

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-25-26  
Baltimore, Maryland 21244-1850



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## State Demonstrations Group

August 10, 2020

MaryAnne Lindeblad  
Medicaid Director  
Washington State Health Care Authority and Department of Social and Health Services  
626 8<sup>th</sup> Ave SE  
PO Box 45502  
Olympia, WA 98504

Dear Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) has approved the evaluation design for Washington's section 1115 demonstration entitled, "Washington COVID-19 Public Health Emergency Demonstration" (Project Number 11-W00345/0), and effective through the date that is sixty calendar days after the public health emergency expires. We sincerely appreciate the state's commitment to efficiently meeting the requirement for an evaluation design stated in the demonstration's Special Terms and Conditions (STC), especially under these extraordinary circumstances.

The approved evaluation design may now be posted to the state's Medicaid website within thirty days, per 42 CFR 431.424(c). CMS will also post the approved evaluation design on Medicaid.gov.

Please note that, in accordance with STC 16, a final report, consistent with the approved evaluation design, is due to CMS one year after the end of the COVID-19 section 1115 demonstration authority.

We look forward to our continued partnership with you and your staff on the Washington COVID-19 Public Health Emergency Demonstration. If you have any questions, please contact your CMS project officer, Mr. Eli Greenfield, who may be reached by email at [Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov).

Sincerely,


**Danielle Daly**  
-S



Digitally signed by  
Danielle Daly -S  
Date: 2020.08.10  
09:04:47 -04'00'

Danielle Daly  
Director  
Division of Demonstration  
Monitoring and Evaluation

**Angela D.  
Garner -S**



Digitally signed by Angela  
D. Garner -S  
Date: 2020.08.10  
12:06:50 -04'00'

Angela D. Garner  
Director  
Division of System Reform  
Demonstrations

cc: Nikki Lemmon, Acting State Monitoring Lead, CMS Medicaid and CHIP Operations Group

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# Washington COVID-19 Public Health Emergency Demonstration

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## **EVALUATION DESIGN**

11-W-00345/0

**Initial Submission: July 2, 2020**  
**Revisions Submitted: July 31, 2020**

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# Washington COVID-19 Public Health Emergency Demonstration

## EVALUATION DESIGN

11-W-00345/0

July 31, 2020

### A. General Background Information

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Washington State received approval for the new Washington COVID-19 Public Health Emergency (PHE) Demonstration (11-W-00345/0) on April 21, 2020. The Demonstration is effective from March 1, 2020 through 60 days after the end of the PHE. Per the terms of the demonstration approval letter, Washington is required to track demonstration expenditures and to evaluate the connection between demonstration expenditures and the state's response to the COVID-19 PHE, as well as the cost-effectiveness of those expenditures. The state will be required to complete a final report, which will consolidate monitoring and evaluation reporting deliverables associated with the approved waiver and expenditure authorities and demonstration Special Terms and Conditions (STCs), no later than one year after the end of the COVID-19 section 1115 demonstration authority.

Towards these ends, an evaluation design is required by CMS. CMS provided guidance for the evaluation design on May 6, 2020, and identified July 6, 2020 as the submission deadline. This document is submitted to meet the state's evaluation design requirements for the Demonstration. Washington recognizes that changes to the proposed evaluation design may be required following CMS review. This document identifies research questions developed by the state that pertain to the approved waivers and expenditure authorities, and describes how the state will test whether and how the approved waivers and expenditure authorities affect the state's response to the PHE. As described herein, the evaluation will also assess cost-effectiveness by tracking administrative costs and health services expenditures for demonstration beneficiaries and qualitatively assessing how these outlays affected the state's response to the PHE. The effective period of the Demonstration is March 1, 2020 through 60 days after the end of the PHE.

The COVID-19 pandemic has profoundly altered the environment for delivering Medicaid-funded long-term services and supports (LTSS), including personal care, residential care, and institutional care for persons with physical, cognitive, developmental, or intellectual disabilities. Washington State was the first state in the nation to identify the outbreak of COVID-19 within a nursing facility. The infection spread rapidly to other facilities. Within a few days, the existing long-term services and supports system saw dramatic changes as providers closed their doors, clients refused to allow their care providers to enter their home, and home care aides were afraid to go to work and provide personal care services in their client's homes. Responding to this crisis required Washington to start delivering services differently. One of the identified solutions was the need for additional flexibilities only available through an 1115 demonstration

waiver request. COVID-19 has changed the way the State interacts with our clients and providers; how we manage and support our workforce; and has had, and will continue to have, lasting repercussions on how the State will deliver essential services to Washingtonians.

According to Department of Health data, as of June 22, 2020 there were 29,386 confirmed cases of COVID-19 in Washington and 1,284 deaths, with nursing facilities bearing the brunt of the mortalities. The impact of COVID-19 on nursing facilities also put a huge burden on acute care hospitals who were struggling to keep beds available for the influx of patients coming through their doors. At the same time, an outbreak of COVID-19 was occurring at the largest State psychiatric hospital and a similar story unfolded with increased demand on the LTSS system to decrease the patient count at the hospitals. The community, including the Washington State Hospital Association, looked to the State for ways to transition patients rapidly out of acute care settings to make way for new patients entering the hospitals.

