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

State Demonstrations Group

October 3, 2025

Lisa Lee
Commissioner, Department for Medicaid Services
Cabinet for Health and Family Services
275 East Main Street
Frankfort, KY 40601

Dear Commissioner Lee:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Reentry Evaluation Design, which is required by the Special Terms and Conditions (STCs), specifically, STC #104 "Evaluation Design Approval and Updates" of Kentucky's section 1115 demonstration, "TEAMKY" (Project No: 11-W-00306/4 and 21-W-00067/4), effective through December 31, 2029. CMS has determined that the Evaluation Design, which was submitted on December 27, 2024 and June 10, 2025, meets the requirements set forth in the STCs and our evaluation design guidance, and therefore approves the state's Reentry Evaluation Design.

CMS has added the approved Reentry Evaluation Design to the demonstration's STCs as Attachment F. A copy of the STCs, which includes the new attachment, is enclosed with this letter. In accordance with 42 CFR 431.424, the approved Evaluation Design may now be posted to the state's Medicaid website within 30 days. CMS will also post the approved Evaluation Design as a standalone document, separate from the STCs, on Medicaid.gov.

Please note that an Interim Evaluation Report, consistent with the approved Evaluation Design, is due to CMS one year prior to the expiration of the demonstration, or at the time of the extension application, if the state chooses to extend the demonstration. Likewise, a Summative Evaluation Report, consistent with this approved design, is due to CMS within 18 months of the end of the demonstration period. In accordance with 42 CFR 431.428 and the STCs, we look forward to receiving updates on evaluation activities in the demonstration monitoring reports.

We appreciate our continued partnership with Kentucky on the TEAMKY section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S

Digitally signed by DANIELLE DALY -S
Date: 2025.10.03 12:38:31 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Christine Davidson, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

Mercer

Government Human Services Consulting

TEAMKY Section 1115 Reentry Demonstration Evaluation Design

Commonwealth of Kentucky

December 29, 2024

Updated June 10, 2025

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Section 1
General Background Information

On July 2, 2024, the Commonwealth of Kentucky (Commonwealth) received approval from the Centers for Medicare & Medicaid Services (CMS) to amend its Section 1115 Demonstration to include pre-release services. The TEAMKY Demonstration (Project Numbers 11-W-00306/4 and 21-W-00067/4) is a comprehensive Demonstration that includes multiple components, including substance use disorder (SUD) and former foster care youth waivers. The pre-release services, or reentry, Demonstration (here after referred to as the Demonstration) allows the Commonwealth to provide certain services to eligible individuals who are incarcerated in Commonwealth prisons or youth correctional facilities. The TEAMKY Demonstration was approved for a five-year extension on December 12, 2024.

To meet CMS' Special Terms and Conditions (STCs), the Kentucky Division of Medicaid Services (DMS) must contract with an independent third party to evaluate the Demonstration. DMS contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop the Evaluation Design for the reentry Demonstration. The Mercer team includes Mercer and its subcontractors, TriWest Group and HealthTech Solutions.

This document provides an overview of the planned evaluation for assessing the effects of the Demonstration and follows CMS' recommended structure for evaluation designs.

Demonstration History

The Commonwealth has leveraged section 1115 demonstrations in the past to address serious healthcare needs for its beneficiaries. The TEAMKY (formerly KYHealth) Demonstration was initially approved on January 12, 2018. The comprehensive Demonstration includes expenditure authority that allows the Commonwealth to provide services to otherwise eligible members with an SUD who are short-term residents in an Institution for Mental Diseases (IMD) and includes coverage of former foster care youth who were in foster care in another state. On June 16, 2020, the Commonwealth received approval to remove a community engagement component of the waiver that was never implemented. In November 2020, the Commonwealth submitted an application to provide substance use treatment for eligible incarcerated members; this amendment was withdrawn and the approved reentry Demonstration amendment was submitted in its stead to be consistent with State Medicaid Directors Letter #23-003.[1] On December 12, 2024,[2] CMS approved the TEAMKY Demonstration for a further five year extension. The approval included approval of additional components, including providing the Commonwealth expenditure authority to provide services to members with a serious mental illness (SMI) who are short-term residents in an IMD, provide recuperative care services to adult beneficiaries who are homeless or at risk of homelessness, and provide recovery residence support services for individuals with an SUD for up to 90 days post-release from incarceration.

[1] CMS. "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals who are Incarcerated." April 17, 2023. https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf

[2] CMS. Special Terms and Conditions. December 12, 2024. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ky-teamky-dmnstn-appvl-12122024.pdf

Since 1970, there has been steady growth in the prison and jail population in Kentucky.[3] The Commonwealth chose to pursue a pre-release services Demonstration to address the physical and behavioral health needs of its population. In 2022, 19,744 and 22,292 individuals were incarcerated in prisons and jails in Kentucky, respectively, resulting in an incarceration rate of 437 per 100,000 people.[4]

Incarcerated individuals have high rates of mental health conditions and SUDs. Estimates put the prevalence of mental health conditions as high as 16% or 17% of incarcerated individuals in state prisons and jails, compared to 5.5% of adults in the general population.[5] 53% of incarcerated individuals in state prisons and 68% of individuals in jails have an SUD, compared to 16.5% of individuals aged 12 years and older in the general population. Estimates suggest that one-third to two-thirds of incarcerated individuals have co-occurring mental health disorders and SUDs. Individuals with a history of incarceration have higher rates of asthma, high blood pressure, cancer, arthritis, tuberculosis, HIV, and hepatitis than the general public.[6] Juvenile incarceration is associated with poorer physical and mental health outcomes than youth never incarcerated or incarcerated as an adult. [7]

A significant portion of incarcerated individuals in the US are pregnant or parenting individuals. In data from 2020 through 2021, 12% of children in Kentucky reported having had a parent who was ever incarcerated.[8] Parental incarceration has been found to be associated with youth substance use[9] and mental health conditions, such as depression, among children.[10] Additionally, a higher proportion of veterans are criminal justice-involved than the civilian population. Studies have found that a large percentage of veterans involved in the justice system have mental health and substance use diagnoses.[11] Research has also found that criminal justice involvement is associated with a higher suicide risk for veterans.[12] In 2016, veterans composed 8% of the state prison population in the US.[13]

The Commonwealth has a long history of addressing incarceration and its associated health needs through legislative and policy actions. Bills passed in 2011 (House Bill 463) and 2015 (Senate Bill 192) emphasized treatment over incarceration through the creation of a drug treatment court program and the Alternative Sentencing Worker Program and expanding access to treatment. Senate Bill 90, passed in 2022, created the Behavioral Health Conditional Dismissal Program, in which individuals receive behavioral health treatment in

[3] Vera. "Incarceration Trends: Kentucky." October 16, 2024. https://trends.vera.org/state/KY.

[4] National Institute of Corrections. Kentucky. 2022. https://nicic.gov/resources/nic-library/state-statistics/2022/kentucky-2022

[5] Substance Abuse and Mental Health Services Administration (SAMHSA). "Best Practices for Successful Reentry From Criminal Justice Settings for People Living With Mental Health Conditions and/or Substance Use Disorders." SAMHSA Publication No. PEP23-06-06-001. Rockville, MD: National Mental Health and Substance Use Policy Laboratory. SAMHSA, 2023.https://store.samhsa.gov/sites/default/files/pep23-06-06-001.pdf

[6] Office of Disease Prevention and Health Promotion. "Incarceration." Accessed December 13, 2024. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/incarceration

[7] Barnert, Elizabeth S. et al. "Child Incarceration and long-term adult health outcomes: a longitudinal study." Int J Prison Health. March 2018: 26–33. https://pmc.ncbi.nlm.nih.gov/articles/PMC6527101/#:~:text=Additionally%2C%20individuals%20incarcerated%20as%20children,older%20ages%20or%20never%20incarcerated.

