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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

December 23, 2020

MaryAnne Lindeblad
Medicaid Director
Health Care Authority
626 8th Avenue SE
P.O. Box 45502
Olympia, Washington 98504-5010

Dear Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the Serious Mental Illness (SMI) Implementation Plan for Washington's approved section 1115(a) demonstration, titled "Medicaid Transformation Project" ("MTP") (Project No. 11-W-00030/1). We have determined that the implementation plans are consistent with the requirements outlined in Washington's Institutions for Mental Disease Waiver for the Serious Mental Illness demonstration's Special Terms and Conditions (STCs). Therefore, CMS is approving the SMI Implementation Plan. With this approval, the state may begin receiving federal financial participation as of the effective date of December 23, 2020, for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment for a serious mental illness (SMI) who are short-term residents in facilities that meet the definition of an institution for mental disease (IMD). A copy of the approved SMI Implementation Plan is enclosed and, hereby, incorporated into the STCs as Attachment O.

If you have any questions, please do not hesitate to contact your project officer, Ms. Diona Kristian. Ms. Kristian can be reached at Diona.Kristian@cms.hhs.gov.

Sincerely,

Angela D. Garner -S

Digitally signed by Angela D. Garner -S
Date: 2020.12.23 11:51:48 -05'00'

Angela D. Garner
Director, Division of System Reform Demonstrations

Enclosure

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

Section 1115 SMI/SED Demonstration Implementation Plan
July 23, 2019

Overview: The implementation plan documents the state's approach to implementing SMI/SED demonstrations. It also helps establish what information the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments.

This template only covers SMI/SED demonstrations. The template has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
5. Financing Plan
6. Health IT Plan

State may submit additional supporting documents in Section 3.

Implementation Plan Instructions: This implementation plan should contain information detailing state strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on "Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]" over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the state already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the state to meet all of the expectations for each milestone, including the persons or entities responsible for completing these actions; and
2. Describe the timelines and activities the state will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.

The state may not claim FFP for services provided to Medicaid beneficiaries residing in IMDs, including residential treatment facilities, until CMS has approved a state's implementation plan.

Memorandum of Understanding: The state Medicaid agency should enter into a Memorandum of Understanding (MOU) or another formal agreement with its State Mental Health Authority, if one does not already exist, to delineate how these agencies will work with together to design, deliver, and monitor services for beneficiaries with SMI or SED. This MOU should be included as an attachment to this Implementation Plan.

State Point of Contact: Please provide the contact information for the state's point of contact for the implementation plan.

Name and Title: Chase Napier, Medicaid Transformation Manager
Telephone Number: (360) 725-0868
Cell Number: (360) 581-3515
Email Address: chase.napier@hca.wa.gov

1. Title page for the state's SMI/SED demonstration or SMI/SED components of the broader demonstration

The state should complete this transmittal title page as a cover page when submitting its implementation plan.

State	*Washington State.*
Demonstration name	*Washington State Medicaid Transformation Project No. 11-W-00304/0*
Approval date	*January 9, 2017*
Approval period	*January 9, 2017-December 31, 2021*
Implementation date	*01/01/2021*

2. Required implementation information, by SMI/SED milestone

Answer the following questions about implementation of the state's SMI/SED demonstration. States should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or non-government entities). Place "NA" in the summary cell if a prompt does not pertain to the state's demonstration. Answers are meant to provide details beyond the information provided in the state's special terms and conditions. Answers should be concise, but provide enough information to fully answer the question.

This template only includes SMI/SED policies.

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk. *To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.*	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized	*Current Status:* At present Washington State currently has 11 mental health Institution for Mental Diseases facilities providing acute inpatient care. All residential facilities are currently licensed by the state to primarily provide treatment for mental illnesses and are Joint Commission accredited. All hospitals are Medicare participating facilities in compliance with Medicare CoPs licensed by the Washington State Department of Health.

accreditation entity prior to participating in Medicaid	*Future Status:* The state will only use federal financial participation for facilities that are licensed by the state to provide short term acute residential treatment and accredited by the Joint Commission or other federally recognized accreditation body.
	Summary of Actions Needed: Revise MCO contracts and FFS payment systems to only allow payments involving Medicaid FFP for exclusion age IMD when services are provided in appropriately licensed and nationally accredited IMD facilities with ALOS of 30 days or less and no individual stay of more than sixty days.
1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	*Current Status:* The inpatient mental health facilities contracted by MCOs in accordance with the provisions of 42 CFR 438.6(e) that meet the institution for mental diseases designation in Washington are Joint Commission accredited and subject to Joint Commission auditing and certification processes. In addition, all psychiatric hospitals and free standing evaluation and treatment facilities are licensed by the Washington State Department of Health. The Department of Health provides annual and unannounced site visits to both facility types. Regulations for evaluation and treatment services can be found in WAC 246-341-1134 Such facilities must meet the agency licensure, certification, administrative, personnel, and clinical requirements in WAC 246-341-0100 through 246-341-0650 and the applicable inpatient services requirements in WAC 246-341-1118 through 246-341-1132. Additionally, the Washington State Legislature recently passed Substitute House Bill 2426 in March of 2020 which became effective on of the date of the Governor's signature. This legislation: • Establishes penalties for psychiatric hospitals and RTFs that fail or refuse to comply with state licensing standards, including civil fines and stop placements. • Requires psychiatric hospitals and RTFs to report patient elopements and specified types of deaths that occur on their grounds.

	• Requires the Department of Health to post health care facility inspection related information on its website.
	Future Status: The state believes it meets the requirements of this milestone.
	Summary of Actions Needed: N/A
1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	*Current Status:* **Managed Care:** Approximately 85% of Washington State Medicaid recipients are enrolled in managed care entities which are at risk for their inpatient psychiatric services at participating facilities not owned by or directly contracted with the state. Authorization and payment of services follow CMS approved language which follows the requirements of 42 CFR 438.206 with patient protections for access to emergency services as required by 42 CFR 438.114. Staff making authorization decisions must be credentialed in mental health (MCO IMC contract term 11.1.4). Managed care entities must publish their criteria used for utilization management decision making. Managed care entities must report on utilization management authorization turnaround time compliance (MCO IMC contract term 11.1.6.5). The state requires Managed Care Organization utilization management decision making to take into account the greater and particular needs of diverse populations, as reflected in health disparities, risk factors (such as Adverse Childhood Experiences for enrollees of any age), historical trauma, and the need for culturally appropriate care. **Fee-for-Service:**

	An expedited prior authorization (EPA) process is utilized for FFS services billed directly to the health care authority (HCA) Authorization criteria for inpatient psychiatric services is published in HCA's provider guide for mental health services and hospitals. The billing provider must document how EPA criteria were met in the client's file and make this information available to HCA upon request. When the patient's situation does not meet published criteria for EPA, formal written PA is required. All services are subject to retrospective review
	Future Status: **Managed Care:** The state believes it meets the requirements of this milestone for this population. **Fee-for-Service:** The state believes it meets the requirements of this milestone for this population.
	Summary of Actions Needed: N/A
1.d Compliance with program integrity requirements and state compliance assurance process	*Current Status:* All facilities participating in the state's Medicaid program must be enrolled with the HCA. HCA has a process for conducting risk-based screening of all newly enrolling providers and revalidating existing providers pursuant to 42 CFR Part 455 Subparts B and E. HCA requires providers enter into Medicaid provider agreements pursuant to 42 CFR 431.107.
	Future Status: The state believes it meets the requirements of this milestone.

	Summary of Actions Needed: N/A
1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	*Current Status:* Washington State's Medicaid inpatient psychiatric care network includes two distinct levels of care: 1. Psychiatric hospitals 2. Residential treatment facilities licensed as evaluation and treatment centers At this time, all of the state's inpatient psychiatric Institution for Mental Diseases facilities are Medicare participating, nationally accredited, state licensed hospitals. Under Washington State Law, RCW 71.24.510, an integrated comprehensive screening and assessment process for substance use and mental disorders is required for any provider offering treatment under the community behavioral health services act which would include all psychiatric hospitals and residential settings. WAC 246-341-0610 also requires facilities to provide a clinical assessment (including an assessment for suicide ideation and SUD). WAC 246-341-0610 also includes the requirement to refer for provision of emergency/crisis services. State rules and managed care contracts require assessment of co-occurring substance use disorder and physical health issues. When comorbid conditions arise, facilities must treat the condition on site or refer the individual to treatment. **Relevant Washington Administrative Code provider rules applicable to FFS and MCO services:** 1. (E&T) WAC 246-337-080 residential treatment facilities must provide or accept a current health screening upon admission of all residents including a tuberculosis and symptom screen. They are required to assist residents with all health care needs and refer to the appropriate level of care when needed. Residential treatment facilities must have policies and procedures in place to address how they will deal with medical emergency situations and that outline the referral process.

	2. (E&T) WAC 246-341-0610 All behavioral health agencies, including residential treatment facilities and crisis stabilization units, must provide a thorough assessment of the client upon admit. This assessment includes a medical history and information about the individual's primary care physician. 3. (Hospitals) WAC 246-341-1126 and (Psychiatric Hospitals) WAC 246-322-170 Facilities must provide a health assessment within 24 hours of admission. The assessment is completed by a nurse practitioner, physician, or physician's assistant and must determine whether the individual needs to be transferred to another level of care due to medical concerns. In addition, facilities must have access to a medical provider for consultation 24 hours a day, 7 days a week. 4. (E&T) WAC 246-341-0610 Each agency licensed by the department of health to provide any behavioral health service must conduct an assessment of any risk of harm to self and others, including suicide, homicide, and a history of self-harm. In addition, all clinical staff in Washington State must attend a training on suicide assessment. **Relevant Managed Care Contract Requirements:** HCA contracts with five Managed Care Organizations to cover inpatient mental health services. HCA contracts require Managed Care Organizations to manage co-occurring disorders at all levels of care: 1. All individuals must be screened using the GAIN-SS SUD and mental health co-occurring disorder tool. 2. Managed Care Organizations must ensure network providers are trained on co-occurring disorders. (IMC 9.11.2.4) 3. Utilization management staff must have an understanding of co-occurring assessment and treatment. (IMC 11.1.4; 11.1.18) **Relevant Fee-for-Service Program Requirement:** Psychiatric hospitals and residential treatment facilities contracted with the state to provide services are required to follow appropriate Washington Administrative Codes related to this topic.