Washington's long-term services and supports system relies on a combination of 1915(c) and 1915(k) federal authorities. The State has eight approved federal waivers and has already received federal approvals for flexibility using Appendix K emergency amendments and under an 1135 waiver. However, most of Washington's personal care services are provided under 1915(k) Community First Choice and the flexibilities needed could not be approved under a state plan amendment. In order to apply changes consistently across Community First Choice and waiver populations, Washington needed the flexibility afforded under an 1115 demonstration waiver. It is within this context that the State looked to the Centers for Medicare and Medicaid Services for flexibility in federal authorities and it is with immense gratitude that on April 21, 2020, Washington became the first State in the nation to be approved for a COVID-19 Disaster 1115 waiver.

The demonstration will assist Washington in promoting the objectives of the Medicaid statute and is expected to help the state furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID-19.

Washington has the following main objectives under this 1115 waiver:

- 1. Ensuring eligibility determinations for clients discharging from acute care and state psychiatric hospitals are not delayed by lengthy disability determinations.** Acute care hospitals struggled with patients who faced barriers to discharge, but no longer met medical necessity criteria for an acute care setting. When a hospital patient has a functional impairment and needs personal care assistance with their activities of daily living, they are referred to the Department of Social and Health Services (DSHS) for an eligibility assessment for long-term services and supports (LTSS). The COVID-19 PHE intensified the critical need to discharge these patients expeditiously to ensure hospital network adequacy for treatment of COVID-19 patients, and those in need of emergency and intensive care services during the ongoing outbreak. This goal targets hospital

patients who are discharging to Home and Community Services (HCS) who require a disability determination. Washington will use the authority under the demonstration to accept self-attestation in making disability determinations for these Medicaid applicants.

- 2. Ensuring Medicaid clients have continuity of care and do not go without needed LTSS services.** Under the Governor’s Stay Home, Stay Healthy order issued in March 2020, Washingtonians were asked to stay home and sequester themselves, limit contact with non-family members, switch to telework where feasible, and only leave their home for essential tasks such as grocery shopping and medical appointments. As a result many LTSS clients could no longer leave their homes to mail documents, staff could not complete in-person assessments except in emergency situations, and it was difficult to connect with many clients who did not have access to the internet or have enough cell phone minutes to complete the full assessment over the phone. Clients were also being moved rapidly from acute care hospitals, to nursing facilities, and then into residential settings or returning home, making it extremely difficult to keep a plan of care up to date.

The state asked for expenditure authority to:

- Authorize services when the plan of care could not be updated in a timely manner during the pandemic; and
- Authorize services when a functional re-assessment could not be completed within a year as a result of the pandemic.

The state was granted the flexibility to temporarily reduce or delay functional assessments to determine level of care and Person-Centered Care Plans for beneficiaries needing LTSS services.

- 3. Ensure the viability of Washington’s LTSS providers.** Our providers are the backbone of the LTSS service delivery system and it was critical for the State to help ensure our providers would be able to continue delivering services throughout the pandemic and its aftermath. Providers experienced a significant increase in costs with the implementation of infection control procedures and the need for personal protective equipment for staff and clients, while at the same time experiencing a rapid decrease in clients and hours due to COVID-19. The State used a two-pronged approach to direct funding to LTSS providers received by Washington under the CARES Act and Families First Corona Response Act: increasing provider rates and authorizing retainer payments.

**HCBS rates.** The State is using the additional flexibility under the demonstration to provide higher rates for HCBS providers to maintain capacity. To that end, the Department identified key provider types at greater risk of being adversely affected by the pandemic, to the extent that these providers would be unable to continue providing essential services. The Department provided higher rates to preserve the network of these key providers and ensure essential services remained available through the pandemic.

**Retainer payments.** The State used the additional flexibility under the demonstration to provide retainer payments to certain habilitation and personal care providers to maintain capacity. To that end, the Department identified providers at greater risk of insolvency due to forced closure or loss of clientele directly due to the pandemic. The Department provided retainer payments to these key provider types to overcome the challenges of clients being absent for a long period of time and the corresponding financial impact this would have on the provider's viability. This was particularly important for congregate and residential settings where the Department was concerned that if these providers closed due to prolonged client absences related to COVID-19, there would be significant delays in discharging individuals who were admitted to acute care or psychiatric hospitals.

## **B. Evaluation Questions and Hypotheses**

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The goals of this section of the evaluation design are to:

1. Describe how the state's demonstration goals will be quantified, so that the performance of the demonstration in achieving these targets can be measured.
2. Provide a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect between demonstration features and intended outcomes.
3. Identify the state's hypotheses about the outcomes of the demonstration and describe how the evaluation questions align with the hypotheses and the goals of the demonstration;

This section and subsequent sections of this document are informed by the Special Methodological Considerations provided by CMS in supplemental guidance for monitoring and evaluating COVID-19 Public Health Emergency Medicaid Section 1115 Demonstrations:

- CMS is not requiring states to submit budget neutrality calculations for COVID-19 section 1115(a) demonstrations.
- Given the nature of the demonstration and the challenges faced in delivering services during the public health emergency, CMS does not expect states to develop an extensive set of monitoring metrics and evaluation hypotheses that would prove burdensome to collect and analyze.
- The focus of the state's final evaluation report should be to respond to qualitative research questions aimed at understanding the challenges presented by the COVID-19 public health emergency to the Medicaid program, how the flexibilities of this demonstration assisted in meeting these challenges, and any lessons that may be taken for responding to a similar public health emergency in the future.



- States are required to track administrative costs and health services expenditures for demonstration beneficiaries and assess how these outlays affected the state's response to the public health emergency.
- States are also required to track demonstration expenditures, including administrative and program costs, and assess these outlays in light of the state's response to the public health emergency.
- States may find it feasible to compare utilization patterns among demonstration beneficiaries to other Medicaid beneficiaries for periods prior to the onset of the pandemic.