[8] The Annie E. Casey Foundation. "Kids Count Data Center: Commonwealth of Kentucky." May 2023. https://datacenter.aecf.org/data/tables/9688-children-who-had-a-parent-who-was-ever-incarcerated?loc=19&loct=2#detailed/2/19/false/2043,1769,1696,1648,1603/any/18927,18928

[9] Davis, Laurel and Rebecca J Shlafer. *Smith Coll Stud Soc Work.* December 2016: 53–58. https://pmc.ncbi.nlm.nih.gov/articles/PMC5695888/#:~:text=Both%20present%20and%20past%20parental%20incarceration%20was%20significantly%20associated%20with,practice%20and%20research%20are%20discussed.

[10] Martin, Eric. "Hidden Consequences: The Impact of Incarceration on Dependent Children. National Institute of Justice." March 1, 2017. https://nij.ojp.gov/topics/articles/hidden-consequences-impact-incarceration-dependent-children

[11] Holliday, Stephanie Brokers et al. "Identifying Promising Prevention Strategies and Interventions to Support Justice-Involved Veterans." Rand. June 12, 2023. *https://www.rand.org/pubs/perspectives/PEA1363-8.html*

[12] Corr, Allison. "Veterans Who Have Been Arrested or Incarcerated Are at Heightened Risk for Suicide." Pew Charitable Trusts. November 8, 2023. https://www.pewtrusts.org/en/research-and-analysis/articles/2023/11/08/veterans-who-have-been-arrested-or-incarcerated-are-at-heightened-risk-for-suicide

[13] Office for Access to Justice. "Fact Sheet: Access to Justice is Access for Veterans." Department of Justice. May 31, 2024. https://www.justice.gov/atj/fact-sheet-access-justice-access-veterans

lieu of incarceration; successful completion results in a dismissal of charges. Senate Bill 162 and House Bill 3 passed in 2023 provide resources for youth who have mental illness. Since 2016, the Kentucky Department of Corrections (DOC) has provided incarcerated individuals with counseling and Vivitrol®; inmates can currently access buprenorphine for opioid use disorder (OUD) at six state prisons. DOC also operates the Supporting Others in Active Recovery program, in which participants engage in an evidence-based program and reentry programs.

The Criminal Justice Kentucky Treatment Outcome Study, conducted by the Center on Drug and Alcohol Research at the University of Kentucky, researches the outcomes and experiences of individuals who participated in SUD treatment while incarcerated in the Commonwealth. Data from July 2020 through June 30, 2021, found that 88.9% of those who engaged in the substance use treatment program were living in stable housing and 76.7% were employed 12 months following release. 23.3% of individuals had received medication-assisted treatment (MAT) for opioids or alcohol.[14]

The Medicaid inmate exclusion policy prohibits Medicaid funds from being used for medical services for inmates while incarcerated, except during an inpatient hospital admission. Historically, states were allowed to terminate rather than suspend Medicaid enrollment for incarcerated individuals. The Commonwealth has suspended rather than terminated Medicaid enrollment for incarcerated individuals since 2020. The TEAMKY reentry Demonstration provides the Commonwealth with the opportunity to build on its already significant work supporting incarcerated and newly released individuals.

Demonstration Overview

On December 12, 2024, the TEAMKY Demonstration was approved for January 1, 2025 through December 31, 2029. The reentry Demonstration had been temporary approved for July 2, 2024 through December 31, 2024. The evaluation described in this design document will include both an implementation assessment and outcome evaluation of the Demonstration over the entire period: July 2, 2024 through December 31, 2029. Details for each evaluation period are included in the Methodology section of this design.

Demonstration Goals

The Demonstration's overarching goal is to improve health and well-being for Medicaid members who are incarcerated. The Demonstration will achieve this goal by increasing access and continuity of care for incarcerated individuals by improving connections and collaboration between carceral settings, community-based organizations (CBOs) and providers, and state agencies. The Commonwealth's goals are:

1. Improve access to services by increasing coverage, continuity of coverage, and appropriate service uptake for eligible incarcerated adults and placed youths.

2. Improve coordination, communication, and connections between correctional systems, Medicaid systems and processes, managed care plans, and community-based service providers delivering enhanced services to maximize successful reentry post-release.

[14] Tillson, Martha et al. CJKTOS: Criminal Justice Kentucky Treatment Outcome Study FY2021. February 2022. Criminal Justice Kentucky Treatment Outcome Study

3. Reduce the number of avoidable emergency department (ED) visits, inpatient hospitalizations, and all-cause mortality.
4. Increase additional investments in healthcare and related services to improve quality of care for Medicaid beneficiaries in carceral settings and post-release reentry community services.

Demonstration Activities

The Demonstration allows the Commonwealth to provide a suite of pre-release services for individuals who are incarcerated in state prisons or youth correctional facilities. The Commonwealth is authorized to provide:

- Case management to assess and address physical and behavioral health needs.
- MAT services for all types of SUD as clinically appropriate, with accompanying counseling/behavioral therapies.
- A 30-day supply of all prescription medications that have been prescribed for the individual at the time of release and over-the-counter drugs (as clinically appropriate), provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid and Children's Health Insurance Plan (CHIP) State Plan coverage authority and policy.

Case management will also facilitate continuity of care and ensure continuity of service in the community post-release from incarceration. These services can be provided no earlier than 60 days prior to release. Individuals qualify for pre-release services if they were found eligible for Medicaid or CHIP prior to or during incarceration.

The Commonwealth will achieve the above goals and provide the services noted above by following the initiatives and actions outlined in the Commonwealth's implementation plan. The Commonwealth's actions include:

- **Maintaining and expanding coverage policies**
  - Continue to suspend rather than terminate Medicaid coverage.
  - Adopt presumptive eligibility for justice-involved individuals.
  - Consider a modified suspension policy for those with shorter incarceration stays.
- **Investing in improved information systems**
  - Implement automated functionality for Medicaid and CHIP applications.
  - Integrated disparate information systems.
  - Utilize an automated system to predict and send alerts about release dates.
- **Training and educating staff and beneficiaries**
  - Train facility staff on Medicaid and CHIP eligibility and applications.
  - Implement comprehensive training programs for case managers.

  - Educate incarcerated beneficiaries about their Medicaid and CHIP eligibility and enrollment information.

- **Developing standardized protocols and procedures**
- **Expanding cross-sector collaboration and communication**
  - Utilizing person-centered care plans to refer individuals to appropriate services.
  - Develop mechanisms for information sharing between case managers and providers.

Impacted Population Groups

The Demonstration is open to individuals who are inmates in state prisons or youth correctional facilities, were deemed Medicaid- or CHIP-eligible prior to or during incarceration, and have a release date no later than 60 days after initiation of services. The Commonwealth utilizes a managed care delivery system for Medicaid and CHIP. Eligible state prisons and youth correctional facilities operate in specific counties in the Commonwealth. Eligible prisons operate in Bell, Caldwell, Elliot, Fayette, Floyd, Lee, Lyon, Mercer, Morgan, Muhlenberg, Shelby, and Oldham counties. The six youth correctional facilities operate in Adair, Graves, Kenton, Morgan, Rowan, and Wayne counties.