	Future Status: The state believes that the Washington Administrative Code requirements for health and co-morbid screening and treatment within inpatient facilities meets the requirements of this milestone.
	Summary of Actions Needed: N/A
1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	*Current Status:* Per WAC 246-341-0320: Agency licensure and certification—on-site reviews and plans of correction. To obtain and maintain a department-issued license and to continue to provide department-certified behavioral health services, each agency is subject to an on-site review to determine if the agency is in compliance with the minimum licensure and certification standards. (1) A department review team representative(s) conducts an entrance conference with the agency and an on-site review that may include: (a) A review of: (i) Agency policies and procedures; (ii) Personnel records; (iii) Clinical records; (iv) Facility accessibility; (v) The agency's internal quality management plan, process, or both, that demonstrates how the agency evaluates program effectiveness and individual participant satisfaction; and (vi) Any other information, including the criteria in WAC 246-341-0335 (1)(b), that the department determines to be necessary to confirm compliance with the minimum standards of this chapter; and

	(b) Interviews with: (i) Individuals served by the agency; and (ii) Agency staff members. (2) The department review team representative(s) concludes an on-site review with an exit conference that includes a discussion of findings. (3) The department will send the agency a statement of deficiencies report that will include instructions andtime frames for submission of a plan of correction. (4) The department requires the agency to correct the deficiencies listed on the plan of correction: *(a)* By the negotiated time frame agreed upon by the agency and the department review team representative; or immediately if the department determines health and safety concerns require immediate corrective action.
	Future Status: The state believes that the Washington Administrative Code requirements for agency licensure and certification meet the requirements for this milestone.
	Summary of Actions Needed: N/A

Prompts	Summary
SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.	
Improving Care Coordination and Transitions to Community-based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.	*Current Status:* Washington State's behavioral health delivery system strives for a culture of effective care coordination among all provider types and between all levels of care. The HCA's move to integrate management of physical and behavioral health and the state's efforts through the other four 1115 demonstration waiver initiatives are evidence of this commitment. While many coordination of care requirements have been in place in the mental health system for decades, the state continues to improve the overall behavioral and physical health link. The state Medicaid director's letter (SMD # 18–0011) announcing the 1115 Mental Health Institution for Mental Diseases waiver opportunity states that nationwide only 38% of adult beneficiaries had a follow-up within 7 days of discharge from a psychiatric admission. 60% had a follow-up visit within 30 days of discharge. Washington State's most recent numbers are significantly higher than the national average. In 2018, 64% had a follow-up within 7 days, and 81% within 30 days. **Relevant Washington Administrative Code Rules:** The state's inpatient and residential treatment facilities licensing rules require consideration of discharge planning early in the individual's stay. Inpatient facilities must coordinate care with the individual's current or future outpatient provider. Discharge plans are documented. 1. (Hospital) WAC 246-320-226 The initial assessment must include a consideration of discharge planning and estimated timeframe. Discharge planning must be coordinated with the outpatient agency and family or caregivers. 2. (Psychiatric Hospital) WAC 246-322-170 Hospitals must provide discharge planning and documentation including

a review of the patient's hospitalization, condition upon discharge, and recommendations for follow-up and continuing care. Discharge planning must be coordinated with outpatient providers.

3. (E&T) WAC 246-337-095 Evaluation and Treatment Centers must document a discharge summary including recommendations for follow up care.

4. (Inpatient MH) WAC 246-341-1126(d) The initial treatment plan must include a plan for discharge and follow up care.

5. (Crisis Stabilization and Crisis Triage) WAC 246-341-1150 and WAC 246-341-1142 Crisis stabilization and crisis triage units must coordinate with outpatient providers and develop a discharge plan with dates, times, and addresses of follow up care appointments.

(All BHA) WAC 246-341-0640 Related to documentation of discharge, including requirements around coordination and information sharing with community based providers. This provision applies to all Behavioral Health Administrations.

Relevant Managed Care Contract Requirements:
As mentioned under Milestone II.E, the state requires Managed Care Organizations to ensure individuals are screened for comorbid conditions. Coordination with physical health and substance use disorder providers is part of the screening and referral process. Managed Care organizations are also required to ensure coordination occurs between inpatient and outpatient levels of care. Contract requirements include:

1. Managed Care Organizations are required to be actively involved in discharge planning. (16.4.6)

2. Managed Care Organizations must develop a plan with inpatient facilities regarding discharge planning responsibilities. This includes a follow-up call within two to three business days of discharge. (14.17)

3. Individuals have a follow up outpatient appointment within seven calendar days of discharge from an inpatient facility. (6.10.1)

4. To monitor proper post-discharge care, the state mandates a 30-day readmission performance measure. (7.3.7)

Relevant Fee-for-Service Programs:
The following programs available to beneficiaries covered by the Medicaid fee-for-service program support pre-discharge planning and care transitions:

Health Home program – This program provides care management and coordination, transition planning, support for the individual and family, referrals to support services in the hopes of promoting better health. Services are provided by a care coordinator who works with the patient and family to develop a health action plan, assist in transitions between types of care and work with providers. Beneficiaries with a chronic condition, including SMI, and at risk for a second condition are eligible.

1. Primary Care Case Management (PCCM) program – This program provides primary care case management through enrolled Indian health service, Tribal, and Urban Indian Health program providers, including support for pre-discharge planning and care transitions.

2. Medicaid Administrative Claiming programs – these programs partially reimburse governmental entities, including the Indian Health Service and Tribes, for time staff spent helping individuals apply for, understand, and access Medicaid services.

Current Statewide Strategies:
The state has invested in several strategies to improve coordination of care and post discharge treatment for individuals leaving inpatient care. Some of these efforts are described below.

1. The Peer Bridgers program delivers services to individuals in state and community hospitals prior to discharge and after their return to their communities. The Peer Bridger develops a relationship of trust with the participant. In developing this trust, the Peer Bridger may function as a role model, peer support, a mentor, a teacher, an advocate, and an ally as they communicate hope and encouragement.

2. State Plan Services: Washington's Medicaid State Plan includes a rehabilitation case management service allowing liaisons from the community to actively participate in discharge planning for individuals receiving psychiatric inpatient care. Currently, when these services occur in an IMD, state-only funds are used for ineligible services.

	3. Step Down Facilities: The Legislature appropriated funding for a new community facility type to address the need for additional discharge placements for individuals leaving the state psychiatric hospitals. Intensive behavioral health treatment facilities serve individuals who possess higher levels of behavioral challenges that existing alternative behavioral health facilities cannot accommodate. 4. Program for Assertive Community Treatment (PACT) teams provide wrap around services for individuals in outpatient treatment. When the individual is in an inpatient facility, the PACT team coordinates care with the inpatient unit and work to ensure stable housing and follow-up care. Currently there are 14 PACT teams across the state. In May 2019 the Legislature provided funding for eight additional PACT teams statewide 5. Washington State's Department of Commerce announced $7.1 million in grants to six health care providers across Washington, adding 71 additional beds to facilities that help people with a wide variety of behavioral health issues. Twenty-eight of the new beds are dedicated as an alternative to treatment in state psychiatric hospitals. These grants are part of the governor's five-year plan to modernize and transform the state's mental health care systems by shifting out of large institutions to smaller, community-based facilities. 6. State-tribal collaboration to improve access to behavioral health care for American Indians and Alaska Natives. The state is currently in collaboration with a newly formed Tribal Centric Behavioral Health Advisory Board to develop a comprehensive plan to increase access to crisis services and culturally appropriate behavioral health care services for American Indians and Alaska Natives in Washington State. This plan includes a Tribal Crisis Coordination Hub to support tribes, Indian health care providers, and non-tribal providers with inpatient placement, transition planning, and care coordination across the continuum of treatment for American Indians and Alaska Natives beneficiaries.
	Future Status: HCA will amend contract and WAC language to ensure that psychiatric hospitals and residential settings carry out intensive pre-discharge planning and include community based providers in care transitions.
	Summary of Actions Needed: AHCA will amend its MCO contracts to require pre-discharge planning and participation of community providers no later than January 2022.

	HCA will amend WAC no later than July 1, 2022 in order to assure that FFS clients will receive pre-discharge planning and include the participation
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	*Current Status:* HCA understands that housing is an integral part of stability for the individuals we serve. Safe and stable housing increases the chances that individuals remain stable in the community and reduces the likelihood of unnecessary inpatient stays. The state has requirements in place requiring providers and managed care entities to address housing issues. In addition, there are several statewide initiatives addressing this issue. **Relevant Washington Administrative Code Rules:** In addition to screenings and assessments for comorbid disorders described in other sections, state rules require facilities to assess for housing and employment needs. 1. (E&T) WAC 246-341-0610 All behavioral health agencies, including residential treatment facilities and crisis stabilization units, must provide a thorough assessment of the client upon admit. This assessment includes a medical history and information about the individual's primary care physician. The assessment must also include an employment and housing assessment. **Relevant Managed Care Contract Requirements:** The state's requirements that Managed Care Organizations participate in discharge planning and coordinate care include a focus on determining and addressing an individual's housing needs. 1. Managed Care Organizations must establish protocols for discharge planning that include community supports necessary for recovery, including housing, transportation, employment and educational concerns, and social supports. (11.1.29.3) 2. Within 60 days of enrollment, Managed Care Organizations must conduct initial health screening assessments, to include a housing and housing instability assessment. (14.3.4).

	3. Managed Care Organizations must demonstrate ongoing coordination with housing agencies (14.1.9.1/14.10.1.17). **Relevant Fee-for-Service Programs:** 1. Health Homes and Medicaid Administrative Claiming programs provide support for coordination with housing service providers, including tribal housing support programs for American Indians and Alaska Natives beneficiaries covered by the Medicaid fee-for-service program. **Current Statewide Strategies:** 1. Washington State has several coordinated entry programs that assist homeless or at-risk individuals in obtaining housing. These programs are available in each region of the state. 2. The state has developed an institutional discharge planning toolkit that involves guidance and a housing assessment tool for individuals discharging from institutions. 3. Initiative 3 of the state's 1115 demonstration waiver focuses on supportive housing and employment services. As of March 2019, 1,991 beneficiaries were enrolled in supportive housing. Non-traditional providers and behavioral health providers, including Indian health care providers, are able to participate in this program. 4. The Legislature appropriated funding for a new community facility type to address the need for additional discharge placements for individuals leaving the state psychiatric hospitals. Intensive behavioral health treatment facilities serve individuals who possess higher levels of behavioral challenges that existing alternative behavioral health facilities cannot accommodate. Intensive behavioral health treatment facilities are intended to serve as a bridge for high needs individuals who stay between12 to 18 months before transitioning to more independent living in supported housing projects. 5. The Housing and Recovery through Peer Services (HARPS) program builds on the successes of the Permanent Options for Recovery-Centered Housing (PORCH) project. PORCH provided consumers with meaningful choice and control of housing and support services, using peer housing specialists. The HARPS project reduces homelessness and supports the recovery and resiliency of individuals with serious mental illness. Each team consists of three full-time employees (a mental health professional and two certified peer counselors). One of the priority target populations for the HARPS program is individuals discharging from inpatient psychiatric care. The state Legislature recently funded four additional HARPS teams with a focus on individuals discharging from

	forensic facilities. Program for Assertive Community Treatment (PACT) teams provide wrap around services for individuals in outpatient treatment. When the individual is in an inpatient facility, the PACT team coordinates care with the inpatient unit and work to ensure stable housing and follow-up care. Currently there are 14 PACT teams across the state. In May 2019 the Legislature provided funding for eight additional PACT teams statewide.
	Future Status: The state believes that the Washington Administrative Code requirements and statewide strategies meet the requirements of this milestone.
	Summary of Actions Needed: N/A
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	*Current Status:* **Current Status:** The state understands the importance of immediate follow-up care upon discharge from an inpatient or residential facility. The rules and initiatives in place demonstrate the state's commitment to ensuring clients receive adequate and immediate care when discharging from a psychiatric facility. **Relevant Washington Administrative Code Rules:** While there are no specific statewide rules regarding follow-up within 72 hours of discharge, see Milestones II.A and II.B for a full discussion of Washington Administrative Code requirements around discharge planning and coordination of care reviews. **Relevant Managed Care Contract Requirements:** As described under Milestone II.A, Managed Care Organizations must develop a plan with inpatient facilities regarding discharge planning responsibilities. This includes a follow-up call within two to three business days of discharge. (14.17) See section II.A and II.B for a full discussion of contract requirements related to discharge planning and coordination of care with outpatient providers.