The preceding considerations reflect the unprecedented emergency circumstances associated with the COVID-19 pandemic and the objectives of COVID-19 section 1115(a) demonstrations.

Our evaluation questions and hypotheses are motivated by the following overarching questions:

**Q. *What challenges is the PHE creating?***

**Q. *What populations are principally affected by the demonstration?***

**Q. *What strategies is the state pursuing to address these challenges?***

**Q. *How will we know if these strategies are successful?***

The table below provides answers to each of these questions for the three main objectives of the demonstration described in the General Background Information section.

TABLE 1.

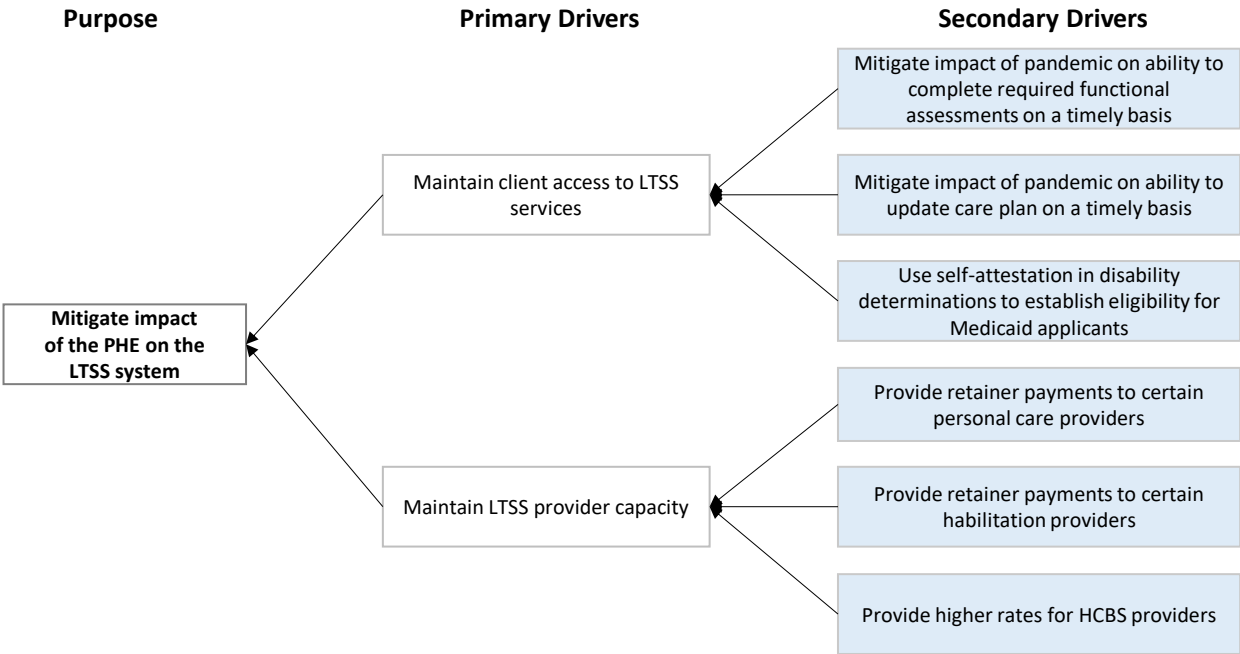
**Evaluation Approach: Challenges, Affected Populations, Strategies, Success Measures**

<b>Challenge</b>	<b>Affected Population</b>	<b>Strategy</b>	<b>Success Measure</b>
PHE intensifies the need to discharge hospital patients requiring LTSS services to ensure surge capacity for COVID-19 patients; PHE disrupts ability to conduct timely disability determinations	Hospital patients discharging to Home and Community Services who require a disability determination	Authority under the demonstration to accept self-attestation in disability determinations for Medicaid applicants requiring a disability determination to establish eligibility for Medicaid LTSS services	Medicaid LTSS caseload trends are consistent with pre-COVID-19 trends
Physical distancing required to protect public health limits ability to complete in-person assessments; many clients lack internet access or	All persons receiving Medicaid funded home- and community-based LTSS services, including persons	Authority under the demonstration to temporarily reduce or delay functional assessments to determine level of care and Person-Centered Care Plans	Medicaid LTSS caseload trends are consistent with pre-COVID-19 trends

phone minutes to complete a full functional assessment over the phone.	with physical, cognitive, developmental, and intellectual disabilities	for beneficiaries needing LTSS services	
LTSS Providers experienced increased costs for infection control procedures and the need for personal protective equipment for staff and clients, while at the same time at risk of a rapid decrease in clients and hours due to COVID-19	Affected LTSS providers and current/future clients in need of services from affected providers	Authority under the demonstration to provide higher rates for HCBS providers in order to maintain capacity; Authority to provide retainer payments to certain habilitation and personal care providers in order to maintain capacity	Medicaid LTSS caseload trends are consistent with pre-COVID-19 trends

Our primary evaluation hypothesis is that the state’s strategies to mitigate the impact of the PHE on LTSS provider capacity and client access to services will be successful, and LTSS caseloads will remain within a range that is reasonably interpreted to be consistent with prior caseload trends. This hypothesis will be “tested” across a range of LTSS services, including services for persons with physical, cognitive, developmental, or intellectual disabilities, as described in the Methodology section. The Driver Diagram below illustrates the logic linking the authorities pursued under the demonstration (Secondary Drivers) with the demonstration goals of maintaining beneficiary access to LTSS services and LTSS provider capacity (Primary Drivers).