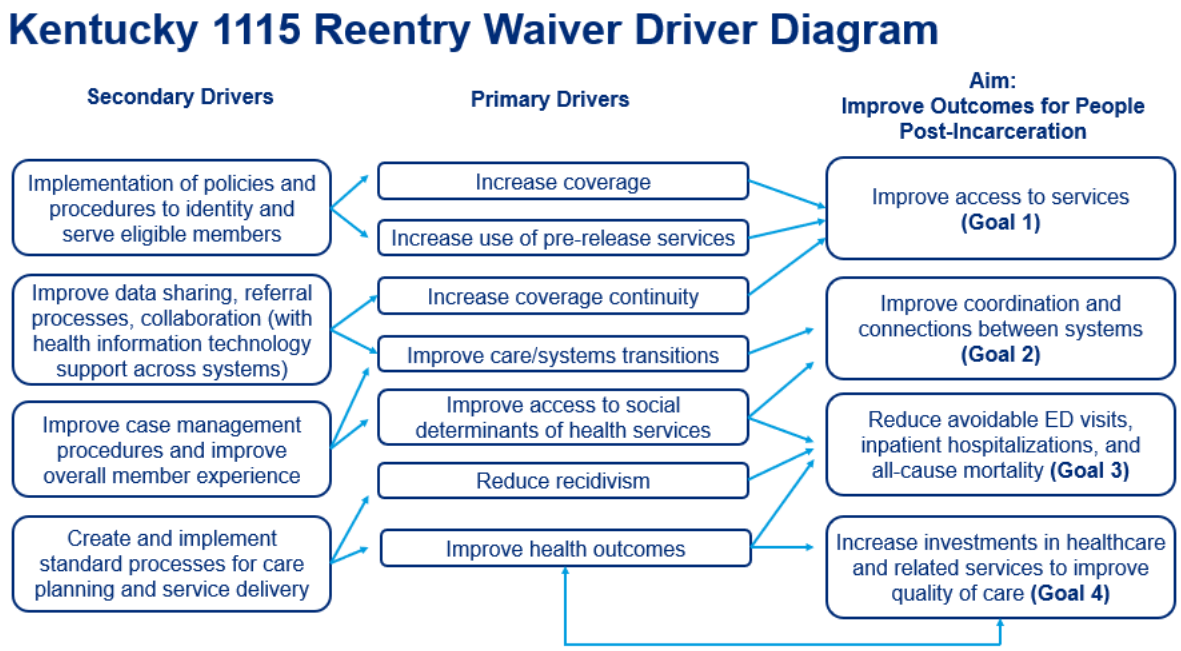
Section 2

Evaluation Questions and Hypotheses

The previous section outlined the Demonstration's goals and activities. The driver diagram below shows how the goals and activities from the Implementation Plan will advance the key aims of the Demonstration, improve health outcomes, reduce all-cause deaths, and reduce overdoses. We additionally hypothesize that the Demonstration will reduce recidivism, which will support the long-term achievement of the Demonstration's aims.

Driver Diagram

Figure 1. Driver Diagram



Hypotheses and Research Questions

The research questions and hypotheses below align with the aims and goals of the Demonstration. Research questions will be used to test each hypothesis, and quantitative and/or qualitative measures will be used to answer each research question. Refer to Section 3 for more detail and a complete list of research questions, hypotheses, and measures.

- **Goal 1: Improve access to services by increasing coverage, continuity of coverage, and appropriate service uptake for eligible incarcerated adults and placed youths.**
  - RQ 1.1: Does the Demonstration increase coverage?

    - Hypothesis 1: The Demonstration will increase the number of individuals who have Medicaid after release from incarceration.
  - RQ 1.2: Does the Demonstration increase the uptake of appropriate services pre-release?
    - Hypothesis 1: The Demonstration will increase the uptake of appropriate services pre-release.
  - RQ 1.3: Does the Demonstration improve continuity of coverage and care?
    - Hypothesis 1: The Demonstration will increase the number of individuals who access Medicaid services post release.
- **Goal 2: Improve coordination, communication, and connections between correctional systems, Medicaid systems and processes, managed care plans, and community-based service providers delivering enhanced services to maximize successful reentry post-release.**
  - RQ 2.1: Did the Demonstration improve coordination and communication between correctional systems, Medicaid, managed care plans, and community-based providers?
    - Hypothesis 1: The Demonstration will improve coordination and communication across sectors.
  - RQ 2.2: Does the Demonstration improve access to health-related social needs (HRSN) services?
    - Hypothesis 1: The Demonstration will increase the number of individuals connected to HRSN services.
  - RQ 2.3: Does the Demonstration improve transitions of care?
    - Hypothesis 1: The Demonstration will improve transitions of care.
- **Goal 3: Reduce the number of avoidable ED visits, inpatient hospitalizations, and all-cause mortality.**
  - RQ 3.1: Does the Demonstration improve healthcare outcomes?
    - Hypothesis 1: The Demonstration will improve healthcare outcomes.
  - RQ 3.2: Does the Demonstration reduce ED visits and inpatient hospitalizations?
    - Hypothesis 1: The Demonstration will reduce ED visits.
    - Hypothesis 2: The Demonstration will decrease preventable inpatient admissions.
    - Hypothesis 3: The Demonstration will decrease the 30-day readmission rate.
  - RQ 3.3: Does the Demonstration decrease the number of overdoses?
    - Hypothesis 1: The Demonstration will decrease the number of overdoses.
    - Hypothesis 2: The Demonstration will decrease the number of OUD overdoses.

  - RQ 3.4: Does the Demonstration reduce all-cause deaths in the near-term post-release?
    - Hypothesis 1: The Demonstration will decrease all-cause deaths in the first six months following release.
    - Hypothesis 1: The Demonstration will decrease overdose deaths in the first six months following release.
  - RQ 3.5: Does the Demonstration decrease the recidivism rate?
    - Hypothesis 1: The Demonstration will decrease the recidivism rate.
- **Goal 4: Increase additional investments in healthcare and related services to improve quality of care for Medicaid beneficiaries in carceral settings and post-release reentry community services.**
  - RQ 4.1: Did the Demonstration increase additional investments in healthcare and related services through the reinvestment plan?
    - Hypothesis 1: The Demonstration will increase investment in additional healthcare and related services through the reinvestment plan.
  - RQ 4.2: How does the Demonstration impact costs?
    - Hypothesis 1: The Demonstration will maintain or reduce per member per month (PMPM) costs for members who received pre-release services.

Section 3
Methodology

Evaluation Design

The evaluation of the Demonstration will use a mixed-methods design that combines both an implementation (process) and outcome evaluation to:

- Describe the progress made on specific Demonstration activities.
- Demonstrate change/accomplishments in each of the Demonstration drivers.
- Demonstrate progress on each of the Demonstration's goals.

Mercer will utilize a mixture of qualitative and quantitative methods to evaluate the Demonstration. Quantitative methods will include a mix of descriptive statistics, pre-/post-tests, and the use of comparison groups when methodologically feasible. When possible, Mercer will use interrupted time series (ITS) analysis to support an assessment on the degree to which Demonstration activities impacted changes over time. Mercer will conduct t-tests, ANOVA tests and/or multivariable regression to compare differences between subpopulations to understand potential disparate impacts of the Demonstration.

Qualitative methods will include a series of interviews and focus groups with key informants at different timepoints in the Demonstration: close to the go-live date of October 1, 2025, mid- to late 2027, and early to mid-2030. The timing of the qualitative data collection will support Mercer in understanding the barriers and facilitators to implementation and the role of the Commonwealth's actions in implementing the Demonstration. Key informants will be key partners, potentially including:

- State officials/agency staff (DMS, DOC, Department of Juvenile Justice [DJJ])
- Case managers and/or managed care organization (MCO) representatives
- Workgroups and advisory committees (Advisory and Community Collaboration for Reentry Services [ACRES], Behavioral Health Technical Advisory Committee [TAC], and Persons Returning to Society from Incarceration TAC)
- Beneficiaries (with a specific effort to recruit parenting individuals and veterans)
- Community providers and CBOs

Thematic analysis (TA) and content analysis will be used to draw conclusions from data collected for qualitative review. TA is a method for identifying, analyzing, and interpreting patterns of meaning within qualitative data. Since key informant interview and focus group data includes individual opinions and subjective perspectives, TA allows for comparisons across different stakeholders and stakeholder groups and uses systematic procedures for generating text coding and themes.[15]

[15] Clarke, V., & Braun, V. "Thematic analysis." (2017). The Journal of Positive Psychology, 12(3), 297–298

Medicaid beneficiaries will include members of important subpopulation groups, such as veterans and pregnant and/or parenting beneficiaries. This stratification supports Mercer in understanding whether groups experienced Demonstration activities differently based on differing levels of need.