	Relevant Fee-for-Service Programs: Health Homes and Medicaid Administrative Claiming programs provide support for coordination with housing service providers, including tribal care coordination and tribal governmental social service programs for American Indians and Alaska Natives beneficiaries covered by the Medicaid fee-for-service program. **Current Statewide Strategies:** See Milestones II.A and II.B for a full discussion of the state's efforts around discharge planning and coordination of care. HCA's Medicaid Program Operations and Integrity reviews data in partnership with state's division of Research and Data Analysis (RDA) and contracted MCOs to monitor follow up after ED and Inpatient readmission rates to monitor trends and institute corrective actions as needed.
	Future Status: Residential treatment facilities and psychiatric hospitals will contact beneficiaries and community based providers through the most effective means possible within 72 hours post discharge.
	Summary of Actions Needed: HCA will amend its MCO contracts to shorten the contact period to 72 hours. Timeline: no later than January 2022. HCA will amend the administrative code it is responsible for to add the 72 hour follow-up requirement to provider WAC in order to assure FFS clients will receive these services. Timeline: no later than July 1, 2022.
2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	*Current Status:* **Current Status:** Washington State demonstrates its commitment to reducing the length of stay in emergency departments through a number of efforts focused on clinical interventions and coordination of care. **Relevant Washington State Law:** Washington law require designated crisis responders to respond to emergency department requests within specified time frames. When an individual self-presents in an emergency department, the hospital may only hold the person for up to six

	hours before the designated crisis responder must make their determination (RCW 71.05.050). If a peace officer delivers the individual to the emergency department, the individual must be examined by a mental health professional within three hours. The designated crisis responder must determine if the individual meets involuntary treatment criteria within 12 hours of patient arrival. If the individual does not meet criteria, the DCR formulates a plan for less restrictive treatment to facilitate discharge from the emergency department. **Relevant Managed Care Contract Requirements:** Reducing unnecessary emergency department visits is a focus of the managed care system in Washington State. Contract requirements include efforts around coordination of care and sharing of information. Examples include: 1. Managed Care Organizations must have a process for communicating with primary care providers around overuse of the ED. (14.5.7.3.3) 2. Unnecessary emergency department visits is a required measure Managed Care Organizations must include in their quality plans. (7.1.1.2.16) 3. Managed Care Organizations utilize the Emergency Department Information Exchange (EDIE) to track and intervene with emergency department high utilizers. **Relevant Fee-for-Service Programs:** The Health Home program helps to prevent or decrease lengths of stay in emergency departments among beneficiaries with SMI or SED prior to admission through intensive case management and care coordination services for eligible beneficiaries (individuals with one or more chronic conditions, a predictive risk scores of 1.5 or greater per WAC 182-557-0200, and covered by the Medicaid fee-for-service program). **Current Statewide Strategies:** The state has implemented a number of programs directed at reducing unnecessary emergency department visits and reducing the overall length of stay in emergency departments for individuals presenting with a behavioral health issue. 1. The Peer Bridgers program delivers services to individuals in state and community hospitals prior to discharge and after their return to their communities. The Peer Bridger develops a relationship of trust with the participant. In developing this trust, the Peer Bridger may function as a role model, peer support, a mentor, a teacher, an

advocate, and an ally as they communicate hope and encouragement.

2. Crisis Triage and Stabilization Investments: Between 2017-18, the state funded several new triage and crisis stabilization facilities across the state. Three facilities are open and four expected to open in the coming year, for a total of 102 crisis stabilization and triage beds across six regions of the state. The 2019 state Legislature funded even more 16-bed triage and stabilization facilities. The Legislature also funded Mobile Outreach Crisis Teams.

3. The Legislature recently funded five mental health peer respite centers to divert individuals from crisis services as well as a pilot program to provide mental health drop-in center services.

4. The Housing and Recovery through Peer Services (HARPS) program builds on the successes of the Permanent Options for Recovery-Centered Housing (PORCH) project. PORCH provided consumers with meaningful choice and control of housing and support services, using peer housing specialists. The HARPS project reduces homelessness and supports the recovery and resiliency of individuals with serious mental illness. Each team consists of three full-time employees (a mental health professional and two certified peer counselors). One of the priority target populations for the HARPS program is individuals discharging from inpatient psychiatric care. The state Legislature recently funded four additional HARPS teams with a focus on individuals discharging from forensic facilities.

5. Program for Assertive Community Treatment (PACT) teams provide wrap around services for individuals in outpatient treatment. When the individual is in an inpatient facility, the PACT team coordinates care with the inpatient unit and works to ensure stable housing and follow-up care. Currently there are 14 PACT teams across the state. In May 2019 the Legislature provided funding for eight additional PACT teams statewide.

6. Washington State's Department of Commerce announced $7.1 million in grants to six health care providers across Washington, adding 71 additional beds to facilities that help people with a wide variety of behavioral health issues. Twenty-eight of the new beds are dedicated as an alternative to treatment in state psychiatric hospitals. These grants are part of the governor's five-year plan to modernize and transform the state's mental health care systems by shifting out of large institutions to smaller, community-based facilities.

7. Co-Responders with Law Enforcement: The state continues to expand programs that fund mental health

	professionals who ride along with law enforcement as they respond to calls where mental health conditions may be involved. 8. Emergency Department is for Emergencies: This legislative initiative prompted by House Bill 2127 in 2012 promotes the implementation of emergency room best practices and requires Washington hospitals to implement seven best practices: 1) tracking ED visits to avoid ED shopping, 2) patient education, 3) institute an extensive case management program, 4) reduction of inappropriate ED visits by collaborative use of prompt visits to primary care, 5) narcotic guidelines to discourage narcotic seeking behavior, 6) data tracking for patients prescribed controlled substances, 7) outcome measurement and reporting. 9. Development of Behavioral Health Aides: The state is collaborating with tribes to support behavioral health aides, who can provide early identification and treatment support for beneficiaries with SED or SMI, to prevent emergency department admission.
	Future Status: The state believes that the Washington Administrative Code requirements and statewide investments and strategies meet the requirements of this milestone.
	Summary of Actions Needed: N/A
2.e Other State requirements/policies to improve care coordination and connections to community-based care	*Current Status:* See sections above.
	Future Status: N/A

	Summary of Actions Needed: N/A

Prompts	Summary
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	
Access to Continuum of Care Including Crisis Stabilization	
3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports.	***Current State:*** The state has conducted the initial SMI service availability assessment through compilation of RDA, Washington Medical Commission, DOH, HCA, MCO, and BH-ASO data.
	Future Status

	HCA's DBHR will work with its partners to conduct and report the required SMI assessments on an annual basis.
	Summary of Actions Needed: • MD and PA demographics related to specialization and board certification will be obtained from the Washington Medical Commission. • Non-prescribing MH professional and facilities information will be provided by DOH and HCA annually. • Network adequacy reports of Medicaid contracted MCOs shall also be used to supplement information drawn from the state MMIS system. • The Research Data Analysis division of our Department of Social and Health Services will provide enrollee data. • The state will convene workgroups on data reporting on a bi-monthly basis to assure that data is collected and collated in a timely manner. • The state will report metrics required by this demonstration in annual monitoring reports.
3.b Financing plan	*Current Status:* Financing Plan is included in separate section see below.
	Future Status: See Below.
	Summary of Actions Needed: See Below.

3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	*Current Status:* Washington state is actively planning on building a statewide bed registry to track inpatient and crisis bed availability. Development of a bed tracking system is essential to support our evidence based system of care aim of delivering timely and appropriate interventions and treatment support to those impacted by SMI and/or SED WATrac is a Washington Department of Health sponsored web-based system that facilitates emergency response. King County, the county with the largest population, is currently using WATrac's bed tracking features too coordinate placements.
	Future Status: The state will have a statewide bed tracking registry with the capacity to include all psychiatric treatment beds and secure withdrawal management beds intended to support the stability and treatment of the Serious Mental Ill (SMI) and the Serious Emotional Disturbance (SED) populations. To this end the state has applied for grants and is seeking funding from the legislature.
	Summary of Actions Needed: • Convening a stakeholder advisory group consisting of representatives from the Behavioral Health Advisory Committee (BHAC), which provides leadership in implementation of Washington's Mental and Substance Use Block Grants and includes members with lived experience, state agencies, community treatment organizations, the state hospital association, and advocacy groups will be assembled to assist in guiding the decisions on the bed registry project. This will include development of system business requirements and use requirements. • Development and activation of an advisory workgroup comprised of key stakeholders • Development of bed registry system functionality and business case requirements • Selection of a bed registry tracking system for statewide use • Procurement or enhancement of a bed registry system if possible within grant funding, and/or an agency budget request package to cover the funding gap • A rapid user acceptance pilot of a small number of facilities • Development of training curriculum and a training plan for statewide implementation

	• Amending administrative rules and/or MCO contracts to require use of the registry • The state intends to have a tailored bed registry in place no later than January of 2022.
3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	*Current Status:* **Relevant Washington Administrative Code (WAC) Rules:** **(**E&T) WAC 246-341-0610 Related to assessments for all Behavioral Health Administration Facilities must provide an age-appropriate, strengths-based psychosocial assessment that considers current needs and the patient's relevant history according to best practices. Such information may include, if applicable: (a) Identifying information; (b) Presenting issues; (c) Medical provider's name or medical providers' names; (d) Medical concerns; (e) Medications currently taken; (f) Mental health history; (g) Substance use history, including tobacco; (h) Problem and pathological gambling history; (i) An assessment of any risk of harm to self and others, including suicide, homicide, and a history of self-harm; (j) A referral for provision of emergency/crisis services must be made if indicated in the risk assessment; (k) Legal history, including information that a person is or is not court-ordered to treatment or under the supervision of the department of corrections; (l) Employment and housing status; (m) Treatment recommendations or recommendations for additional program-specific assessment; and (n) A diagnostic assessment statement, including enough data to determine a diagnosis supported by the current and applicable Diagnostic and Statistical Manual of Mental Disorders (DSM-5). **Relevant Managed Care Contract Requirements:** Managed Care Organization contracts include several requirements around utilization management and authorization of inpatient care: • 1.35 Care management must include evidence-based approach for screening and intervention;