FIGURE 1.  
**Driver Diagram**



## C. Methodology

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Per CMS guidance, the goals of this section of the evaluation design are to describe:

1. How the evaluation will be designed;
2. Characteristics of the target and comparison populations;
3. Time periods for which data will be included;
4. Measures to be calculated to evaluate the demonstration;
5. Data sources, quality, and limitations;
6. Analytic methods used to assess the effectiveness of the demonstration; and
7. Reporting and public forum commitments.

### **How the evaluation will be designed**

The main evaluation activities will be comprised of monitoring and analyzing LTSS caseload and expenditure time series data, and comparing pre-PHE and post-PHE caseload and expenditure trends. The state may conduct formal statistical tests of whether post-PHE caseload trends diverged from pre-PHE trends using an interrupted time series approach. However, the primary approach to assessing caseload and expenditure trends will be qualitative, and include a narrative description of observed trends and other factors affecting caseloads and expenditures, including potential future legislative actions taken in response to state budget shortfalls resulting from the COVID-19 pandemic. We note that the state anticipates there may be some reduction in “per cap” expenditures during the Demonstration, at the same time that the authorities available under the Demonstration are expected to mitigate caseload impacts.

While we will not attempt to formally evaluate the direct impact of specific, individual authorities pursued to mitigate the impact of the PHE, we will provide a narrative assessment of the relationship between the authorities used under the Demonstration and the overall impact achieved in stabilizing LTSS provider networks and caseloads. The figures later in this section illustrate the proposed time series approach in the context of proposed caseload metrics, using data from the state’s Caseload Forecast Council (CFC). The CFC is the state’s official body for determining caseload forecasts for state budget purposes. Data provided in this section reflect actual caseload data for affected LTSS programs and services from the June 2020 CFC forecast.

A qualitative assessment will provide information on how the flexibilities provided under the demonstration assisted in meeting challenges associated with the COVID-19 pandemic, and lessons that may be taken for responding to a similar public health emergency in the future. Qualitative research activities will include:

- Defining the number of focus groups, key informant interviews, and/or surveys;

- Determining the universes and/or sample frames from which participants would be selected;
- Determining when focus groups, interviews, and/or surveys would be conducted;
- Designing data collection instruments to address the overarching research question of how the authorities accessed by the state through the demonstration mitigated the impact of the PHE on LTSS provider capacity and client access to services;
- Conducting focus groups, interviews, and/or surveys; and
- Analyzing and reporting findings from the collected data.

The contextual data provided by the qualitative analysis could enhance the analysis of LTSS caseload and expenditure time series data by providing “on the ground” insight into any changes observed in caseload and/or expenditures.

### **Characteristics of the target and comparison populations**

As suggested in CMS guidance for COVID-19 section 1115(a) demonstrations, the state proposes comparing utilization patterns among beneficiaries receiving Medicaid LTSS services during the demonstration period (demonstration beneficiaries) to other Medicaid beneficiaries receiving Medicaid LTSS services during periods prior to the onset of the pandemic (comparison beneficiaries). This will be done by monitoring and analyzing LTSS caseload and expenditure time series data, and comparing pre-demonstration and post-demonstration caseload and expenditure trends. Target populations for which caseloads and expenditures will be monitored and evaluated will include:

- DSHS Aging and Long-Term Support Administration (AL TSA):
  - Nursing Home
  - Community Residential
    - Adult Family Homes
    - Assisted Living
    - Adult Residential Care
  - In-home personal care
    - Agency
    - Individual Provider
  - Program of All-inclusive Care for the Elderly (PACE)
- DSHS Developmental Disabilities Administration (DDA):
  - Personal Care
  - Residential Programs

Pre-demonstration actual caseload trends for these populations are illustrated in the Figures 2 – 9 later in this section.

### **Time periods for which data will be included**

LTSS caseload and expenditure measures will be developed for the period from July 2016 through the end of the demonstration period. CFC caseload data is generally subject to a 2-6 month data lag, depending on caseload type, with the longest lags associated with AL TSA nursing home services. If necessary to meeting reporting timelines, forecasted caseload levels may be used in lieu of actuals. Demonstration expenditures will be reported for the full demonstration period (March 1, 2020 through 60 days after the end of the PHE).

### **Measures to be calculated to evaluate the demonstration**

Evaluation measures will fall into three broad categories:

- Monthly LTSS caseload counts, by major service categories identified in the “target population” section above;
- Monthly LTSS expenditures in the same major service categories; and
- Demonstration expenditures in categories specified by CMS.

The figures later in this section illustrate the proposed measurement approach for caseload counts, in the context of the latest actual monthly caseload trend from the June 2020 CFC forecast. If significant divergence from prior caseload trends are observed in the demonstration period, the state may stratify caseload data (e.g., regionally) to better understand and report on sources of this potential variation.

We emphasize that expenditure metrics will focus on AL TSA and DDA LTSS services (including demonstration-related expenditures), and will not include medical, mental health, or substance use disorder treatment services provided through the Washington State Health Care Authority. There are two main reasons for this proposed approach. First, the goals of the demonstration are focused on stabilizing LTSS delivery systems. Second, the vast majority of the demonstration population is dually eligible for Medicare, and the majority of non-LTSS health care costs for the demonstration population will be Medicare-paid. Based on these considerations, we are focusing expenditure measures on LTSS services.