Mercer will stratify metrics, when methodologically feasible and based on data availability, by age, gender/sex, risk level/acuity level, race/ethnicity, geography, pregnancy status, and veteran status. Research shows an association between incarceration and suicide for veterans, as well as an association between poor outcomes and parental incarceration for children. Mercer does not hypothesize that the Demonstration will have an **intentional** impact on different subpopulations, as the Demonstration is not targeting activities to specific groups. However, subpopulations interact with the medical community and justice systems in differing ways, which may have an unintentional impact on the uptake and continuation of services. Therefore, stratifying data by these subpopulations could highlight areas for future Demonstration activities or other state actions.

To assess the extent to which the 60-days pre-release coverage timeline facilitated improved outcomes beyond that of a more time-limited 30 days of pre-release coverage, Mercer will additionally stratify analyses, when feasible and appropriate, by pre-release service level (i.e., those beneficiaries who received services between 31 days to 60 days pre-release period and those who only received services up to 30-days prior to release). This stratification will help identify differences in outcomes based on service provision timing. Additionally, Mercer will include “days of pre-release service provision,” counted as the days between the first claim for pre-release services to release date, as a control variable in the analyses to assess whether a longer period of pre-release service provision contributed to improved outcomes.

Mercer is working with the Commonwealth to identify the data elements available to properly define all subpopulations and control variables. Mercer is investigating using the presence of pre-incarceration Medicaid or CHIP coverage as a control variable in the Demonstration. Mercer is still working with the Commonwealth to determine the best geographical unit to include in the Demonstration evaluation. Individuals released from incarceration may first reside in a half-way home or other post-release housing before eventually moving to other areas of the Commonwealth. This makes efforts to understand impacts by geography difficult, as beneficiaries may interact with multiple different community care systems during the life of the Demonstration. In places where Mercer is unable to identify the proper data element or data is unavailable to conduct quantitative analysis, Mercer will leverage qualitative data collection to investigate perceived disparities in outcomes and barriers and facilitators to service delivery and cross-sector collaboration and coordination.

Target and Comparison Populations

The target population of the evaluation is Medicaid and CHIP members who are eligible for the Demonstration. As noted above, the Demonstration is open to individuals who are inmates in state prisons or youth correctional facilities, were deemed Medicaid- or CHIP-eligible prior to or during incarceration, and have a release date no later than 60 days after initiation of services.

In Kentucky, inmates in DOC custody are generally held in a state operated correctional facility. Due to capacity constraints at state operated prisons, DOC also partners with county/local jails to house DOC inmates. Since reentry services through this 1115 authority

are only available at state prisons and youth correctional facilities, some DOC inmates despite their eligibility for reentry services, may not receive them because they are housed in facilities where reentry services are not available. Demonstration services are also voluntary, and incarcerated individuals can refuse to participate in pre-release services. Mercer investigated the use of two potential comparison populations: 1) DOC inmates housed in county/local jails where 1115 reentry services are not available and 2) DOC inmates of state run prisons who refuse pre-release services.

Mercer identified some potential challenges that may limit our ability to utilize the aforementioned comparison groups. The ability to use a comparison population is based on the ability to: 1) identify the population and 2) have data for the comparison population for all measures. While Kentucky Medicaid data can determine the time period someone is incarcerated, it alone cannot distinguish between a person incarcerated in a state operated prison versus a county/local jail. To identify the location of incarceration, Medicaid data would need to be matched to DOC data. Kentucky is in the process of including DOC and DJJ data in the Kentucky Health Information Exchange (KHIE) and Mercer is working with the Commonwealth to understand if it will be possible to use DOC and Medicaid data to identify the target and comparison population in the historical data. Some other limitations of these comparison groups include small sample sizes and selection bias; Mercer will discuss the implications of these limitations in the Interim and Summative Evaluation Reports.

Mercer may also make comparisons between the subpopulations described above, in order to better understand potential unintended differential impacts of the Demonstration on certain groups. These comparisons may also help the Commonwealth to better understand whether modifications of outreach, referral, or service delivery strategies are needed to reduce disparities among some subpopulations.

Evaluation Period

The Demonstration is approved for January 1, 2025 through December 31, 2029. The Evaluation Design described in this document includes both an implementation evaluation and an outcome evaluation that will together encompass the entire Demonstration period, as well as the temporary extension period of July 2, 2024 through December 31, 2024. The full evaluation period is July 2, 2024 through December 31, 2029. Evaluation periods are defined below.

Midpoint Assessment

The Midpoint Assessment will discuss early findings from the implementation evaluation period. The primary goal will be to assess progress in achieving the milestones of the project and conducting activities with fidelity to the original implementation plan. The outcome evaluation data presented in the midpoint assessment will include a descriptive analysis of available measures.

- Midpoint Implementation Evaluation Period: July 2, 2024 through January 2027
- Midpoint Outcome Evaluation Period (descriptive only):
  - Pre-Demonstration Period: January 1, 2024 to September 30, 2025
  - Post-Demonstration Period: October 31, 2025 to January 31, 2027

Interim Evaluation Report

The Interim Evaluation Report will discuss implementation successes and challenges of the waiver, particularly in the context of the Commonwealth's ability to provide services with fidelity to the original implementation plan (implementation evaluation) and early indications of the effects of Demonstration activities (outcome evaluation). The interim evaluation report will be submitted with a renewal application or by December 31, 2028.

- Interim Implementation Evaluation Period: July 2, 2024 through July 2027
- Interim Outcome Evaluation Period:
  - Pre-Demonstration Period: January 2024 to September 2025
  - Post-Demonstration Period: October 2025 to July 31, 2027

Summative Evaluation Report

The Summative Evaluation Report will focus primarily on the outcomes for people participating in the Demonstration and costs to the Commonwealth. It will include the degree to which implementation challenges and successes may have impacted results and summarize key Commonwealth learnings.

- Summative Implementation Evaluation Period: July 2, 2024 through December 31, 2029
  - Interim Outcome Evaluation Period:
    - Pre-Demonstration Period: January 1, 2024 to September 30, 2025
    - Post-Demonstration Period: October 1, 2025 to December 31, 2029

Evaluation Measures and Data Sources

Mercer chose the measures for the evaluation that provide the most reliable data on which to determine the impact of the evaluation on the outcomes of interest, namely improved health outcomes and reduced deaths. Mercer is using both process measures and outcome measures in its evaluation. When possible, evaluation metrics have been chosen from nationally recognized measure stewards and from the Commonwealth's submitted reentry Monitoring Protocol. In some instances, Mercer will need to deviate from approved technical specifications for established quality measures in order to capture the Demonstration population. For example, Mercer may use a larger age range for some measures and will restrict the inclusion criteria to those beneficiaries in the Demonstration population (i.e., incarcerated people who were eligible for and/or accessed pre-release services).

Table 1 below lists the proposed research questions, hypotheses, and measures for the Demonstration evaluation, organized by goal. The table includes the measure steward, if applicable, and all potential data source(s) and proposed analytical method(s). Mercer is working with the Commonwealth and other relevant parties to determine data availability to inform the final measures, analytical methods, and other specifications. Mercer will potentially use data from Medicaid claims and encounters for the Commonwealth, DOC (Kentucky Offender Management System [KOMS]) or DJJ systems (Juvenile Kentucky Offender Management System [JKOMS]), the KHIE, Vital Statistics, case manager notes, and data from kynect resources. kynect resources is a platform through which individuals can

find community organizations to address needs such as housing and transportation. Community organizations can manage referrals and collaborate with other organizations through the platform..[16] Mercer is working with the Commonwealth and other partners to determine the data sources needed for all measures proposed below.

Mercer will also conduct TA on qualitative data collected through key informant interviews and focus groups. Qualitative analysis will be used to understand the barriers and facilitators to implementation of the Demonstration, as well as to provide context to the quantitative findings. Mercer will interview a diverse set of key informants to capture the broadest range of experiences possible.