	• 9.11.2.2.1 Must train behavioral health providers on evidence-based practices; • 14.3.2.1 Use of evidence-based screening tools; • 11.1.4 Requirements of utilization management staff; • 11.1.15-18; • 11.1.11 Inter rater reliability; • 11.1.9 Utilization management policy requirements; • 11.1.29 LOC guidelines. FFS follows the same WAC listed above in this section. For Mental Health Rehabilitation services the FFS program follows 13.d of the state plan. The intake assessment used is determined by the licensed mental health professional, and should be culturally and age relevant prior to the provision of any other mental health services (pg. 77(9) of 13.d state plan). The appropriate assessment will determine medical necessity, and length of stay based on the individual's needs (pg. 69(4) of 13.d state plan https://www.hca.wa.gov/assets/program/SP-Att-3-Services-General-Provisions.pdf
	Future Status: We believe this requirement is met
	Summary of Actions Needed: N/A
3.e Other state requirements/policies to improve access to a full continuum of care including	*Current Status:* The state described its requirements around access to a full continuum of care in the sections above.

crisis stabilization	*Future Status:* N/A
	Summary of Actions Needed: N/A

Prompts	Summary
SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	
Earlier Identification and Engagement in Treatment	
4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported employment and supported programs	*Current Status:* **Current Statewide Strategies:** 1. Trauma Informed approach a. HCA awarded nearly 1.4 million dollars in grants to organizations across the state to build on the trauma-informed work already happening across the state, and to support interest that has been unfunded to date. b. HCA offered free trainings throughout Washington State on trauma informed approach for state employees, direct care staff, supervisors, leaders, and community members, including train the trainer sessions. Online versions of the training will be available soon. c. HCA, in collaboration with other state agencies and people throughout the state, is creating a toolkit of trauma informed resources. d. Federal block grant funds, awarded through the Substance Abuse and Mental Health Service Administration, are allocated for HCA's trauma-informed work. 2. Initiative 3, Supported Employment, includes services that identify and assist individuals in obtaining employment based on their preferences, and support to maintain employment to reduce higher cost services and incarceration. In March 2019, 2,562 clients were enrolled in Supported Employment. 3. The Becoming Employed Starts Today (BEST) project is designed to promote sustainable access to evidence-based supported employment. Becoming Employed Starts Today provides consumers with meaningful choice and control of employment, provides support services, uses peer counselors, reduces unemployment, and supports the recovery and resiliency of individuals with serious mental illness, including co-occurring disorders. The project will provide services to 450 people over five years.

	4. In May 2019 the state Legislature eliminated the income and age limits from the Healthcare for Workers with Disabilities program. Funding was provided for additional clients expected to enroll in this program as a result of these eligibility changes.
	Future Status: The state believes the efforts described above meet the requirements of this milestone.
	Summary of Actions Needed: N/A
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	*Current Status:* As of January 2020, every region in the state is participating in Integrated Managed Care which is a significant advancement in the trajectory toward behavioral health integration and whole-person care. Beginning July 2020, the state began requiring Managed Care Organization utilization management decision making to take into account the greater and particular needs of diverse populations, as reflected in health disparities, risk factors (such as adverse childhood experiences for enrollees of any age), historical trauma, and the need for culturally appropriate care. **Current Statewide Strategies:** 1. WISe Services – Wraparound intensive services for youth in need of intensive services. 2. Jail services Targeted at linking individuals with outpatient care upon release. 3. Juvenile justice programs – healing courts 4. Telehealth 5. School settings School-Based Health Care Services (SBHS) services for children with a disability aged 0-20 who

	receive Medicaid via a categorically needy program or medically needy program when included in their IEP or IFSP. 6. Primary care PHQ-9 screening tool promotion. 7. The state recently increased funding to develop a statewide plan to implement evidence-based specialty care programs that provide early identification and intervention for individuals experiencing psychosis. This includes funding to increase the number of teams providing these services from five to ten. 8. The Legislature recently funded five mental health peer respite centers to divert individuals from crisis services as well as a pilot program to provide mental health drop-in center services. 9. The state obtained funding to create and operate a tele-behavioral health video call center staffed by the University of Washington's Department of Psychiatry and Behavioral Sciences to serve emergency department providers, primary care providers, and county and municipal correctional facility providers with on demand tele-psychiatry and substance use disorder consultation. 10. Other Consultation a. The Partnership Access Line (PAL), operated by Seattle Children's Hospital through funding from HCA, connects pediatric and adolescent primary care providers to child and adolescent psychiatrists for consultations on mental health care, including diagnostic clarification, medication adjustment or treatment planning. In partnership with the University of Washington, PAL for Schools connects school staff and students to psychologists and psychiatrists at Seattle Children's and the University of Washington. b. PAL also partners with Washington's Mental Health Referral Service for Children and Teens which connects patients and families with evidence-supported outpatient mental health services in their community.

	Future Status: Community Health Aide program (CHAP) – Behavioral Health Aides. The state is collaborating with tribes to support behavioral health aides, who can expand capacity for tribal behavioral health services and enable more integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment. The state and local partners are in the process of identifying a common integration assessment tool to be administered across behavioral and physical health providers in the state. This effort will be informed by ACHs and MCOs based on integration advancement in recent years, including the use of various integration assessment approaches. The workgroup has met over the course of the past six months and is currently reviewing preliminary data and lessons learned related to integration assessment conducted by ACHs under the Medicaid Transformation Project.
	Summary of Actions Needed: The state will continue to evaluate the effectiveness of CHAP in addressing behavioral health, including the effective use of culturally appropriate providers), which includes providers such as Community Health Aides (CHAs), Behavioral Health Aides (BHAs), and Dental Health Aide Therapists (DHATs). The state and tribes will consider additional expansion through MTP funding to tribes and IHCPs. In early 2021, the state and partners will decide on the common integration assessment tool. This will also require the identification of specific expectations regarding the administration of the tool and evaluation of results. The state will continue engagement with ACHs, MCOs and providers to ensure the tool is implemented and data utilized to measure the advancement of behavioral health integration in non-specialty settings. This is a significant milestone and will reinforce the partnership between ACHs and MCOs to expand behavioral health integration as Integrated Managed Care ramps up.

4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	*Current Status:* Current Statewide Strategies: 1. Wraparound intensive services (WISe). Washington State's Wraparound with Intensive Services (WISe) provides comprehensive behavioral health services and supports to Medicaid eligible youth, up to 21 years of age, with complex behavioral health needs. WISe is designed to provide individualized, culturally competent services that strive to keep youth with intense mental health needs safe in their own homes and communities, while reducing unnecessary hospitalizations. . To assist in achieving this goal, WISe also offers 24/7 crisis stabilization services. WISe offers a higher level of care through these core components: Time and location of services: WISe is community- based. Services are provided in locations and at times that work best for the youth and family, such as in the family home and on evenings and weekends. Team-based approach: Using a Wraparound approach, WISe relies on the strengths of an entire team to meet the youth and family's needs. Intensive care coordination between all partners and team members is essential in achieving positive outcomes. Each team is individualized and includes the youth, family members, natural supports, a therapist, a youth partner and/or family partner, and members from other child-serving systems when they are involved in a youth's life. Other team members could include family friends, school personnel, a probation officer, a religious leader, a substance use disorder treatment provider, or a coach/teacher. The team creates ONE Cross- System Care Plan that identifies strategies and supports, using the youth and family's voice and choice to drive their plan. 2. The Peer Bridgers program delivers services individuals in state and community hospitals prior to discharge and after their return to their communities. The Peer Bridger develops a relationship of trust with the participant. In developing this trust, the Peer Bridger may function as a role model, peer support, a mentor, a teacher, an advocate, and an ally as they communicate hope and encouragement. 3. State Plan Services: Washington's Medicaid State Plan includes a rehabilitation case management service

	allowing liaisons from the community to actively participate in discharge planning for individuals receiving psychiatric inpatient care. This is currently a state funded service for individuals in institute of mental disease facilities. 4. Crisis Triage and Stabilization Investments: Between 2017-18, the state funded several new triage and crisis stabilization facilities across the state. Three facilities are open and four expected to open in the coming year, for a total of 102 crisis stabilization and triage beds across six regions of the state. The 2019 state Legislature funded even more 16-bed triage and stabilization facilities. The Legislature also funded Mobile Outreach Crisis Teams. 5. The Legislature recently funded five mental health peer respite centers to divert individuals from crisis services as well as a pilot program to provide mental health drop-in center services. 6. Step Down Facilities: The Legislature appropriated funding for a new community facility type to address the need for additional discharge placements for individuals leaving the state psychiatric hospitals. Intensive behavioral health treatment facilities serve individuals who possess higher levels of behavioral challenges that existing alternative behavioral health facilities cannot accommodate. 7. The Housing and Recovery through Peer Services (HARPS) program builds on the successes of the Permanent Options for Recovery-Centered Housing (PORCH) project. PORCH provided consumers with meaningful choice and control of housing and support services, using peer housing specialists. The HARPS project reduces homelessness and supports the recovery and resiliency of individuals with serious mental illness. Each team consists of three full-time employees (a mental health professional and two certified peer counselors). One of the priority target populations for the HARPS program is individuals discharging from inpatient psychiatric care. The state Legislature recently funded four additional HARPS teams with a focus on individuals discharging from forensic facilities. 8. Program for Assertive Community Treatment (PACT) teams provide wrap around services for individuals in outpatient treatment. When the individual is in an inpatient facility, the PACT team coordinates care with the inpatient unit and works to ensure stable housing and follow-up care. Currently there are 14 PACT teams across

	the state. In May 2019 the Legislature provided funding for eight additional PACT teams statewide. 9. Washington State's Department of Commerce announced $7.1 million in grants to six health care providers across Washington, adding 71 additional beds to facilities that help people with a wide variety of behavioral health issues. Twenty-eight of the new beds are dedicated as an alternative to treatment in state psychiatric hospitals. These grants are part of the governor's five-year plan to modernize and transform the state's mental health care systems by shifting out of large institutions to smaller, community-based facilities. 10. In addition, the state requires Managed Care Organization utilization management decision making to take into account the greater and particular needs of diverse populations, as reflected in health disparities, risk factors (such as adverse childhood experiences for enrollees of any age), historical trauma, and the need for culturally appropriate care.
	Future Status: The state believes the efforts described above meet the requirements of this milestone. The state has been collaborating with tribes and Indian health care providers to develop a WISe provider curriculum that is culturally appropriate to serving American Indians and Alaska Native individuals and families. The state has also established a wraparound intensive services case rate for tribes and Indian health care providers.
	Summary of Actions Needed: N/A

4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	*Current Status:* New Journeys is a collaborative effort of HCA (The State Medicaid Agency and Mental Health Authority), the University of Washington, and Washington State University. New Journeys is a growing program focusing on first episode psychosis.
	Future Status: Expand program as legislative funding allows.
	Summary of Actions Needed: Monitor outcomes of New Journeys.