### **Data sources, quality, and limitations**

The figures later in this section illustrate the proposed time series monitoring approach, using data from the state’s CFC. The CFC is the state’s official body for determining caseload forecasts for state budget purposes. CFC forecasts are updated three times per year on a February, June and November cadence. Data provided in this section reflect historical actual caseload data for affected LTSS programs and services from the June 2020 CFC forecast.

The state maintains a comparable “per cap” forecast process providing per-served-client, per-month expenditure data for the caseloads forecasted by the CFC. “Actuals” from the per-cap forecast process will be combined with caseload “actuals” to provide monthly LTSS expenditure trend data, for the service categories previously identified. If necessary for meeting reporting

timelines, forecasted values may be used in lieu of actuals. Demonstration expenditure data will be provided by agency fiscal staff, in the format specified by CMS.

The caseload and expenditure data proposed for use in this evaluation are of high quality, drawing from the official data sources used in the state budget process. Data are regularly updated, with extensive oversight from legislative and executive branch staff. Previous caveats notwithstanding, data lags are not expected to significantly impact the state's ability to meet reporting deadlines for the demonstration. In rare circumstances, issues may be identified with forecast processes that require historical revision to caseload trends, but such revisions would be available for use in evaluation, allowing the state to maintain consistent time series definitions for evaluation, monitoring, and reporting purposes. The use of a time series analysis is also dependent on having sufficient post demonstration data available.

### **Analytic methods**

The outline below summarizes our analytic approach:

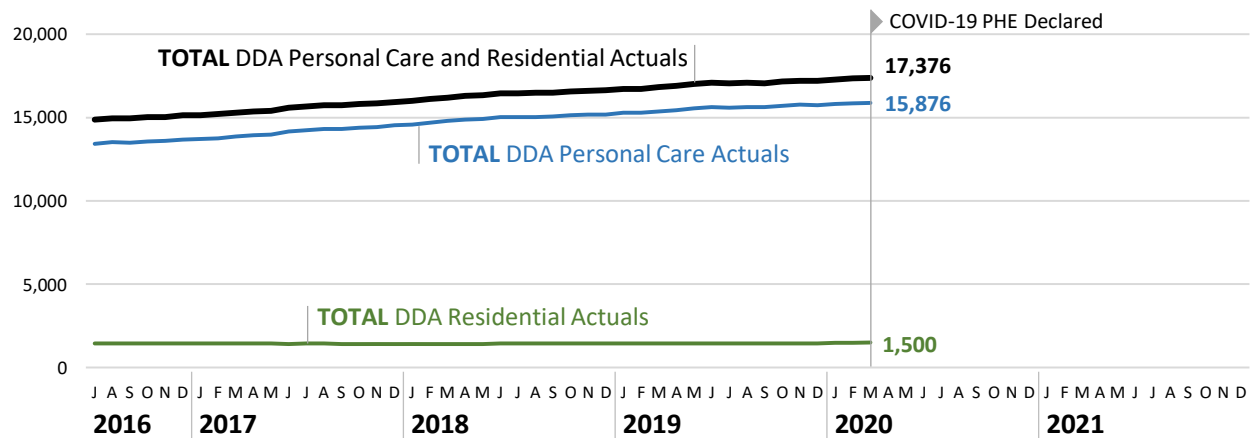
- Research Questions
  - Overarching: Are the authorities accessed by the state through the demonstration effective in mitigating the impact of the PHE on LTSS provider capacity and client access to services?
  - Specific:
    - Do LTSS caseloads and expenditures, including services for persons with physical, cognitive, developmental or intellectual disabilities, remain within a range that is reasonably interpreted to be consistent with prior caseload trends?
    - This research question will be "tested" across the range of specific LTSS service categories previously described and illustrated in Figures 2 – 9 below.
- Outcome measures used to address the research questions
  - Monthly LTSS caseload counts, by major service categories identified in the "target population" section above;
  - Monthly LTSS expenditures in the same major service categories; and
  - Demonstration expenditures in categories to be specified by CMS.
- Population subgroups to be compared
  - Demonstration beneficiaries: beneficiaries receiving Medicaid LTSS services during the demonstration period
  - Comparison beneficiaries: beneficiaries receiving Medicaid LTSS services during period prior to the demonstration
- Data Sources

- Washington State Caseload Forecast Council (CFC) monthly time series data for affected LTSS caseloads
- Washington State Medicaid LTSS per cap (per user per month) expenditure data for affected LTSS caseloads
- Analytic Methods
  - Descriptive time series with qualitative interpretation, including a discussion of other factors affecting caseload and expenditure trends contemporaneous to the demonstration (e.g., legislative actions to address state budget shortfalls)
  - Potential use of interrupted time series models to test differences in pre/post caseload and expenditure trends, at state option if sufficient post COVID-19 caseload and expenditure data is available
  - Subgroup (e.g., regional trend) analyses if caseloads or expenditures show significant divergence from pre-demonstration trend, at state option
  - As described above, the qualitative assessment will provide information on how the flexibilities provided by the demonstration assisted in meeting challenges associated with the PHE, and lessons that may be taken for responding to a similar public health emergency in the future.

### Historical caseload data for affected LTSS programs and services

FIGURE 2.