[16] The Commonwealth of Kentucky. "Kynect resources. Community Partners. Frequency Asked Questions." Accessed December 19, 2024. https://www.chfs.ky.gov/agencies/dms/kynect/krFAQCommunityPartners.pdf

Table 1. Evaluation Measures

Measure(s)	Measure Steward	Numerator	Denominator	Potential Data Sources	Potential Analytical Method
Goal 1: Improve access to services by increasing coverage, continuity of coverage, and appropriate service uptake for eligible incarcerated adults and placed youths.					
RQ 1.1: Does the Demonstration increase coverage?					
Hypothesis 1: The Demonstration will increase the number of individuals who have Medicaid after release from incarceration.					
Individuals eligible for pre-release services	n/a	Count of individuals eligible for pre-release services (i.e., incarcerated in eligible facilities, eligible for Medicaid except for incarceration status)	n/a	Claims/encounter data Eligibility systems KOMS and JKOMS	Descriptive trends over time (one-group post-test-only design) Multivariable regression ANOVA/t-test
Individuals newly enrolled in Medicaid following release	n/a	Number of individuals enrolled in Medicaid at release who were not enrolled in Medicaid at time of incarceration	Number of individuals not enrolled in Medicaid at time of incarceration	Claims/encounter data Eligibility systems	Descriptive trends over time (one-group post-test-only design) Multivariable regression ANOVA/t-test
RQ 1.2: Does the Demonstration increase the uptake of appropriate services pre-release?					
Hypothesis 1: The Demonstration will increase the uptake of appropriate services pre-release.					
Individuals receiving reentry services prior to release from incarceration (and by type of service)	n/a	Number of individuals who received any pre-release service	Number of individuals eligible for pre-release services	Claims/encounter data Eligibility data KOMS and JKOMS	Descriptive trends over time (one-group post-test-only design) Multivariable regression ANOVA/t-test
Commonwealth actions to increase uptake of	n/a	n/a	n/a	Interviews and focus groups with Medicaid	TA

Measure(s)	Measure Steward	Numerator	Denominator	Potential Data Sources	Potential Analytical Method
Demonstration pre-release services (implementation of policies and procedures to identity and serve eligible members, changes in technology and information management/sharing) Member and case manager experience with pre-release services				beneficiaries, case managers, Kentucky ACRES/advisory groups, and DMS/DOC/DJJ representatives	
RQ 1.3 Does the Demonstration improve continuity of coverage and care?					
Hypothesis 1: The Demonstration will increase the number of individuals who access Medicaid-services post-release.					
Percentage of individuals who accessed community-based/ essential services within 7 days post-release	n/a	Number of released individuals who access essential services within 7 days post-release	Number of individuals eligible for pre-release services and have been released	Claims/encounter data Eligibility data KOMS and JKOMS KHIE	Descriptive trends over time (one-group post-test-only design) Multivariable regression ITS (pending data availability) ANOVA/t-test
Percentage of members who continued to access community-based providers within 30 days, 6 months, and 1 year following release	n/a	Number of released individuals who accessed essential services within 30 days, 6 months, and 1 year post-release (3 rates)	Number of individuals who were eligible for pre-release who accessed essential services within 7 days post-release	Claims/encounter data Eligibility data KOMS and JKOMS KHIE	Descriptive trends over time (one-group post-test-only design) Multivariable regression ITS (pending data availability) ANOVA/t-test

Measure(s)	Measure Steward	Numerator	Denominator	Potential Data Sources	Potential Analytical Method
Percentage of individuals who complete post-release follow-up with case manager	n/a	Number of released individuals who had at least one post-release follow-up with case manager within 30 days of release	Number of individuals who were eligible for pre-release services and have been released	Claims/encounter data Eligibility data KOMS and JKOMS KHIE	Descriptive trends over time (one-group post-test-only design) Multivariable regression ITS (pending data availability) ANOVA/t-test
Percentage of members who continued with MAT following release	CMS Adjusted SUD Metric #12	Number of released individuals who received at least one MAT service post-release	Number of individuals who received MAT during their 60-day pre-release period and have been released	Claims/encounter data Eligibility data KOMS and JKOMS KHIE	Descriptive trends over time (one-group post-test-only design) Multivariable regression ITS (pending data availability) ANOVA/t-test
Percentage of members who accessed preventative and routine healthcare visits (i.e., annual check-ups) following release	CMS/HEDIS Adjusted SUD Metric #32	Number of released individuals who received at least one preventative and routine healthcare visit post-release	Number of individuals who were eligible for pre-release services and have been released	Claims/encounter data Eligibility data KOMS and JKOMS KHIE	Descriptive trends over time (one-group post-test-only design) Multivariable regression ITS (pending data availability) ANOVA/t-test
Percentage of members who accessed behavioral health services, among those with a SUD or SMI, following release	n/a	Number of released individuals who have at least one behavioral healthcare visit post-release	Number of individuals who were eligible for pre-release services, have been released,	Claims/encounter data Eligibility data KOMS and JKOMS	Descriptive trends over time (one-group post-test-only design) Multivariable regression

Measure(s)	Measure Steward	Numerator	Denominator	Potential Data Sources	Potential Analytical Method
			and have an SUD/SMI diagnosis	KHIE	ITS (pending data availability) ANOVA/t-test
Perceptions on the Demonstration's impact on access to healthcare services	n/a	n/a	n/a	Interviews and focus groups with Medicaid beneficiaries, case managers, ACRES/advisory groups, and DMS/DOC/DJJ representatives	TA
Goal 2: Improve coordination, communication, and connections between correctional systems, Medicaid systems and processes, managed care plans, and community-based service providers delivering enhanced services to maximize successful reentry post-release.					
RQ 2.1: Did the Demonstration improve coordination and communication between correctional systems, Medicaid, managed care plans, and community-based providers?					
Hypothesis 1: The Demonstration will improve coordination and communication across sectors.					
Changes to data and information sharing processes Commonwealth actions to develop and implement referral processes and information sharing Changes to cross-sector communication and collaboration Commonwealth efforts to support cross-sector	n/a	n/a	n/a	Interviews and focus groups with Medicaid beneficiaries, CBOs/providers, MCOs, ACRES/advisory groups, and DMS/DOC/DJJ representatives Document review	TA

Measure(s)	Measure Steward	Numerator	Denominator	Potential Data Sources	Potential Analytical Method
collaboration (i.e., trainings, outreach plans, establishment of ACRES, policy standardization) Implementation, expansion, and use of health information technology/health information exchange to support collaboration					
RQ 2.2: Does the Demonstration improve access to HRSN services?					
Hypothesis 1: The Demonstration will increase the number of individuals connected to HRSN services.					
CBO referrals	n/a	Count of individuals referred to CBOs	Individuals who were eligible for pre-release services and are now released	Claims/encounter data Eligibility data kynect resources	Descriptive trends over time (one-group post-test-only design) Multivariable regression ITS (pending data availability) ANOVA/t-test
Number and percentage of individuals in stable housing 6 months post-release	n/a	Number of individuals in stable housing	Number of released individuals eligible for pre-release reentry services.	Claims/encounter data Eligibility data kynect resources	Descriptive trends over time (one-group post-test-only design) Multivariable regression ITS (pending data availability) ANOVA/t-test

Measure(s)	Measure Steward	Numerator	Denominator	Potential Data Sources	Potential Analytical Method
Number and percentage of individuals connected to employment 6 months post-release	n/a	Number of individuals employed	Number of released individuals eligible for pre-release reentry services.	Claims/encounter data Eligibility data kynect resources	Descriptive trends over time (one-group post-test-only design) Multivariable regression ITS (pending data availability) ANOVA/t-test
RQ 2.3: Does the Demonstration improve transitions of care?					
Hypothesis 1: The Demonstration will improve transitions of care.					
Commonwealth actions to create and implement standard processes for care planning and service delivery Changes in technology and information management/sharing Member experience with transitions of care and continuity of care	n/a	n/a	n/a	Interviews and focus groups with Medicaid beneficiaries, CBOs/providers, MCOs, ACRES/advisory groups, and DMS/DOC/DJJ representatives Document review	TA
Goal 3: Reduce the number of avoidable ED visits, inpatient hospitalizations, and all-cause mortality.					
RQ 3.1: Does the Demonstration improve healthcare outcomes?					
Hypothesis 1: The Demonstration will improve healthcare outcomes.					
Glycemic Status Assessment for Patients with Diabetes	CMS Adult Core Set (National Committee for	Number of individuals whose most recent glycemic status was < 8.0%	Number of individuals aged 18 years–75 years with a dx of diabetes who were	Claims/encounter data Eligibility data Health records	Descriptive trends over time (one-group post-test-only design)

