and quality of substance use disorder (SUD) treatment of Medicaid beneficiaries.

West Virginia's 1115 SUD Demonstration:

Description of the State's Demonstration: West Virginia's SUD demonstration allows the state to expand the continuum of care for Medicaid enrollees with SUD through the use of Peer Recovery Support Services, short-term adult Residential Treatment in IMDs, and methadone maintenance therapy. Although some of these could have been implemented through changes in the state plan, West Virginia chose to use the 1115 demonstration process to begin implementation of all three areas and the evaluation assesses the impact of each treatment approach.

The Demonstration's Research Questions:

1.1 What is the impact of the demonstration on quality of care for Medicaid enrollees?

1.2 What is the impact of the demonstration on population health outcomes among Medicaid enrollees?

2.1 What is the impact of the demonstration on access to SUD treatment among Medicaid enrollees?

2.2 What is the impact of the demonstration on use of SUD treatment among Medicaid enrollees?

3.1 What is the impact of the demonstration on emergency department (ED) utilization by Medicaid enrollees with SUD?

3.2 What is the impact of the demonstration on inpatient hospital use by Medicaid enrollees with SUD?

4.1 What is the impact of the demonstration on the integration of physical and behavioral health care among Medicaid enrollees with SUD and comorbid conditions?

4.2 What is the impact of the demonstration on care transitions among Medicaid enrollees with SUD?

Where is the Demonstration in its Evaluation Process? West Virginia received approval from CMS on their evaluation design in May 2020.

California's 1115 SUD Demonstration:

Description of the State's Demonstration: California's Drug Medi-Cal Organized Delivery System added Medicaid coverage of IMD residential treatment, peer recovery services, and case management. Treatment delivery is organized around the ASAM Criteria levels of care[2], which works to promote physical and behavioral health integration and evidence based practices.

The Demonstration's Research Questions:

1. How did beneficiary access to treatment increase in counties that opted in to the demonstration compare to access in the same counties prior to demonstration implementation and in comparison to counties that did not opt in?

2. How did quality of care improve in counties that opted in to the demonstration compare to quality in the same counties prior to demonstration implementation, and in comparison to counties that did not opt in?

3. Did health care costs become more appropriate pre/post demonstration implementation among comparable patients (e.g., SUD treatment costs offset by reduced inpatient and emergency department use)?

4. Did SUD treatment coordination with primary care, mental health, and recovery support services improve?

Where is the Demonstration in its Evaluation Process? The SUD demonstration has been implemented and researchers are evaluating the results. California counties started implementing the demonstration on a rolling basis in 2017. Their final report is to be submitted by January 2021.

2. https://www.asam.org/asam-criteria/about

Impact of Federal Guidance

Researchers from West Virginia and California both noted the importance of federal guidance in their SUD demonstration evaluations. In West Virginia, the federal guidance and oft-cited **2018 Government Accounting Office (GAO) report**[3] helped them develop a strategy to incorporate a comparison state. Parallel OUD treatment outcomes research with MODRN and SUPLN peers aided them in enhancing their measures, and better capturing these measures from claims data. Their work with the Learning Collaborative and SUPLN in general helped them broaden their qualitative measures and think about broader implications of the 1115 demonstration. In California, researchers noted that while their evaluation plan was approved in 2016 before there was any guidance, they did look at 1115 evaluations from other states that were available at the time during the development of their evaluation plan. Furthermore, they did use the federal guidelines on reporting to try to align their 2019 report with those. They expect they will refer to these guidelines in shaping their next evaluation plan. With their state agency acting as an intermediary, they have already had some preliminary discussions with CMS. They initially thought they would write a new evaluation plan this year in anticipation of a new 1115 demonstration starting in January 2021, but due to COVID-19, California will request extension of the current demonstration for one year. If CMS approves, the new evaluation plan may be written next year.

Successes/Challenges in Evaluating SUD Demonstrations:

Process: Researchers were asked to provide the successes and challenges of their state's SUD demonstration evaluation process.

- Workforce and Infrastructure: California researchers noted that a success factor in their demonstration was the Treatment of Perception surveys, developed by the University of California - Los Angeles (UCLA), as part of the evaluation. These are also used for the state's required External Quality Review Organization (EQRO) process, as well as county and provider level quality improvement processes. UCLA provides reports to the counties in a timely manner within two months of data collection. Researchers from West Virginia benefitted from having members of the project team embedded with the Medicaid agency. These embedded analysts work full time out of the Medicaid offices where they assist with state-funded program evaluations, including the 1115 waiver evaluation, as well as other initiatives. These analysts helped to promote open, daily communication between the state and the evaluation team, and were also available to help troubleshoot issues with the Medicaid claims data. The West Virginia evaluation team was able to leverage the Medicaid data to answer strong research questions that other researchers have taken an interest in.