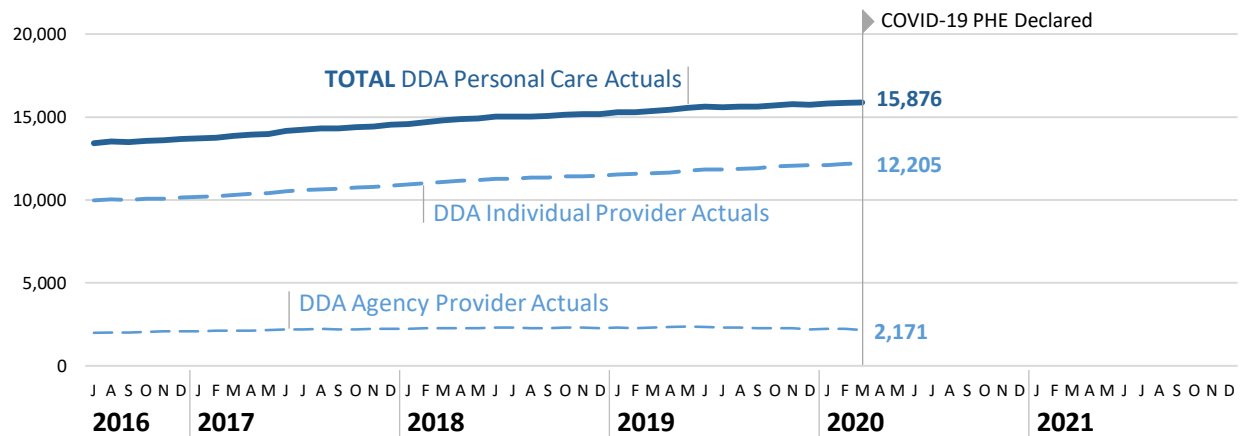
#### Developmental Disability Personal Care and Residential Caseloads



SOURCE: Washington State Caseload Forecast Council, June 2020 Forecast.

FIGURE 3.

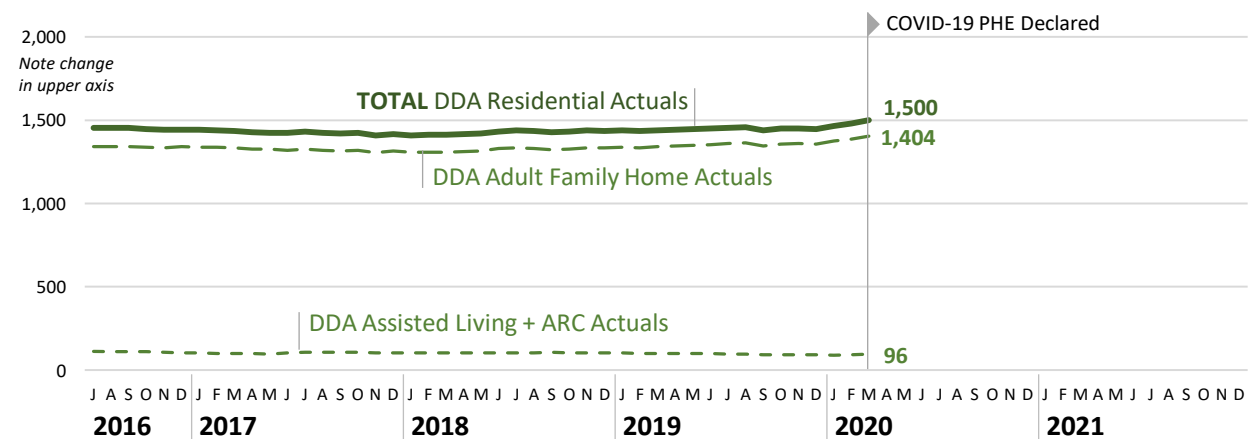
### Developmental Disability Personal Care Caseload Detail



SOURCE: Washington State Caseload Forecast Council, June 2020 Forecast.

FIGURE 4.

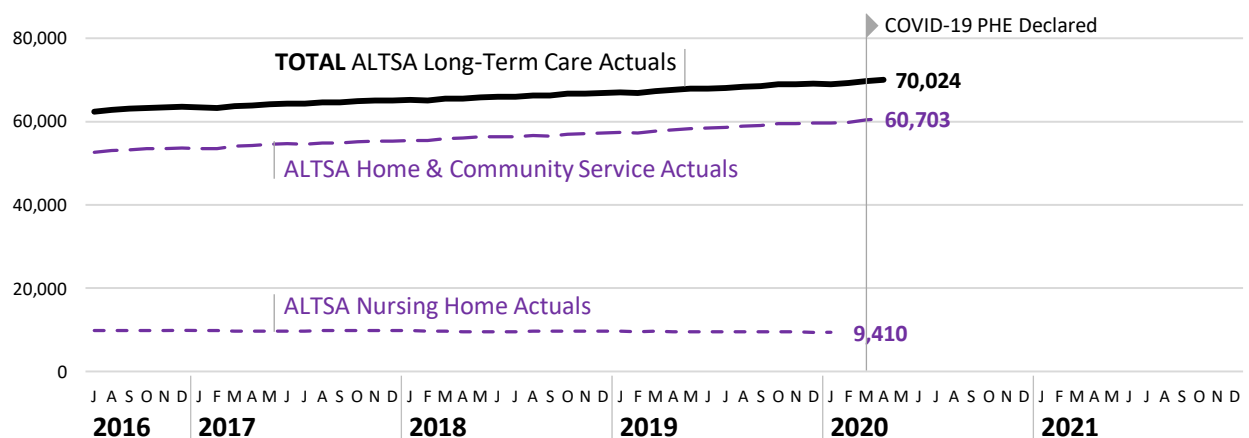
### Developmental Disability Residential Caseload Detail



SOURCE: Washington State Caseload Forecast Council, June 2020 Forecast.

FIGURE 5.