Measure(s)	Measure Steward	Numerator	Denominator	Potential Data Sources	Potential Analytical Method
	Quality Assurance [NCQA] #1820)		eligible for pre-release services	KHIE	ITS (pending data availability) Multivariable regression ANOVA/t-test
Controlling Blood Pressure	NCQA #167	Number of individuals whose most recent blood pressure reading during the measurement year was <140/90	Number of individuals aged 18 years–75 years with a diagnosis of hypertension who were eligible for pre-release services	Claims/encounter data Eligibility data Health records KHIE	Descriptive trends over time (one-group post-test-only design) ITS (pending data availability) Multivariable regression ANOVA/t-test
Continuity of Pharmacotherapy for OUD	National Quality Forum #3175	Number of individuals with at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days	Number of individuals aged 18+ years with a qualifying encounter during the performance year, and a diagnosis of OUD and pharmacotherapy for OUD during the denominator identification period who were eligible for pre-release services	Claims/encounter data Eligibility data KHIE	Descriptive trends over time (one-group post-test-only design) ITS (pending data availability) Multivariable regression ANOVA/t-test
HIV Viral Load Suppression	CMS Adult Core Set Measure — (Health Resources	Number of individuals who had a HIV viral load less than 200 copies/ml at last test during measurement year	Number of individuals 18+ years with a diagnosis of HIV who were eligible for pre-release services	Claims/encounter data Eligibility data Health records KHIE	Descriptive trends over time (one-group post-test-only design) ITS (pending data availability)

Measure(s)	Measure Steward	Numerator	Denominator	Potential Data Sources	Potential Analytical Method
	and Services Administration #325)				Multivariable regression ANOVA/t-test
Beneficiary self-report on improved health outcomes				Interviews and focus groups with Medicaid beneficiaries	TA
RQ 3.2: Does the Demonstration reduce ED visits and inpatient hospitalizations?					
Hypothesis 1: The Demonstration will decrease unnecessary ED visits.					
ED visits	CMS Adjusted SUD Metric #23	Number of ED visits for SUD	Number of released individuals who were eligible for pre-release services	Claims/encounter data Eligibility data KHIE	Descriptive trends over time (one-group post-test-only design) ITS (pending data availability) Multivariable regression ANOVA/t-test
Hypothesis 2: The Demonstration will decrease preventable inpatient admissions.					
Inpatient admissions	CMS Adjusted SUD Metric #24	Number of inpatient discharges related to SUD	Number of released individuals who were eligible for pre-release services	Claims/encounter data Eligibility data KHIE	Descriptive trends over time (one-group post-test-only design) ITS (pending data availability) Multivariable regression ANOVA/t-test
Hypothesis 3: The Demonstration will decrease the 30-day readmission rate.					

Measure(s)	Measure Steward	Numerator	Denominator	Potential Data Sources	Potential Analytical Method
30-day readmission rate	CMS Adjusted SUD Metric #25	Count of 30-day readmissions	Number of released individuals who were eligible for pre-release services	Claims/encounter data Eligibility data KHIE	Descriptive trends over time (one-group post-test-only design) ITS (pending data availability) Multivariable regression ANOVA/t-test
RQ 3.3: Does the Demonstration decrease the number of overdoses?					
Hypothesis 1: The Demonstration will decrease the number of overdoses.					
Overdoses	n/a	Number of overdoses	Number of released individuals who received pre-release services	Claims/encounter data Eligibility data KHIE Vital Statistics	Descriptive trends over time (one-group post-test-only design) ITS (pending data availability) Multivariable regression ANOVA/t-test
Hypothesis 2: The Demonstration will decrease the number of opioids overdoses.					
Opioid overdoses	n/a	Number of opioid overdoses	Number of released individuals who received pre-release services	Claims/encounter data Eligibility data KHIE Vital Statistics	Descriptive trends over time (one-group post-test-only design) ITS (pending data availability) Multivariable regression ANOVA/t-test

Measure(s)	Measure Steward	Numerator	Denominator	Potential Data Sources	Potential Analytical Method
RQ 3.4: Does the Demonstration reduce all cause deaths in the near term post release?					
Hypothesis 1: The Demonstration will decrease all cause deaths in the first 6 months following release.					
All-cause deaths	n/a	Number of deaths within 6 months post release	Number of released individuals who received pre-release services	Claims/encounter data Eligibility data Vital statistics	Descriptive trends over time (one-group post-test-only design) ITS (pending data availability) Multivariable regression ANOVA/t-test
Hypothesis 2: The Demonstration will decrease overdose deaths in the first 6 months following release.					
Overdose deaths	CMS Adjusted SUD Metric #27	Number of overdose deaths within 6 months post-release	Number of released individuals who received pre-release services	Claims/encounter data Eligibility data Vital statistics	Descriptive trends over time (one-group post-test-only design) ITS (pending data availability) Multivariable regression ANOVA/t-test
RQ 3.5: Does the Demonstration decrease the recidivism rate?					
Hypothesis 1: The Demonstration will decrease the recidivism rate.					
Recidivism rate	Based on DOC's	Number of new felony convictions or return to custody within 24 months of release	Number of individuals released from custody	DOC/DJJ data DOC annual report Claims/encounter data Eligibility data	Descriptive trends over time (one-group post-test-only design) ANOVA/t-test

Measure(s)	Measure Steward	Numerator	Denominator	Potential Data Sources	Potential Analytical Method
	recidivism definition.[17]				
Goal 4: Increase additional investments in healthcare and related services to improve quality of care for Medicaid beneficiaries in carceral settings and post-release reentry community services					
RQ 4.1: Did the Demonstration increase additional investments in healthcare and related services through the reinvestment plan?					
Hypothesis 1: The Demonstration will increase investment in additional healthcare and related services through the reinvestment plan.					
Changes in investments Commonwealth efforts to improve quality of care through investments	n/a	n/a	n/a	Interviews and focus groups with CBOs, MCO, ACRES, and DMS/DOC/DJJ representatives Document review	TA
RQ 4.2: How does the Demonstration impact costs?					
Hypothesis 1: The Demonstration will reduce or maintain PMPM costs for members who received pre-release services.					
PMPM cost for members who received pre-release services	n/a	Total costs for people who received pre-release services	Total member months for people who received pre-release services	Claims/encounter data	Descriptive trends over time (one-group post-test-only design) ITS (pending data availability) Multivariable regression ANOVA/t-test

[17] Kentucky Department of Corrections. 2023 Annual Report. September 18, 2024. https://corrections.ky.gov/public-information/researchandstats/Documents/Annual%20Reports/2023%20DOC%20Annual%20Report%20-%20final%20(1).pdf

Analytical Methods

As noted above in Table 1, Mercer will use a combination of quantitative and qualitative analytical methods to evaluate the Demonstration. Quantitative methods will include the use of ITS, multivariable regression, and statistical tests such as t-tests, based on data availability and methodological appropriateness. Qualitative methods will include TA of key informant interviews and focus groups and document review.

ITS analysis will be used if sufficient historical data from incarcerated facilities or Medicaid is available. As mentioned in the Target and Comparison Group section above, The Commonwealth is in the process of integrating data from carceral facilities into KHIE. The Commonwealth suspends, rather than terminates, Medicaid coverage when an individual is incarcerated and transitions the individual to fee-for-service (FFS). Those who were not Medicaid beneficiaries at the time of incarceration will be assessed for Medicaid eligibility; individuals identified as likely eligible for Medicaid will have an application submitted by DOC to initiate FFS benefits. Mercer will assess FFS Medicaid enrollment to determine whether this data element can help identify individuals who were incarcerated and released prior to the start of the reentry Demonstration to assess post-incarceration outcomes. Mercer will also work with the Commonwealth to understand if it can use DOC or DJJ data to identify those who are incarcerated in eligible facilities in order to construct comparison populations.