In regards to challenges, California researchers noted that while much administrative data existed, other data sources had to be developed and initiated for the evaluation. These included Treatment Perception Surveys, a one-page survey given to all clients during a one-week period during the year to assess their perceptions of treatment, and ASAM Level of Care Data, which was a new data reporting system used whenever an ASAM assessment or ASAM-based brief screening was performed. West Virginia researchers had challenges engaging academics to complete evaluation work without clearly defined outcomes that would benefit their academic career. Researchers stated that they often get faculty who don't see the academic value in evaluation for several reasons. First, some faculty don't see their ability to publish evaluation-related work. Secondly, especially among tenure track faculty, there can be an expectation to seek out federal, peer-reviewed funding such as an R01, K01, etc.

- Design and Methodology: California researchers noted that triangulation from multiple data sources was useful for addressing their aforementioned challenges. For example, Medicaid claims showed very little billing for recovery services while provider surveys suggested these services were being provided. Interviews confirmed that the services were being provided, but providers were confused about what was billable so claims were not being submitted. If the researchers had relied solely on claims or surveys, the data would have been incomplete. West Virginia researchers were able to secure a comparison state's data, resulting in productive conversations with CMS. In regards to challenges, California researchers identified data lags and ensuring data quality as persistent challenges. In West Virginia, researchers explained difficulties in demonstrating the comparison state as a sufficient comparator while simultaneously maintaining that state's anonymity, which was a contingency of the comparator state's willingness to participate. They also experienced a lag in CMS response to questions and draft evaluation plans.

Outcome: Researchers were asked to provide the successes and challenges of their state's SUD demonstration evaluation. As stated prior, West Virginia researchers are waiting for final approval for their SUD demonstration evaluation design and therefore cannot comment on the measures below.

- Impact and Results: California researchers noted mostly positive results on access, quality, and coordination. In regards to challenges, California researchers stated implementation of demonstration services has been slowly rolled-out in some counties. This has made measuring the overall impact of the demonstration more difficult over the short term.

- Interpretation and Dissemination: California researchers noted that presentations to stakeholders have been well received and resulted in useful feedback. The findings have been presented to California's Department of Health Care Services, the legislature, counties, a statewide conference, CMS conference, and via an open webinar. California researchers noted that smaller in-person meetings with stakeholders provided the best opportunity to dive into the results and discuss interpretations and implications for next steps (either in terms of policy or further analysis). In regards to challenges, California researchers have taken a while to get reports approved for release. However, it must be noted that discussions with the stakeholders mentioned above have had a larger impact than the reports themselves, making delays in the public release of these reports relatively unimportant.

3. https://www.gao.gov/assets/690/689506.pdf

1115 Delivery System Reform Incentive Payment Demonstration

Executive Summary:

Delivery System Reform Incentive Payment (DSRIP) demonstrations provide states with significant funding that can be used to support hospitals and other providers to alter how they provide care to Medicaid beneficiaries and ensure cost and quality improvements. While DSRIP demonstrations were originally more narrowly focused on funding for safety net hospitals and often grew out of negotiations over the appropriate way to finance hospital care, they are now used to promote a far more sweeping set of payment and delivery system reforms.

Massachusetts' 1115 DSRIP Demonstration:

Description of the State's Demonstration: Massachusetts' demonstration is multifaceted in that it covers DSRIP, SUD, and eligibility changes. The following description specifically describes the DSRIP component of Massachusetts' demonstration.

The Demonstration's Research Questions:

1. Measure progress towards meeting the following DSRIP goals: improve care integration; meet member needs; and moderate cost trends while maintaining or improving care quality; and

2. Ascertain stakeholders' (i.e., members, clinicians, representatives from participating organizations, Massachusetts Medicaid (MassHealth) employees) perspectives regarding DSRIP implementation, successes, and challenges.

Where is the Demonstration in its Evaluation Process?
Massachusetts' demonstration approval period is July 1, 2017 through June 30, 2022. Their interim report is due in June 2021.

Washington's 1115 DSRIP Demonstration:

Description of the State's Demonstration: Washington's DSRIP demonstration, which is known as the Washington State Medicaid Transformation Project, has three initiatives. The first is the implementation of accountable communities of health (ACHs). ACHs promote efforts to improve health information technology (HIT) capacity, increase value-based payment (VBP) adoption, and address workforce shortages. In addition, ACHs also select up to eight specific projects (some of which are mandatory) to focus on care transformation efforts such as improving care coordination or addressing the opioid crisis. The second initiative focuses on long-term services and supports (LTSS). This statewide initiative expands care options for seniors, adults with disabilities, and their family caregivers. The third initiative focuses on foundational community services (FCS), a state program that offers supportive housing and supported employment for Medicaid-eligible beneficiaries with complex needs.

The Demonstration's Research Questions:

Washington's demonstration describes their research questions in the form of the following "Aims":

1. Assess Medicaid system performance under the DSRIP program;

2. Assess progress toward VBP adoption targets;

3. Assess impact of reform on health care workforce capacity;

4. Assess impact of reform on HIT adoption;

5. Measure impacts of ACH health improvement projects;

6. Assess LTSS projects implementation and impacts; and

7. Assess FCS projects implementation and impacts.

Where is the Demonstration in its Evaluation Process?
Washington's demonstration approval period is January 9, 2017 through December 31, 2021. Washington is currently finishing their baseline report, which will provide an overview of activities and results during the first phase of the demonstration, and planning to move to their main evaluation analysis.