### AL TSA Home and Community Services and Nursing Home Caseloads

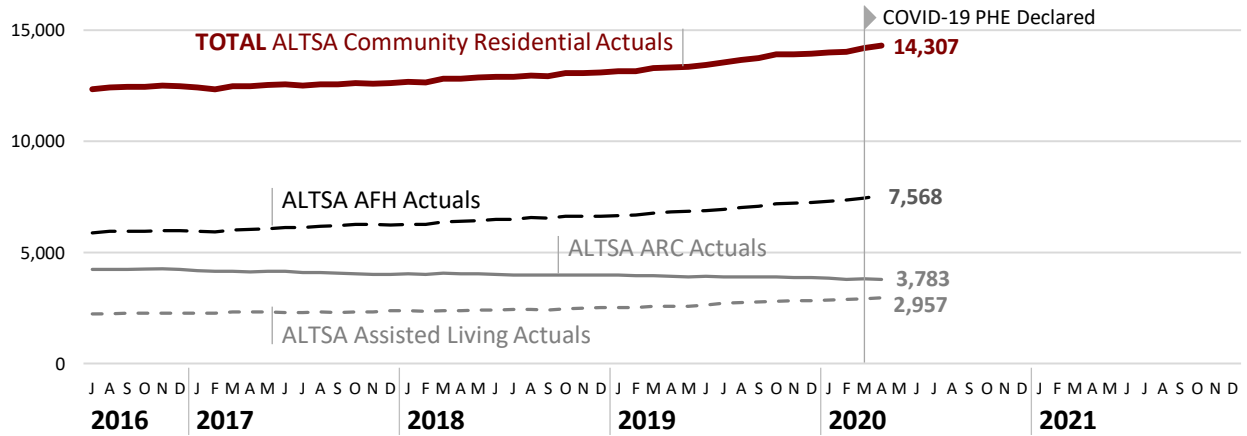


SOURCE: Washington State Caseload Forecast Council, June 2020 Forecast.



FIGURE 6.

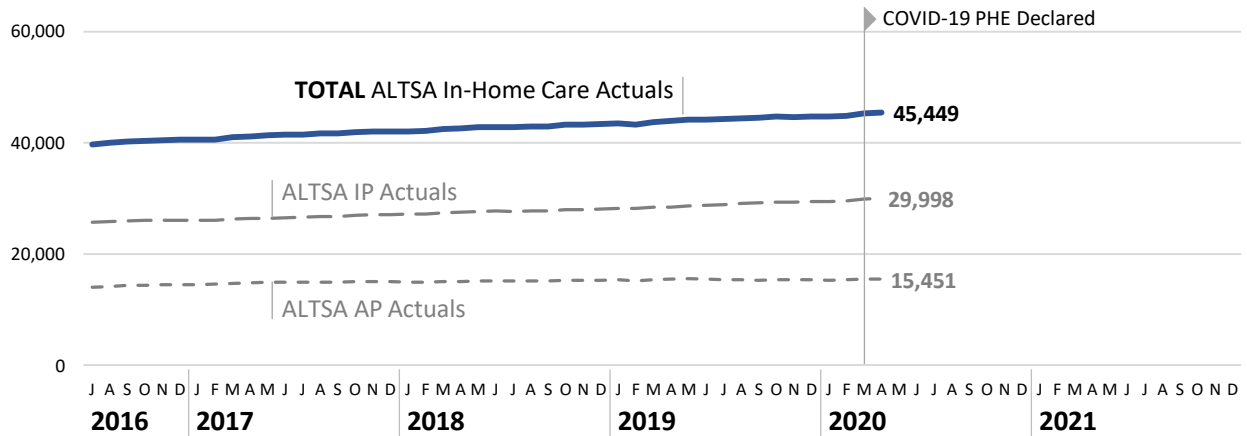
### AL TSA Community Residential Caseload Detail



SOURCE: Washington State Caseload Forecast Council, June 2020 Forecast.

FIGURE 7.

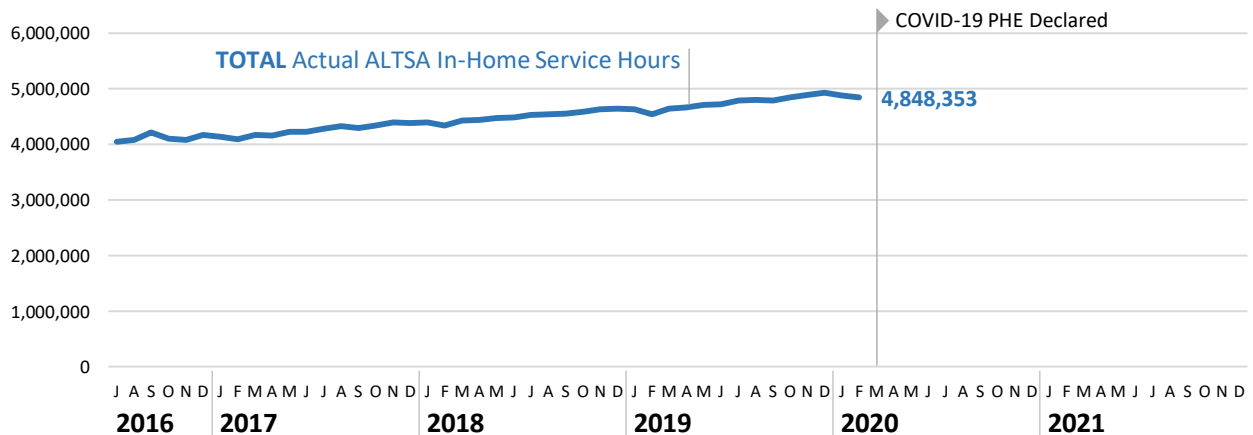
### AL TSA In-Home Personal Care Detail



SOURCE: Washington State Caseload Forecast Council, June 2020 Forecast.