Prompts	Summary
SMI/SED.Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.	
F.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	*Current Status* Crisis Triage and Stabilization services: the state has funded several new triage and crisis stabilization facilities across the state. Current capacity is a total of 105 crisis stabilization and triage beds in eight facilities across six regions of the state. The 2019 state Legislature funded additional 16-bed triage and stabilization facilities. The Legislature also enhanced funding for Mobile Crisis Outreach. . Step Down Facilities: the Legislature appropriated funding for a new community facility type to address the need for additional discharge placements for individuals leaving the state psychiatric hospitals. Intensive behavioral health treatment facilities serve individuals who possess higher levels of behavioral challenges that existing alternative behavioral health facilities cannot accommodate. Peer Respite Centers: the Legislature recently funded five mental health peer respite centers to divert individuals from crisis services as well as a pilot program to provide mental health drop-in center services. Washington State's Department of Commerce announced $7.1 million in grants to six health care providers across Washington, adding 71 additional beds to facilities that help people with a wide variety of behavioral health issues. Twenty-eight of the new beds are dedicated as an alternative to treatment in state psychiatric hospitals. These grants are part of the governor's five-year plan to modernize and transform the state's mental health care systems by shifting out of large institutions to smaller, community-based facilities. Co-Responders with Law Enforcement: The state continues to expand programs that fund mental health professionals who ride along with law enforcement as they respond to calls where mental health conditions may be involved.

	Future Status • To better serve the needs of the individual and in an effort to prevent needless hospitalization or unwarranted incarceration, the state is implementing programs designed to intervene at the point of contact with law enforcement. By broadening the options available through WAC the state provides law enforcement discretion in determining the level of care needed to better address the needs of the individual. The state is establishing broader guidelines for utilizing community based interventions as primary options. By working with licensed mental health professionals, mobile crisis response services and community crisis stabilization or crisis triage facilities, law enforcement officers are able to safely release individuals to settings which can address stabilization concerns and better determine level of acuity, housing needs, behavioral health needs, rather than placing them in the judicial systems where individuals may decompensate without treatment. • Enhancement of Mobile Crisis Response Teams (eMCR): currently the enhancement was only in three of the states ten regions. The state anticipates continuing to develop enhanced capacity in the remaining seven regions in stages. This enhanced MCR services are designed to work in a coordinated effort with Co-responders services to provide pre-arrest diversions by reducing its response time in an effort to free law enforcement from addressing behavioral health by handing off these services to programs designed to better meet their needs. The MCR model integrates a multidisciplinary approach to improve behavioral health outcomes. The MCR services includes teams of licensed clinicians, community behavioral health specialists, and individuals with lived experience and, is designed to operate 24-hours, seven days a week. • Development of six additional enhanced Crisis Stabilization and Crisis Triage facilities equipped to accept police drop-offs or mental health holds for evaluations by a mental health professional. These enhanced facilities are a place for individuals recovering from a behavioral health crisis to receive stabilization support from a multi-disciplinary treatment team. While designed to reduce the impact of individuals that are unduly incarcerated due to a lack of pre-arrest options for officers, as mentioned above, the state has taken wide steps to address this through WAC. These enhanced facilities will be operated 24-hours, seven days a weeks by a multidisciplinary team of clinicians, Certified Peers with lived experience, prescribers and behavioral health specialist. 171 crisis triage beds will be added. • Development of short-term emergency hotel and motel vouchers for individuals that are homeless or unsafely sheltered in facilities that further contribute to exposure to environments that lead to interaction with problematic elements. Working in unison with the Housing and Recovery through Peer Services (HARPS), a program which is designed to serves and support individuals that experience behavioral health disorders (either

	a mental health disorder, substance use disorder or both) and who demonstrate a medical necessity for housing supports. HARPS provides oversight for individuals utilizing vouchers to ensure that continued housing needs will be met to include more permanent housing supports. Tribes in the 3 regions are also provided to address housing needs for their community members. • Tribal Crisis Coordination Hub: The state is collaborating with tribes to develop a tribal crisis coordination hub, to help Indian Health Care Providers more efficiently place patients in inpatient treatment and with care coordination and transition planning.
	Summary of Actions Needed • Open six additional crisis stabilization centers across the state beginning in January of 2021. HCA will use currently allocated braided funding utilizing over 15 million dollars of Washington Department of Commerce grants. (Timeline: 1-14 months.) • As part of the Governor's budget request, additional funding will be devoted to enhanced mobile crisis response teams and other programs such as vouchers. (Timeline: 12 months.) • HCA will move money into contracts upon approval through appropriate regional rate increases and general fund state dollar allocations to BH-ASOs for non-Medicaid individuals. (Timeline: 6-12 months following budget approval.) • Contracts will be amended to reflect changes in funding. (Timeline: 6-12 months following budget approval.) • HCA will coordinate with the American Indian Health Commission to contract for the implementation of the tribal crisis coordination hub. (Timeline: completion of project imminent.) • The legislatively mandated Children and Youth Behavioral Health Work Group is expected to be making recommendations for youth mobile crisis models during the upcoming 2021 legislative session.
F.b Increase availability of on-going community-based services, e.g., outpatient, community	*Current Status* Program for Assertive Community Treatment (PACT) teams provide wrap around services for individuals in outpatient treatment. When the individual is in an inpatient facility, the PACT team coordinates care with the inpatient unit and

mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.	works to ensure stable housing and follow-up care. Currently there are 14 PACT teams across the state. In May 2019 the Legislature provided funding for eight additional PACT teams statewide. Intensive Residential Teams: This is a team based approach to serving individuals with significant behavioral health disorders who reside in assisted living facilities and group homes. Services are geared towards individuals who are recently discharged from long term involuntary treatment or who are at risk of losing their placement due to increased symptoms of their mental illness The teams will provide medication management, medication monitoring, clinical mental health interventions, group treatment services, therapeutic psychoeducation and peer services. Treatment will focus on the reinforcement of safety, the promotion of stability and independence of the individual in their structured settings, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and without this level of intervention would be at risk for more restrictive levels of care such as psychiatric inpatient hospitalization or are at risk for involuntary treatment. Services are team-based and will be provided within adult family homes and assisted living centers. Within Initiative 3 of the current Medicaid Transformation Waiver, Foundational Community Supports (FCS) provides supportive housing and supported employment services for high-risk Medicaid who have behavioral health needs or other risk factors including chronic homelessness, substance use disorder, or qualifying long-term care or physical disability care need. The primary goal of these services is to promote self-sufficiency, promote integration into the community, and reduce potentially avoidable use of more intensive services, by helping individuals with significant support needs obtain and maintain stable housing or competitive employment. FCS has created a strong connection between entry points such as hospital discharge planners, coordinated entry sites, community services offices and the third party administrator who manages the FCS provider network. These targeted Medicaid benefits follow two evidence-based practices: Individual Placement and Support for the supported employment services, and SAMHSA's Permanent Supportive Housing for the supportive housing services. Accountable Communities of Health also provide incentives to Community Behavioral Health providers and Community Social Service providers to increase support for persons transitioning from behavioral health treatment to community, and to promote prevention.
	Future Status As Washington seeks to support Initiative 1 of the Medicaid Transformation Waiver: Accountable Communities of Health. Initiative 1 provides incentives for providers who are committed to changing how we deliver care. Each region,

	through its Accountable Community of Health (ACH), pursues projects aimed at transforming the Medicaid delivery system to serve the whole person and use resources more wisely., the Accountable Communities of Health are working to determine how they can continue support of regional community based services.
	Summary of Actions Needed HCA will move money into MCO contracts upon approval through appropriate regional rate increases and general fund state dollar allocations to BH-ASOs for non-Medicaid individuals. (Timeline 6 -12 months following budget approval.) Contracts will be amended to reflect changes in funding. (Timeline 6 -12 months following budget approval.) The Medicaid Transformation Project evaluation will inform overall delivery system performance, including community supports to address behavioral health and stabilization needs, integration of behavioral and physical care, and community-based care coordination to address social needs in the community setting. The draft interim evaluation will be available in December 2020. Subsequent evaluation reports and mid-point assessments will be made available over the course of 2021-2023. These evaluation efforts, among other monitoring activities, will inform additional service and funding needs including sustainability of stabilization and intervention supports being provided through the Medicaid Transformation Project.

Prompts	Summary
SMI/SED. Topic_6. Health IT Plan	
As outlined in State Medicaid Director Letter (SMDL) #18-011, "[s]tates seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan ("HIT Plan") that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals."[1] The HIT Plan should also describe, among other items, the: • *Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and* • *Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.* *Please complete* all *Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.*	
Statements of Assurance	

Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period	**Behavioral Health Provider Survey:**
	From January 9 through April 12 2019, HCA fielded the Behavioral Health Provider Survey (BHPS), a web-based survey of publicly funded behavioral health agencies that provided mental health and/or substance use disorder services. Out of the 611 behavioral health agencies eligible to participate, 316 completed and another 30 partially completed the survey, for a 56.6 percent response rate. The 2019 survey included questions regarding the providers' adoption and use of electronic health records, including certified electronic health records. Findings from the 2019 survey included:
	• Regardless of type and size, 85% of behavioral health agencies overall reported using an electronic health record or a certified electronic health record.
	  ○ 15% of behavioral health agencies use a paper record system.
	  ○ More substance use disorder agencies (29.8%) use a paper record system than mental health (18.3%) and mental health substance use disorder agencies (7.2%)
	• 93% of mental health substance use disorder agencies reported using an electronic health records or certified electronic health records system compared to 82% of mental health only and 70% of substance use disorder only agencies.
	• 91% of large agencies use an electronic health records or certified electronic health records system compared to 87% of medium and 84% of small agencies.

- Regardless of type and size, over 90% of agencies using a paper record system plan or are thinking of transitioning to electronic health records.

HCA recognizes that the 2019 survey responses by behavioral health agencies regarding their use of electronic health records or certified electronic health records exceed or is nearly the same as rates of electronic health records and certified electronic health records use reported by physicians eligible for the HITECH Electronic Health Records incentive programs. The Office of the National Coordinator for Health IT reports that in 2017 almost 86% of physicians reported using any electronic health records and nearly 80% reported using a certified electronic health records (https://dashboard.healthit.gov/quickstats/pages/physician-ehr-adoption-trends.php).

Given that behavioral health agencies were not eligible for incentives or technical assistance available to physicians via the HITECH electronic health records Incentive Programs, the 2019 survey findings raise questions not only about the relative extent of electronic health records or certified electronic health records adoption among behavioral health agencies but also about its use and functions in behavioral health agencies' clinical operations and wider role in a healthcare ecosystem.

Following consultation with the Office of the National Coordinator for Health IT, HCA modified the electronic health records questions in our Behavioral Health Provider survey to reflect the electronic health records questions that are expected to be included in a future Substance Abuse and Mental Health Services Administration survey on Health IT. HCA supplemented these questions by including additional functionality required in the Mental Health Institute of Mental Disease Waiver.

As a result, the 2020 HCA Behavioral Health Provider survey will attempt to drill down on specific uses of the electronic health records by the behavioral health (including mental health) providers. The 2020 Behavioral Health Provider survey questions will gather information about specific functionality, use and exchange, including:

- Use of electronic health records to create and use electronic care plans;
- Use of electronic health records to record referrals, including closed loop referrals; and
- Use of electronic health records to support interoperable screenings, intake, and assessments tools.