Specific outcome measure(s) will be collected for multiple time periods both before and after the start of the intervention. Segmented regression analysis will be used to statistically measure the changes in level and slope in the post-intervention period (after the Demonstration was implemented) compared to the pre-intervention period (before the Demonstration was implemented). If used, the ITS design will be dependent on the availability of historical data for specific outcome measures (see Section 4, “Methodology Limitations,” for more information). The ITS design uses historical data to forecast the **counterfactual** of the evaluation (i.e., what would happen if the Demonstration did not occur). Mercer proposes using basic time series linear modeling to forecast these **counterfactual** rates for three years following the Demonstration implementation. The more historical data available, the better these predictions will be. Mercer will use October 1, 2025 as the start of the post-implementation period for any ITS analysis. October 1, 2025 is the Commonwealth’s anticipated “go-live” date when it will begin providing pre-release services to incarcerated individuals. If the “go-live” date changes, analyses will be adjusted to accommodate that change.

In ITS analyses, the t-test statistic will be reviewed to understand the significance of changes across evaluation time periods: pre-Demonstration and the Demonstration period.

For this Demonstration, establishing the counterfactual is somewhat nuanced. The Driver Diagram and evaluation hypotheses assume that Demonstration activities will have overall positive impacts on outcome measures. The figure below illustrates an ITS design that uses basic regression forecasting to establish the counterfactual. The counterfactual is based on historical data (the blue line). It uses time series averaging (trend smoothing) and linear regression to create a predicted trend line (shown below as the green line). The purple line in the graph is the (sample) actual observed data. Segmented regression analysis will be used to statistically measure the changes in level and slope in the post-intervention period compared to the predicted trend (see “effect” in the graph below).

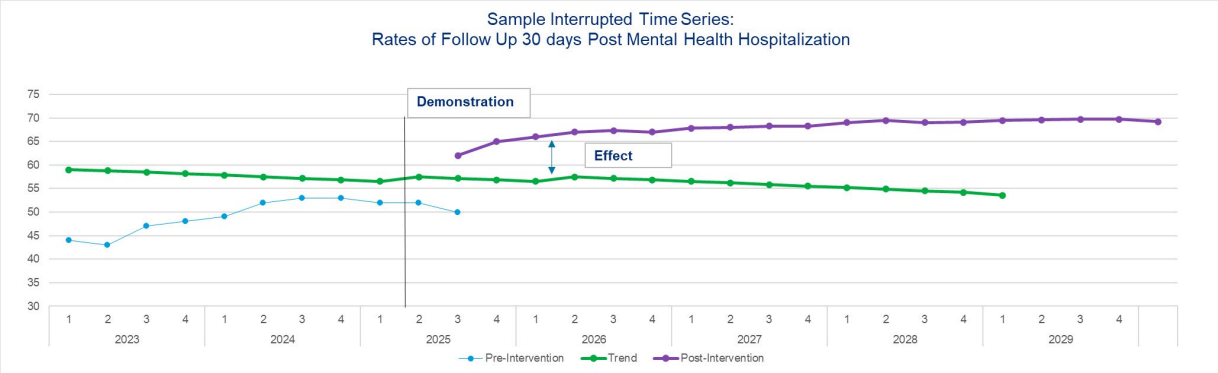
The ITS regression equation is depicted below.

$$Y_{i,t} = \beta_0 + \beta_1 Time_t + \beta_2 Treatment_t + \beta_3 (Treatment_t \times Time_t) + \gamma X_{i,t} + \varepsilon_{i,t}$$

Where β_0 represents the baseline observation, β_1 is the change in the measure associated with a time unit (quarter or year) increase (representing the underlying pre-intervention trend), β_2 is the level change following the treatment (Demonstration implementation), and β_3 is the slope change following the treatment (using the interaction between time and treatment: $Treatment_t \times Time_t$).[18] $X_{i,t}$ is a vector of control variables and $\varepsilon_{i,t}$ represents unobservable factors that may affect the outcome.

This can be represented graphically as follows.

Figure 3: Example of ITS Graphical Representation



Additionally, Mercer will conduct multivariable regression analyses to assess the associational relationship between the Demonstration and outcomes of interest, as well as stratified analyses by subpopulation to understand how differences in beneficiary characteristics,[19] such as age, sex, and pregnancy status, contribute to the relationship between the Demonstration and outcomes of interest.

The multivariable regression equation is depicted below:

$$Y_{i,t} = \beta_0 + \beta_1 Treatment_{i,t} + \gamma X_{i,t} + \varepsilon_{i,t}$$

Where β_0 represents the baseline observation and β_1 represents the relationship between receipt of reentry services and the outcome $Y_{i,t}$. $X_{i,t}$ is a vector of control variables and $\varepsilon_{i,t}$ represents unobservable factors that may affect the outcome. The above regression can be adjusted and stratified by subpopulations of interest, as noted above, to assess whether the relationship between receiving reentry services through the Demonstration (Treatment) varies by subpopulation categories.

Mercer assessed the possibility of utilizing DID analyses. Due to data limitations, namely the lack of pre-Demonstration data on the reentry population and the lack of an appropriate comparison group that would facilitate quasi-experimental analyses to identify causal effects

[18] Bernal JL, Cummins S, Gasparrini A. "Interrupted time series regression for the evaluation of public health interventions: a tutorial." (2017 Feb). International Journal of Epidemiology 46(1): 348–355.

[19] https://academic.oup.com/ejcts/article/55/2/179/5265263

of the reentry Demonstration. As such, DID analyses are most likely not feasible for this evaluation.

Mercer will conduct qualitative data collection at three time points: late 2025 and early 2026, mid- to late 2027, and early to mid-2030. The first round of data collection will capture the early implementation activities and actions that occurred early in the Demonstration's implementation (i.e., "ramp up" period). The second round of qualitative data collection will capture the early period of service provision. The third round of qualitative data collection will occur once the Demonstration has matured and will help illuminate how processes have changed over time, as well as individual's perceptions on the barriers and facilitators to Demonstration success. Standardized interview guides will be developed based on the driver diagram and leverage aspects of the "Consolidated Framework for Implementation Research."[20] Mercer will develop a code book based on the standardized interview guides to analyze the interview transcripts. TA of qualitative data will allow Mercer to draw conclusions from a diverse range of experiences and viewpoints.

[20] Center for Clinical Management Research. 2024, https://cfirguide.org/

Section 4
Methodological Limitations

All analyses are subject to data availability and completeness. Some data sources may be insufficient to complete the analyses as proposed or contain errors that will impact the analysis. Proposed analytical measures (such as ITS, t-tests, multivariable regression, or descriptive time series) do not allow Mercer to draw causal inferences and directly attribute changes to the Demonstration. ITS requires a sufficient number of pre- and post-implementation data points. The amount and accuracy of historical data, especially for those without pre-incarceration Medicaid or CHIP coverage, could impact the usability of that method. Mercer will work closely with the Commonwealth to determine whether pre-Demonstration DOC and DJJ data will be included in the KHIE. However, if pre-Demonstration data is not included, Mercer will not be able to conduct analyses that require pre-implementation data or a comparison group. In such case, Mercer will utilize a one-group post-test-only design (also referred to as "descriptive trends over time" analyses) that will track outcomes over time to assess trends post-implementation, consistent with CMS recommendations in "Selecting the Best Comparison Group and Evaluation Design: A Guidance Document for State Section 1115 Demonstration Evaluations."[21]

Furthermore, the target population and design of the Demonstration introduces its own limitations into the evaluation. The population is relatively narrow, comprising only those who are incarcerated in eligible facilities with a release date that is 60 days in the future. Therefore, it is highly possible that the population of the total Demonstration and/or subpopulations may be too small from which to draw meaningful conclusions. Mercer will leverage qualitative analyses to supplement findings when quantitative analyses are insufficiently powered to yield definitive conclusions. In instances when national data is sufficiently available, such as overdose fatalities post-incarceration, Mercer will conduct benchmarking analyses to evaluate the Commonwealth's performance through the reentry Demonstration in relation to the broader United States.