Impact of Federal Guidance

Researchers from Massachusetts and Washington both noted the importance of federal guidance in their DSRIP demonstration evaluation. In Massachusetts, federal guidance has provided a deeper understanding of implementation processes and outcomes, which encouraged the state to make adequate investment in evaluation resources, including data access and primary data collection. Researchers in Washington noted that their evaluation was guided by and built on the evaluation design put together by Washington's Health Care Authority (HCA), which is also based on federal guidance and was approved by CMS.

Successes/Challenges in Evaluating DSRIP Demonstrations:

Process: Researchers were asked to provide the successes and challenges of their state's DSRIP demonstration evaluation process.

- Workforce and Infrastructure: Massachusetts researchers noted that they were successfully able to build a dedicated team for the project. In comparison, Washington researchers were able to clarify crucial demonstration components through phone calls with the state. In regards to challenges,

Massachusetts researchers had hurdles with recruiting and maintaining an academically trained workforce willing to deal with changing demands and timelines. In comparison, Washington researchers noted that there were initial challenges with collecting all of the quantitative data for this evaluation.

- Design and Methodology: Massachusetts researchers noted that they will be utilizing differences in differences as a control measure, as well as modeling population controls. In comparison, Washington researchers were able to refine their methodology for the LTSS and FCS evaluation based on information provided by the state. The researchers learned some contextual information about these programs. For instance, for FCS they learned that people apply for these benefits from different access points, and that it might be of interest to examine this in the evaluation. In regards to challenges, Massachusetts researchers noted that they had difficulty in achieving cross state comparisons due to a lack of consistent data metrics or similar populations of study. Similarly, Washington researchers noted that it was in some circumstances hard to find suitable comparison groups for the ACH health improvement projects.

Outcome: Researchers were asked to provide the successes and challenges of their state's DSRIP demonstration evaluation. As stated prior, Massachusetts researchers are in the process of analyzing the impact of their DSRIP demonstration, and therefore cannot comment on the measures below.

- Impact and Results: Washington researchers noted that preliminary enrollment records indicate strong participation increases for FCS projects in the early phase of the demonstration. In regards to challenges, only a small number of hospitals responded to their survey, resulting in a small response rate.

- Interpretation and Dissemination: Washington researchers noted that they are working closely with the state to report preliminary findings as they emerge. Similar to the challenges within impact and results, challenges with interpretation and dissemination were fueled by the small response rate to their survey.

Cross-Cutting Best Practices for Future Evaluation:

Below is a summarized list of best practices for evaluation implementation, design, and dissemination. The following list of key elements, while not exclusive, aims to help future evaluators in both formulating and strengthening their demonstrations. The best practices are divided up by process, methodology, and communication.

Key Elements for Successful 1115 Demonstration Evaluations:

Process:

1. Embed analysts to bridge the gap between Medicaid and the evaluation team and facilitate timely communication and data exchange;

2. Leverage federal guidance, as well as national peer networks and resources when possible, such as the SUPLN and MODRN;

3. Achieve agreement, prospectively, on the logic model inclusive of the major components of the demonstration; and

4. Ensure the evaluation defines an appropriate comparison group to support causal inference.

Methodology:

1. Prioritize research questions that are directly relevant and of import to state Medicaid agencies as opposed to focusing on big picture questions of interest to the federal government, or one's personal research agendas;

2. Use existing secondary data sources wherever possible, but triangulate different data sources;

3. Do not take claims data at face value and draw conclusions without some sort of secondary confirmation;

4. Employ mixed-methods design where feasible as the two methods can complement each other and thus provide a better understanding of how activities might affect outcomes; and

5. Balance feasibility in your evaluation goals, with the need to draw conclusions from your findings.

Communication:

1. Establish good communication with state partners and CMS throughout the duration of evaluation planning and implementation;

2. Share interim results and data points with state partners on a regular basis to better understand trends and discrepancies in observed results; and

3. Be flexible to a dynamic policy environment.

Where to Find More Information:

About the Evidence-Informed State Health Policy Institute: *AcademyHealth has a long history of working with state policymakers and health services researchers to support evidence-based decision making at the state level. AcademyHealth's Evidence-Informed State Health Policy Institute aims to increase the use of relevant, timely and translatable evidence in state policymaking to improve health and health care quality, outcomes, equity, accessibility, and affordability. Through the management of three state-based learning and research networks, including the Medicaid Medical Directors Network (MMDN), the State-University Partnership Learning Network (SUPLN), and the Medicaid Outcomes Distributed Research Network (MODRN), we foster relationships between academic institutions and state policy decision-makers to inform policy and practice. With this leadership, we cultivate collaboration across a diverse network of health policy researchers and practitioners who can adopt policy change to broaden their capacity to promote data-driven evidence informed state policy and programs.*

Please visit the program's website: **https://academyhealth.org/about/programs/Medicaid-Demonstration-Evaluation-Learning-Collaborative**

Endnotes
1. https://www.gao.gov/products/GAO-18-220
   https://www.asam.org/asam-criteria/about

   https://www.gao.gov/assets/690/689506.pdf