Responses to these questions will help us:

- Target needed enhancements to electronic health record functionality required by the Mental Health Institute of Mental Disease Waiver; and
  Identify and make available supports for the use this functionality by behavioral health agencies that provide

	mental health services. The 2020 Behavioral Health Provider survey is currently being programmed into a web survey. Beta-testing of the web survey will immediately follow. We plan to launch the survey by March 23, 2020 and the survey will remain open until we have obtained a robust response rate. The 2020 Behavioral Health Provider survey will target Washington state-certified, community-based behavioral health agencies that offer publicly funded mental health and/or substance use disorder treatment services. Correctional and hospital-based treatment programs are not included. The draft survey questionnaire is attached. See Q17k, pages 9-10, of the attached draft questionnaire for questions related to electronic health records/certified electronic health records adoption and use. **Accountable Communities of Health:** In Washington State, Medicaid Transformation is being supported by nine regional Accountable Communities of Health. Accountable Communities of Health support a variety of projects and engage in a variety of activities. These projects include support for the integration of physical health and behavioral health services, use of electronic care plans, and closed-loop referrals. Washington State's health IT infrastructure continues to evolve at every level (i.e., state, delivery system, health plan/Managed Care Organization and individual provider) to achieve the goals of the demonstration. **2020 Health IT Operational Plan:** Critical activities/tasks needed to advance the Health IT infrastructure/ecosystem in Washington State are specified in our annual, calendar year Health IT Operational Plan. The 2020 Health IT Operational Plan can be found on HCA's website at: https://www.hca.wa.gov/about-hca/health-information-technology/washington-state-medicaid-hit-plan. Click on the 2020 Operational Plan. A key strategic initiative underway within the HCA and included in our 2020 Health IT Operational Plan are initial steps to explore: (i) how best to promote the adoption of certified electronic health record technology for providers that do not use certified electronic health record solutions or do not have needed functionality to support caregiving. This initiative includes a particular focus on behavioral health, rural, and/or tribal providers; and Department of Corrections/jails providers.

	This work involves the identification of potential funding sources and pursuit of viable option(s). This effort may lead to the development of request for information or potentially a request for proposals to connect these technology solutions with providers needing them. In addition, the 2020 Health IT Operational Plan identifies several key activities that will be undertaken during the calendar year that will support the goals of this demonstration, including work to advance: • Electronic care planning; • Electronic closed loop referrals; • Exchange of summary of care documents at transitions in care; • Electronic consent management; • Use of provider directories; • Work to support the use of a master patient index. In addition, as reflected in our 2020 Health IT Operational Plan, HCA is supporting other work to strengthen and enhance the state's health IT infrastructure. **Managed Care Organizations:** As the State Medicaid Agency in Washington State, the HCA recognizes the important role that Medicaid Managed Care Organizations play in supporting Medicaid service providers. As reflected in our State Health IT Operational Plan and this application, HCA has and will continue to incorporate requirements for Managed Care Organizations to support their network providers in their use of interoperable Health IT. For example, our January 1, 2020 Managed Care Organizations contract includes requirements that Managed Care Organizations promote bi-directional behavioral and physical health integration through education, training, financial, and nonfinancial incentives to promote integrated care including the use of electronic health records, clinical data repository, decision support tools, client registries, data sharing, and other similar program innovations.

[1] See SMDL #18-011, "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Statement 2: Please confirm that your state's SUD Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	Washington State's substance use disorder and mental health, Health IT Plans are aligned with and integrated into our State's Medicaid Health IT Plan.
	
	HCA's annual, calendar year 2020 Health IT plan can be found on HCA's website at: https://www.hca.wa.gov/about-hca/health-information-technology/washington-state-medicaid-hit-plan. Click on the 2020 Operational Plan.
	
	• Tasks for the Health IT Plan for mental health Institute of Mental Disease Waiver are in rows 6-20.
	  ○ Implementation of these tasks is contingent on funding.
	  ○ HCA's 2020 Health IT Operational Plan adds in the following financial mapping task:
	  ▪ HCA (DBHR and Health Information Technology) will develop a financial map that identifies sources of funds (e.g., decision package, MMIS, CMS grants, Substance Abuse and Mental Health Service Administration Grants) to execute the health information technology/health information exchange activities required in the mental health information technology plan in the Mental Health Institute of Mental Disease Waiver.
	  ▪ Know: HCA anticipates financial mapping will be an ongoing activity.
	• Tasks for the Health IT Plan for the substance use disorder institute of mental disease Waiver are in rows 21-30.
	
	The Health IT Operational Plan is updated at the end of each calendar year to identify additional tasks that will be implemented in the next calendar year.

Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[2] and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts. The ISA outlines relevant standards including but	The state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory and 45 CFR 170 Subpart B and, based on that assessment, intends to include these standards as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts and in the design, development, and implementation of health IT tools. The state anticipates that (i) the assessment of the applicability of Interoperability Standards Advisory standards will be ongoing as these standards evolve and (ii) standards will be included in the state's Medicaid Managed Care contracts and in the design, development, and implementation of health IT tools as standards emerge and as gaps in our infrastructure are identified and can be addressed. For example, in our January 2020 Medicaid Managed Care Organization contract requirements: • Managed Care Organization contractors are required to (i) support provider use of health information

not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	technology/health information exchange tools and services including certified electronic health record Technology and (ii) develop policies and procedures for care coordination and care management services that encourage and support the use of health information technology and health information exchange technologies (e.g., certified electronic health records, existing statewide health information exchange and health information technology, and other technology solutions) to coordinate care across the care continuum including with entities that provide mental health, substance use disorder services, and oral health services. Managed Care Organization contractors are required to participate in a workgroup with HCA to explore the extent to which the health information technology infrastructure can be developed to support care coordination and continuity of care requirements. • As part of our 2020 Health IT Operational Plan we have included a task requiring: HCA and Managed Care Organization staff participate in a workgroup to identify, prioritize, and explore methods to address gaps in an interoperable health information technology infrastructure to support these services, including electronic care plans and closed loop referrals. We anticipate that this workgroup will include consideration of standards available via the Interoperability Standards Advisory. We anticipate that future Managed Care Organizations contract requirements will require the use ISA standards related to care plans and closed loop referral (as these standards emerge). • Managed Care Organization contractors are required to develop data exchange protocols (in accordance with applicable privacy laws, including HIPAA and 42 C.F.R. Part 2) including consent to release before initiating services with any subcontracted entity. Protocols must support integrated behavioral health-physical health coordination (including sharing of claims and pharmacy data, treatment plans or care plans, crisis plans) to coordinate service delivery, and care management for each enrollee. As reflected in our 2020 Health IT Operational Plan, HCA is supporting work as part of its Substance Use Disorder Institute of Mental Disease Waiver (leveraging funds available via the Partnership/SUPPORT Act) to specify requirements to enable the electronic exchange of information subject to 42 CFR Part 2 and will use available Health IT interoperability standards. Once these requirements are final and ready for widespread use, we anticipate that future Managed Care Organization contract language will incorporate the use of these

	requirements. • Managed Care Organization contractors are required to submit to HCA their "Population Health Management" Plans. Population Health Management Systems are defined in our Managed Care Organizations contract language as "health information technology and health information exchange technologies that are used at the point-of-care, and to support service delivery. Examples of health information technology tools include, but are not limited to, electronic health records, OneHealthPort clinical data repository, registries, analytics, decision support and reporting tools that support clinical decision-making and care management. The overarching goal of Population Health Management Systems is to expand interoperable health information technology and health information exchange infrastructure and tools so that relevant data (including clinical and claims data) can be captured, analyzed, and shared to support value-based purchasing models and care delivery redesign. We anticipate that future Managed Care Organization contract requirements related to Population Health Management activities will require the use of specific Interoperability Standards Advisory standards.

2 Available at https://www.healthit.gov/isa/.

Prompts	Summary
To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact. [3] *Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."*[4]	
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider	*Current State:* *1) # and/or % of Behavioral Health Providers who have adopted "Certified" EHRs (CEHRT-Certified EHR Technologies) and utilize it for e-referrals and or closed loop referrals.* *2) # and/or % of Behavioral Health Providers who utilize "Direct" secure messaging for e-referrals and or closed loop referrals* *3) # and/or % of Primary Care Providers who have adopted "Certified" EHRs (CEHRT-Certified EHR Technologies) that are utilizing it for e-referrals and or closed loop referrals with mental health providers* *4) # or % of Primary Care Providers who utilize "Direct" secure messaging for e-referrals and or closed loop referrals with Mental Health Providers* **Behavioral Health Provider Survey:** As described in Assurance Statement #1 above, responses by behavioral health agencies (including those providing mental health services) to the 2019 Behavioral Health Provider survey raise questions about the relative extent of electronic health records/certified electronic health records adoption among these agencies and their use of electronic health records/certified electronic health records to support the behavioral health agencies' clinical operations and wider role in a health care ecosystem. As a result, the 2020 HCA Behavioral Health Provider survey will drill down on specific uses of the electronic health records by the behavioral health (including mental health) providers and gather information about specific functionality, use and exchange, including the use of electronic health records to record referrals, including closed loop referrals.

	Responses to these questions will help us: • Target needed enhancements to electronic health record functionality required by the Mental Health Institute of Mental Disease Waiver; and • Identify and make available supports for the use this functionality by behavioral health agencies that provide mental health services. **The HCA 2020 Health IT Operational Plan includes the following requirements (contingent on the availability of funds):** Task 8-01: HCA staff will, based on a review of ACH submitted documents, consult with A Accountable Communities of Health to better understand some of the shared needs identified across several Accountable Communities of Health (e.g., shared care plans, population health management, closed loop referral); and identify activities and funding sources that could be leveraged to support sustainable shared health information technology/health information exchange needs and technical support for providers across Accountable Communities of Health. Task 8-02: Q1- Q4: HCA staff, in consultation with representatives from Accountable Communities of Health and their partnering providers (e.g., acute care, primary care, behavioral health, Federally Qualified Health Centers, jails) and other stakeholders will produce written descriptions of: • Emerging / best practices across communities to provide health information technology-enabled integrated person-level care, and • Opportunities for shared /sustaining investments. The paper will include descriptions of practices and opportunities to provide health information technology-enabled integrated person-level care including the use of e-consults and close-loop referral processes, shared care plans, and population health. Task 8-04: Q1-Q2: HCA health information technology section staff, in collaboration with Policy and DBHR staff, will engage Managed Care Organizations in a workgroup to: Identify how plans define: service coordination, care coordination services, care management, and complex care management services; and

	• Identify, prioritize, and methods to address gaps in an interoperable health information technology infrastructure to support these services, including electronic care plans and closed loop referrals. HCA staff will summarize for the Medicaid Transformation Priorities Steering Committee gaps identified by the workgroup and suggested methods for addressing these gaps. Task 2-05: HCA staff will engage and collaborate with Accountable Communities of Health and Managed Care Organization representatives to identify: • Mechanisms that are being/could be used to support close loop referrals (e.g., digital health commons) and e-referrals (e.g., use of collective medical tools, including mental health providers' use of these tools and considerations that are needed to advance the use of these tools (including aligning with health IT standards to support interoperable exchange and standard implementation across the state).
	Future State: Contingent on the availability of funds, mental health providers in Washington State will pilot the use Health IT functionalities to support referrals in care, including closed loop referrals.
	Summary of Actions Needed: • HCA will conduct a survey in 2020 of behavioral health providers' adoption and use of certified electronic health records technologies including the use of this technology to support electronic referrals to and from physicians and mental health providers. o The HCA/DBHR is leading the survey of behavioral health providers. o Preliminary survey results will be published by July 2020. • Contingent on the availability of funds, HCA will engage a contractor to support Tasks 8-01 and 8-02; and integrate information that emerges from Tasks 8-04 and 2-05 into written documents describing: o Current practices and opportunities to support and advance the use of health information technology-enabled integrated person-level care including the use of e-consults and close-loop referral processes, interoperable care plans, and population health. o The availability of standards in the Interoperability Standards Advisory to support interoperable exchange of this content.