FIGURE 8.

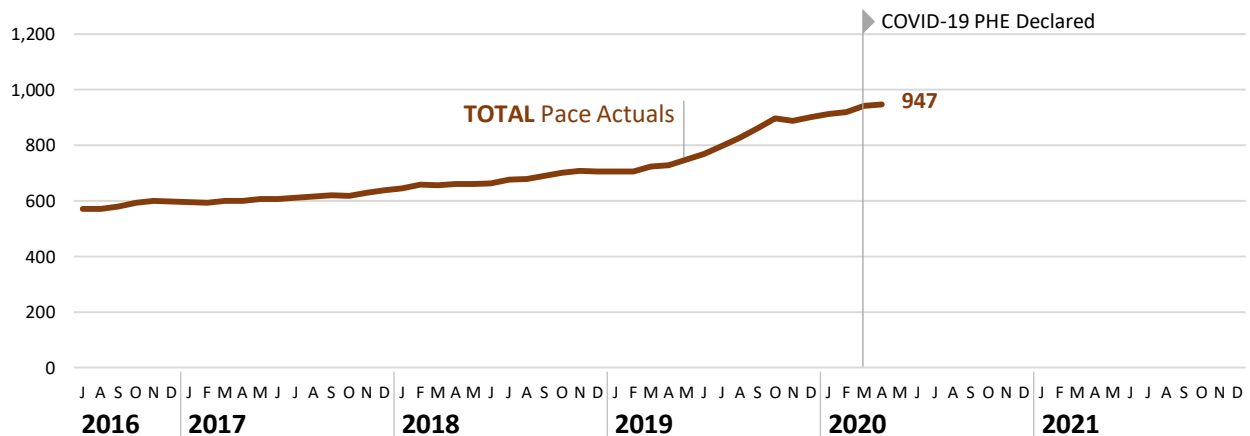
### AL TSA In-Home Personal Care Service Hours



SOURCE: DSHS Research and Data Analysis Division, Integrated Client Databases, June 2020.

FIGURE 9.

### PACE Managed Care Caseloads



SOURCE: DSHS Research and Data Analysis Division, Integrated Client Databases, June 2020.

## D. Methodological Limitations

The goals of the demonstration are to ensure LTSS provider network stability and access to services for Medicaid beneficiaries needing LTSS services, in the face of a global pandemic. In this context, monitoring caseload and expenditure trends provides an appropriately focused approach to evaluation, and is consistent with CMS guidance for this class of demonstrations. Although the state will be reporting extensive time series information about affected LTSS caseloads and expenditures, analyses will be primarily qualitative and descriptive, consistent with CMS guidance. The state will not attempt to tease out the individual impact of specific waiver authorities used under the demonstration, particularly in a context where other contemporaneous factors are likely to impact observed caseload and expenditure trends in the demonstration period, including legislative actions to address the forecast \$8.8 billion State General Fund shortfall through the 2023-25 Biennium.

## E. Additional Information

**Independent Evaluator Selection Process – No Attachment.** Per CMS’ instructions, this evaluation is state-led and no independent evaluator is required.

**Evaluation Budget – No Attachment.** At the time this evaluation design was submitted to CMS, no Demonstration funds are being allocated to evaluation activities.

### Timeline and Major Milestones

Due Date	Milestone / Deliverable
March 1, 2020	Official start date of COVID 19 PHE Demonstration
July 06, 2020	COVID 19 PHE Evaluation Design due
July 15, 2020	Comments received from CMS
July 31, 2020	Revised COVID 19 PHE Evaluation Design
60 days after end of PHE	Official end date of COVID 19 PHE Demonstration

One year after expiration of demonstration      Final report with consolidated Monitoring and Evaluation requirements

## Reporting and Public Forum Commitments

**Annual reporting.** The duration of the demonstration is contingent on the duration of the COVID-19 PHE, which is unknown at this time. If the duration of the demonstration extends beyond one year, the state will, for each year of the demonstration, submit the annual report required under 42 CFR 431.428(a). Evaluation and monitoring information included in the report will reflect the evaluation design and methodology described in the state’s approved evaluation design. The annual report content and format will follow CMS guidelines.

**Final report.** The final report will consolidate Monitoring and Evaluation reporting requirements for the demonstration. The state will submit the final report no later than one year after the end of the COVID-19 section 1115 demonstration authority. The final report will capture data on demonstration implementation, evaluation measures and interpretation, and lessons learned from the demonstration, per the approved evaluation design. The state will track separately all expenditures associated with the demonstration, including but not limited to, administrative costs and program expenditures. The annual report content and format will follow CMS guidelines. The state’s final evaluation report is expected to include, where appropriate, items required under 42 CFR § 431.428. If the demonstration lasts longer than one year, the annual report information for each demonstration year will be included in the final report, when submitted to CMS one year after the end of the demonstration authority.

**Public forum requirement.** For the annual, post-award public forum requirement, if public gatherings are discouraged, the state will notify CMS whether it intends to host the forum as a webinar without an in-person audience, accepting comments via webinar and in writing. The state will comply with applicable civil rights and other laws pertaining to accessibility, and make these alternate public hearings as accessible as possible in the current environment. If necessary depending on future circumstances, the state may seek an extension of the deadline to meet this deliverable.