Additionally, members may get "exposed" to the intervention multiple times, as a result of changes in release dates that may allow a person to be eligible for pre-release services more than once or being incarcerated and released multiple times during the Demonstration period. Mercer will address this through sensitivity tests either by including a control variable that accounts for multiple exposures due to release date changes or by re-running analyses that limit consideration to individuals leaving incarceration who did not have their release date change.

As has been stated previously in the Evaluation Design, Mercer is continuing to work with the Commonwealth to define all the proposed metrics and identify data sources. There is a possibility that the data needed for some metrics will not be available or will require a high level of cleaning/matching between sources to create a useable data set for analysis that may not be feasible due to resource limitations. Additionally, the Commonwealth is working to integrate disparate data sources, which may cause delays in data availability or other issues which may impact the data's usability. Once data sources are identified, Mercer will

[21] https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/comparison-grp-eval-dsgn.pdf

work with the Commonwealth and subcontractors as needed to acquire and integrate data sources. If any proposed metrics are not feasible, Mercer will assess the data from the Commonwealth and its partners to determine whether an alternative measure is feasible and appropriate. If that is the case, Mercer will document any changes and rationale in the Interim and/or Summative Evaluation Reports, as applicable.

Although Mercer will use qualitative data collected from key informant interviews and focus groups to understand policy and implementation changes that may impact the quantitative findings, qualitative research methods have their own set of methodological limitations. Qualitative research focuses on a specific group of individuals' experiences with a policy or policy change and therefore has limited generalizability. Qualitative data is also subject to bias and reflects the individual informant's perspective and experience of the program. Mercer will attempt to limit the impact of this by collecting data from a variety of sources and the use of standardized interview guides. Mercer will check for inter-rater reliability when coding interviews.

Section 5
Attachments

As part of the STCs, as set forth by CMS, the Commonwealth is required to arrange with an independent party to conduct an evaluation of the reentry Demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses.

Mercer was chosen as the independent evaluator through an Individual Project Request process. Mercer will develop the Evaluation Design, calculate the results of the study, evaluate the results for conclusions, and write the Interim and Summative Evaluation Reports. Mercer has over 25 years of experience assisting state governments with the design, implementation, and evaluation of publicly sponsored healthcare programs. Mercer currently has over 25 states under contract and has worked with over 35 different states in total. They have assisted states like Arizona, Connecticut, Missouri, and New Jersey in performing independent evaluations of their Medicaid programs; many of which include 1115 Demonstration waiver evaluation experience. Given their extensive experience, the Mercer team is well equipped to work effectively as the external evaluator for the Demonstration project.

The table below includes contact information for the lead coordinators from Mercer for the evaluation.

Name	Position	Email Address
Nicole Comeaux	Engagement Leader	nicole.comeaux@mercer.com
Stacy Smith	Project Manager	stacy.smith@mercer.com
Faye Miller	Contract Manager	faye.miller@mercer.com
Tonya Aultman-Bettridge, PhD	Evaluator	taultman-bettridge@triwestgroup.net

Appendix A
Conflict of Interest

Mercer's Government specialty practice does not have any conflicts of interest, such as providing services to any MSO or healthcare providers doing business in the Commonwealth under the Commonwealth program or providing direct services to individual recipients. One of the byproducts of being a nationally operated group dedicated to the public sector is the ability to identify and avoid potential conflicts of interest with our firm's multitude of clients. To accomplish this, market space lines have been agreed to by our senior leadership. Mercer's Government group is the designated primary operating group in the Medicaid space.

Before signing a contract to work in the Medicaid market, either at the state level or otherwise, we require any Mercer entity to discuss the potential work with Mercer's Government group. If there is a potential conflict (i.e., work for a Medicaid health plan or provider), the engagement is not accepted. If there is a potential for a perceived conflict of interest, Mercer's Government group will ask our state client if they approve of this engagement, and we develop appropriate safeguards such as keeping separate teams, restricting access to files, and establish process firewalls to avoid the perception of any conflict of interest. If our client does not approve, the engagement will not be accepted. Mercer has collectively turned down a multitude of potential assignments over the years to avoid a conflict of interest.

Mercer is a technical assistance provider for the Commonwealth on a separate Medicaid project. Given that Mercer is acting as both technical assistance provider and independent evaluator for this project, Mercer has implemented measures to ensure there are no perceived conflicts of interest and project teams do not overlap. The Mercer and TriWest teams are functionally and physically separate from the technical assistance team, and the contract does not include any performance incentives that would contribute to a perception of conflicted interests between technical assistance services and the independence of the evaluation process.

In regards to Mercer's proposed subcontractors, all have assured Mercer there will be no conflicts and that they will take any steps required by Mercer or DMS to mitigate any perceived conflict of interest. To the extent that we need to implement a conflict mitigation plan with any of our valued subcontractors, we will do so. Mercer, through our contract with DMS, has assured that it presently has no interest and will not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services. Mercer has further assured that in the performance of this contract, it will not knowingly employ any person having such interest. Mercer additionally certified that no member of Mercer's Board or any of its officers or directors has such an adverse interest.

Appendix B
Evaluation Budget

Table B.1 below presents the budget for the evaluation for the TEAMKY reentry Demonstration. Budget estimates include hours for staff, development of data collection instruments, development of metrics and determination of data sources, data cleaning and ingestion, data collection, analysis, and report writing.

Table B.1 Evaluation Budget

Category	State Fiscal Year 2025 (SFY25)	SFY26	SFY27	SFY28	SFY29	SFY30	SFY31	SFY32	Total
Project Management	$61,187	$61,187	$61,187	$61,187	$61,187	$61,187	$61,187	$61,187	**$489,500**
Evaluation Design	$68,625	x	x	x	x	x	x	x	**$68,625**
Interim Evaluation Report	x	$26,294	$26,294	$26,294	$26,294	$19,000	x	x	**$124,175**
Midpoint Assessment	x	x	x	$46,000	$10,000	x	x	x	**$56,000**
Summative Evaluation Report	x	x	x	x	x		$42,800	$19,000	**$61,800**
Data	$162,762	$294,094	$309,703	$309,703	$309,703	$309,703	x	x	**$1,695,671**
Total	**$292,575**	**$381,575**	**$397,185**	**$443,185**	**$407,185**	**$389,891**	**$103,988**	**$80,168**	**$2,495,771**

Table B.2 Hours by Evaluation Staff Role

Year	Project Director	Principal Consultants	Senior Consultants	Consultant	Junior Consultant	Project and Administrative Support	Total Hours
SFY25	175	359	265	135	100	95	**1,129**
SFY26	375	359	255	245	110	95	**1,439**
SFY27	375	359	255	245	110	95	**1,439**
SFY28	375	359	255	245	110	95	**1,439**
SFY29	375	359	255	245	110	95	**1,439**
SFY30	375	359	255	245	110	95	**1,439**
SFY31	375	359	255	245	110	95	**1,439**
SFY32	100	180	125	135	55	45	**640**
Final Total	**2,425**	**2,513**	**1,795**	**1,605**	**760**	**665**	**10,403**

Appendix C
Potential Timeline and Major Deliverables

The table below highlights key evaluation milestones and activities for the Demonstration and the dates for completion. Dates are estimated based on a full approval date of January 1, 2025.

Table C.1 Deliverables

Deliverable	STC Reference	Date
Submit Evaluation Design to CMS	68	December 29, 2024
Final Evaluation Design	69	60 days after comments received from CMS
Midpoint Assessment Due	37	60 days after December 12, 2027
Draft Interim Evaluation Report	72	December 31, 2028
Final Interim Evaluation Report	72	60 days after CMS comments received
Draft Summative Evaluation Report Due 18 Months Following End of the Demonstration	73	July 2031
Final Summative Evaluation Report	73	60 days after CMS comments received

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