	○ Opportunities for shared/sustaining investments. • The HCA health information technology section will: ○ Lead this work in collaboration with other HCA components, Managed Care Organizations, Accountable Communities of Health, technology vendors, and behavioral health and physical health providers; and ○ Present the scope of work, progress reports, and recommendations to the (i) HCA Medicaid Steering Committee and (ii) Mental Health Institute of Mental Disease Waiver Workgroup. • Contingent on the availability of funds, a contract for this scope of work will be awarded in July and work will be completed in December 2020. • Contingent on the availability of funds, HCA will engage a contractor to specify requirements and design an open source FHIR-Based APIs for ○ E-consults; ○ Close-loop referral processes; and ○ Interoperable care plans, including the identification of care team members (including mental health providers). • Contingent on the availability of funds, a contract for this scope of work will be awarded in January 2021 and work will be completed in June 2021. • Contingent on the availability of funds, HCA will support pilots (including physicians and mental health providers) using the FHIR-Based APIs for: ○ E-consults; and ○ Close-loop referral processes: The pilot will include use of a FHIR-Based API to support electronic and closed loop referrals: ▪ Between physicians/mental health providers. ▪ From institution/hospital/clinic to physician/mental health provider. ▪ From physician/mental health provider to community-based supports. ○ Care plans • Contingent on the availability of funds, a contract for this scope of work will be awarded in March 2021 and work will be complete in December 2021.

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[3] See SMDL #16-003, "Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd16003.pdf.

[4] Guidance for Administrative Claiming through the "No Wrong Door System" is available at https://www.medicaid.gov/medicaid/finance/admin-claiming/no- wrong-door/index.html.

1.2 Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider	*Current State:* See Section 1.1.
	Future State: See Section 1.1.
	Summary of Actions Needed: See Section 1.1.
1.3 Closed loop referrals and e-referrals from physician/mental health provider to community based supports	*Current State:* See Section 1.1.
	Future State: See Section 1.1.

	Summary of Actions Needed: See Section 1.1.
Electronic Care Plans and Medical Records (Section 2)	
2.1 The state and its providers can create and use an electronic care plan	Current State: **Behavioral Health Provider Survey:** As described in Assurance Statement #1 above, responses by behavioral health agencies (including those providing mental health services) to the 2019 Behavioral Health Provider survey raise questions about the relative extent of electronic health records/certified electronic health records adoption among these agencies and their use of electronic health records/certified electronic health records to support the behavioral health agencies' clinical operations and wider role in a healthcare ecosystem. As a result, the 2020 HCA Behavioral Health Provider survey will drill down on specific uses of the electronic health records by the behavioral health (including mental health) providers and gather information about specific functionality, use and exchange, including the use of electronic health records to create and use electronic interoperable care plans accessible by all relevant members of the care team, including mental health providers. Responses to these questions will help us: • Target needed enhancements to electronic health records functionality required by the Mental Health Institute of Mental Disease Waiver; and • Identify and make available supports for the use this functionality by behavioral health agencies that provide mental health services. **The HCA 2020 Health IT Operational Plan includes the following requirements (contingent on the availability of funds):** Task 2-06: Requires that the HCA health information technology section, in collaboration with other HCA staff, will gather information on use of electronic/interoperable care plans by behavioral health (including mental health), providers; collaborate and coordinate with Managed Care Organizations via a workgroup to develop a shared care plan template; and coordinate with Department of Corrections and jails to consider the need for and use of care plans between health care providers in jails/prisons and community-based health providers.

	Task 2-07: HCA/DBHR staff, in collaboration with other HCA staff, will: • Identify best practice standards for transition planning from inpatient and residential care prior to discharge. • Consider strategies to incentivize discharge outcomes that ensure housing stability. • Advance recommendations to implement best practices for successful discharge planning. HCA Policy staff will explore opportunities to support information exchange on behalf of incarcerated persons 30 days prior to release. Health information technology section staff, in coordination with HCA Policy, DBHR, and data governance staff, will explore opportunities and approaches to support creation, exchange, and access of CCDs/other health records including: • From youth-oriented systems of care to and from adult systems of care; and • On behalf of incarcerated persons, including: o Providing technical assistance to these providers regarding: ▪ The creation, exchange and access to CCDs via clinical data repository. ▪ View/download of the Problems, Medication, and Interventions (PAMI) report from the clinical data repository. o Access to clinical data repository/ Problems, Medication, and Interventions by health providers upon incarceration. HCA/DBHR staff, in coordination with other HCA staff, will work to align the requirements in Task 2-07 in the Health IT Operational Plan with Managed Care Organization requirements, including in Sec. 14 of the Managed Care Organization Integrated Managed Care contract. **Managed Care Organization Requirements:** Task 2-07 in the Health IT Operational Plan cross references several requirements in Sec. 14 of the Managed Care Organization Integrated Managed Care contract, including requirements that the MCO: • Develop in collaboration agencies and systems transition plans to that identify enrollees' goals, objectives, and strategies to achieve goals as these individuals transition between systems of care;

	• Complete the Uniform Discharge Tool reporting template for every individual discharging from a mental health inpatient setting hospital stay. • Coordinate with the behavioral health treatment agencies to ensure there is adequate coordination for enrollees transitioning between various levels of treatment services to ensure continuity of care (i.e., an enrollee receives timely and applicable follow-up services from ancillary referral agencies). This includes ensuring that discharge plans and facilitation to post-discharge services are documented in the enrollee's electronic health record. Task 2-09: Requires the HCA health information technology section to: • Contract to gather information on additional data sources including use/barriers/options to encourage use of electronic/interoperable care plans and electronic assessment/screening/ intake tools (among other requirements). • Coordinate with Office of the National Coordinator for Health IT and CMS and other states to standardize selected intake assessment and screening tools. • Link standardized care plans and electronic assessment/screening/intake tools with health information technology standards. • Create FHIR enabled interoperable tools for the exchange of care plans and electronic assessment/screening/intake tools. • Pilot use of the FHIR-enabled interoperable care plans and electronic assessment/screening/intake tools. Task 8-01: HCA staff will, based on a review of Accountable Communities of Health submitted documents, consult with Accountable Communities of Health to better understand some of the shared needs identified across several Accountable Communities of Health (e.g., shared care plans, population health management, closed loop referral); and identify activities and funding sources that could be leveraged to support sustainable shared health information technology/health information exchange needs and technical support for providers across Accountable Communities of Health. Task 8-02: Q1- Q4: HCA staff, in consultation with representatives from Accountable Communities of Health and their partnering providers (e.g., acute care, primary care, behavioral health, federal qualified health centers, jails) and other stakeholders will produce written descriptions of: • Best practices across communities to provide health information technology-enabled integrated person-level

	care; and • Opportunities for shared/sustaining investments. The paper will include descriptions of practices and opportunities to provide health information technology-enabled integrated person-level care including the use of e-consults and close-loop referral processes, shared care plans, and population health. Task 8-04: Q1-Q2: HCA health information technology section staff, in collaboration with Policy and DBHR staff, will engage Managed Care Organizations in a workgroup to: • Identify how plans define: service coordination, care coordination services, care management, and complex care management services; and • Identify, prioritize, and methods to address gaps in an interoperable health information technology infrastructure to support these services, including electronic care plans and closed loop referrals. HCA staff will summarize for the Medicaid Transformation Priorities Steering Committee gaps identified by the Workgroup and suggested methods for addressing these gaps. Task 8-05: references Medicaid managed care management and care coordination services. This section of the Health IT Operational Plan references the: **MCO Requirements:** Managed Care Organizations contract requirements that became effective 1/1/2020 require that Managed Care Organizations: • Support, to the maximum extent possible, the development and implementation of, and updates to interoperable electronic care plans; • Ensure that such care plans are transmitted to the clinical data repository when developed and updated; and • Participate in a workgroup with HCA to assess the utilization of interoperable care plans and barriers to using electronic care plans.

	Task 12-07: Requires that HCA, in collaboration with Accountable Communities of Health and providers, identify existing health information technology standards and interoperable care management tools that could be deployed in conjunction with the health information exchange and clinical data repository (e.g., consider: shared care planning, post-discharge care management for patients recently discharged from inpatient mental health facilities). Task 12-08: Requires HCA to develop a Discharge Summary API (for use by providers with limited technology adoption) and guidance that conforms to the Discharge Summary C-CDA specifications adopted for the 2015 version of certified electronic health records.
	Future State: Contingent on the availability of funds, mental health providers in Washington State will pilot use Health IT functionalities to support the: • Creation and use of electronic interoperable care plan accessible by all relevant members of the care team, including mental health providers including via the clinical data repository; • Creation, exchange, and access of clinical data repository's/other health records via the clinical data repository. • Creation and exchange interoperable discharge tools
	Summary of Actions Needed: HCA will conduct a survey in 2020 of behavioral health providers' adoption and use of certified electronic health records technologies including the use of this technology to support electronic referrals to and from physicians and mental health providers. • The HCA/DBHR is leading the survey of behavioral health providers. • Preliminary survey results will be published by July 2020. • Contingent on the availability of funds, using the contractor to be identified for work referenced in Sec. 1 (Closed Loop Referrals and e-Referrals), HCA will engage this contractor to support Tasks 2-06 (in addition to Tasks 8-01 and 8-02; and Tasks 8-04) to incorporate into written document a description of: o Current practices and opportunities to support and advance the use of health information technology-enabled integrated person-level care including the use of e-consults and close-loop referral processes, interoperable care plans, and population health. ▪ The description will include information on the opportunities and barriers to exchange

	interoperable care plans and other documents on behalf of incarcerated persons and persons being released from incarceration, including the exchange of information 30 days prior to release from incarceration. o The availability of standards in the Interoperability Standards Advisory to support interoperable exchange of this content. o Opportunities for shared/sustaining investment. Per Section 1 (Closed Loop Referrals and e-Referrals), and contingent on the availability of funds, the contract for this scope of work will be awarded in July and work will be complete in December 2020. • Contingent on the availability of funds, HCA will engage a contractor to map the work flow of mental health providers related to: o Completion of intake, screening, and assessment tools; o Development of care plans; o Referrals for ancillary services; and o Discharge/transition planning. • The workflow will highlight opportunities and barriers to the use of health IT to support interoperable exchange and re-use of this information within and across care providers. • The HCA health information technology section, Policy, and DBHR staff will co-lead this work: o In collaboration with other HCA components, Managed Care Organization, Accountable Communities of Health, technology vendors, and behavioral health and physical health providers; and o Present the scope of work, progress reports, and recommendations to the (i) HCA Medicaid Steering Committee and (ii) Mental Health Institute of Mental Disease Waiver Workgroup. • Contingent on the availability of funds, a contract for this scope of work will be awarded in July and work will be complete in December 2020. • Contingent on the availability of funds and the ability to leverage the expertise of Oregon Health Sciences University and activities underway via the Sec. 1003 Roadmap to Recovery grant, HCA will:

	○ Engage the Oregon Health Sciences University to identify best/promising practices to support transition planning prior to discharge on behalf of individuals transitioning from inpatient and residential care; ○ Identify and advance recommendations to implement best practices for successful discharge planning as part of the Roadmap to Recovery produced under the Sec. 1003 grant. HCA, Clinical Quality and Care Transformation, in collaboration with DBHR staff, will lead this work. If needed, a contract for this scope of work will be awarded no later than September 2020 and will be complete by March 2021. • Contingent on the availability of funds, HCA will engage a contractor to specify requirements for and design open source FHIR-based APIs that could be piloted using certified electronic health records for the exchange: ○ Interoperable care plans, including the identification of care team members (including mental health providers); and ○ Interoperable discharge summaries. Requirements will include the transmission and receipt of care plans and discharge summary documents to the clinical data repository, between providers using certified electronic health records (including members of the care team), and by providers to Managed Care Organizations. The health information technology section will lead this work. Contingent on the availability of funds a contract for this scope of work will be awarded in January 2021 and work will be complete in December 2021. • Contingent on the availability of funds, HCA will support pilots using the FHIR-Based APIs to support the creation and electronic exchange of: ○ Care plans ○ Discharge summaries • The pilot will include mental health providers:

	○ Sending electronic interoperable care plans and discharge summaries to other providers, the clinical data repository, and Managed Care Organizations. ○ Receiving interoperable care plans and discharge summaries from other providers. ○ Sending interoperable care plans and discharge summaries to the clinical data repository. ○ Viewing interoperable care plans and discharge summaries created by other providers in the clinical data repository. The health information technology section will lead this work. • Contingent on the availability of funds a contract for this scope of work will be awarded in January 2021 and work will be complete in December 2021.
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	*Current State:* See description above in Sec. 2.1.
	Future State: See description above in Sec. 2.1.
	Summary of Actions Needed: See description above in Sec. 2.1.
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic	*Current State:* See description above in Sec. 2.1.

communications	*Future State:* See description above in Sec. 2.1.
	Summary of Actions Needed: See description above in Sec. 2.1.
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State:* See description above in Sec. 2.1.
	Future State: See description above in Sec. 2.1.
	Summary of Actions Needed: See description above in Sec. 2.1.
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	*Current State:* See description above in Sec. 2.1.
	Future State: See description above in Sec. 2.1.

	Summary of Actions Needed: See description above in Sec. 2.1.
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	*Current State:* Beginning in 2018: • HCA sponsored an environmental scan to identify states and communities that had deployed electronic consent management solutions intended to support the exchange of information subject to 42 CFR Part 2; and • Whether these solutions incorporated the use of health IT standards to support the exchange of this sensitive information. • HCA led a public-private substance use disorder workgroup that assisted in the development and publication of "Sharing Substance Use Disorder Information: A Guide for Washington State". The guide helps clarify the applicable federal regulations and law (e.g., HIPAA and 42 CFR Part 2) and includes additional provider and patient resources, such as a sample paper consent form. • In addition, HCA started work to specify the requirements that an electronic consent management solution would need to support to comply with 42 CFR Part 2 requirements. **The HCA 2020 Health IT Operational Plan includes the following requirements:** Task 2.08: HCA health information technology section is required to: • Enter into contracts to support: o Development of technical assistance materials for substance use disorder and mental health providers re: privacy requirements (related to 42 CFR Part 2).

	○ Substance use disorder provider workflow related to consent. ○ Vendor procurement and system development for consent management solution. ○ Pilot an electronic consent management solution. ○ Seek continued funding to expand consent management past pilot. Task 3-09: Beginning in Q3 - Q4, the HCA health information technology section is required to: develop and pilot an electronic consent management solution that can be used to support the exchange of information subject to 42 CFR Part 2 and allow for the appropriate re-disclosure of this information. Task 14-01: Requires that HCA continue conversations with Tribal partners and the American Indian Health Commission on the value of health information exchange including how the technical solution to be deployed for consent management could be extended to protect tribal member's health information in the clinical data repository. In 2020, leveraging federal funds available through the Partnership/SUPPORT Act, HCA contracted for work that includes: • Development and implementation of technical assistance materials for providers regarding requirements related to the consent and sharing of information subject to 42 CFR Part 2: • Completion of the requirement specifications for an electronic consent management solution that supports information exchange in compliance with 42 CFR Part 2; and Solicitation of a request for proposal for an electronic consent management solution.
	Future State: Contingent on the availability of funds, mental health providers in Washington State who treat individuals with substance use disorders and are subject to the requirements of 42 CFR Part2 will pilot the: • Exchange protected information in compliance with 42 CFR Part 2; and • Use an electronic consent management tool that supports the exchange protected information in compliance with 42 CFR Part 2.

	Summary of Actions Needed: Contingent on the availability of funds, HCA will: • Develop/acquire an electronic consent management solution that support the exchange of protected information in compliance with 42 CFR Part 2; and • Pilot the use of an electronic consent management solution, including by mental health providers who treat persons with substance use disorders and are subject to 42 CFR Part 2 requirements.
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	*Current State:* **Behavioral Health Provider Survey:** As described in Assurance Statement #1 above, responses by behavioral health agencies (including those providing mental health services) to the 2019 Behavioral Health Provider survey raise questions about the relative extent of electronic health records/certified electronic health records adoption among these agencies and their use of electronic health records/certified electronic health records to support the behavioral health agencies' clinical operations and wider role in a healthcare ecosystem. As a result, the 2020 HCA Behavioral Health Provider survey will drill down on specific uses of the electronic health records by the behavioral health (including mental health) providers and gather information about specific functionality, use and exchange, including the use of electronic health records to record intake, assessment, and screening information including whether that information is interoperable with other health information technology systems. Responses to these questions will help us: • Target needed enhancements to electronic health records functionality required by the Mental Health Institute of Mental Disease Waiver; and • Identify and make available supports for the use this functionality by behavioral health agencies that provide mental health services. **The HCA 2020 Health IT Operational Plan includes the following requirements (contingent on the availability of funds):**

	Task 2-09: Requires the HIT Section: • Contract to gather information on additional data sources including use/barriers/options to encourage use of electronic/interoperable care plans and electronic assessment/screening/intake tools (among other requirements). • Coordinate with Office of the National Coordinator for Health IT, CMS and other states to standardize selected intake, assessment and screening tools. • Link standardized care plans and electronic assessment/screening/intake tools with health information technology standards. • Create FHIR enabled interoperable tools for the exchange of care plans and electronic assessment/screening/intake tools. • Pilot use of the FHIR-enabled interoperable care plans and electronic assessment/screening/intake tools. Task 12-05: Requires the HCA health information technology section to design and develop four use cases for providers/entities with limited health information technology/electronic health records technology to • Create and; • Transmit and/or; • Download information to/from the clinical data repository. Initial use case may focus on health action plans. If additional funds become available, use cases could focus on discharge plans/assessment, screening and intake tools. **Managed Care Organization Requirements:** The January 2020 Managed Care Organization requirements include several requirements related intake, screening, and assessment applicable to behavioral health providers including (but not limited to) the following sections of the Integrated Managed Care Plan: • Sec. 9.5 Health Care Provider Subcontracts; • Sec. 9.7 Administrative Functions with Subcontractors and Subsidiaries (changed in Sec. 9.8 effective July 1, 2020); • Sec. 9.11 Provider Education (changed in Sec. 9.12 effective July 1, 2020); • Sec. 9.16 Behavioral Health Administrative Service Organization (BH-ASO) (changed to 917 effective July 1,

	2020); • Sec. 14.3 Population Health Management: Identification and Triage; • Sec. 14.5 Bi-Directional Behavioral and Physical Health Integration; • Sec. 14.6 Care Coordination Services (CCS); • Sec. 14.13 Children's Long-Term Care Inpatient Program; • Sec. 17.1 Contract Services.
	Future State: Contingent on the availability of funds, mental health providers in Washington State will pilot use of health IT functionalities to record interoperable intake, assessment, and screening information.
	Summary of Actions Needed: • HCA will conduct a survey in 2020 of behavioral health providers' adoption and use of c certified electronic health records technologies including the use of this technology to support electronic and interoperable intake, assessment and screening tools. • HCA/DBHR is leading the survey of behavioral health providers. • Preliminary survey results will be published by July 2020. • Contingent on the availability of funds, HCA will engage a contractor to support work required in the Health IT Operational Plan Tasks 2-06 and 12.05. Specifically, this contractor will: o Gather information (from mental health providers, Managed Care Organizations, and technology vendors) and produce a written description of: ▪ Assessment, screening, and intake tools that are commonly used by mental health providers and/or required (e.g., by Managed Care Organizations) in Washington State; and ▪ Whether any of these tools are electronic, included in electronic health records, and

interoperable with other Health IT systems (i.e., incorporate standards from the Interoperability Standards Advisory).

- If needed, and in consultation with HCA, create a framework for prioritizing which intake, assessment and screening tools should be made electronic and linked with health IT standards (including FHIR). For example, the framework would take into account intake, assessment and screening tools:
  - Used for different populations and conditions (including for patients experiencing their first episode of psychosis);
  - That are required to be used in Washington State;
  - That are freely available for use (e.g., open source);
  - That are electronic;
  - That have been (at least partially) linked to health IT standards;
  - That other states that have received a Mental Health Institute of Mental Disease Waiver are seeking to advance.

The HCA health information technology and DBHR sections will co-lead this work and present the scope of work, progress reports, and recommendations to the (i) HCA Medicaid Steering Committee and (ii) Mental Health Institute of Mental Disease Waiver workgroup.

- Contingent on the availability of funds, a contract for this scope of work will be awarded in July and work will be complete in December 2020.
- Contingent on the availability of funds, by February 2021, the Steering Committee and the Mental Health Institute of Mental Disease Waiver workgroup will collectively determine which intake, screening, and assessment tools will be linked with health IT standards to support interoperable exchange and re-use.
- Based on decisions made by the Medicaid Steering Committee and Mental Health Institute of Mental Disease Waiver workgroup and contingent on the availability of funds, HCA will engage a contractor to:
  - Specify requirements and design open source FHIR-Based APIs that could be implemented using certified electronic health records for the exchange intake, screening, and assessment tools; and

	○ Support pilots that include mental health providers using the FHIR-Based APIs to support the creation and exchange of intake, screening, and assessment tools. The HCA health information technology section will lead this work. • Contingent on the availability of funds, a contract for this scope of work will be awarded in March 2021 and work will be complete in December 2021. • The HCA health information technology section will present the scope of work, progress reports, and recommendations to the HCA Medicaid Steering Committee and the Mental Health Institute of Mental Disease Waiver workgroup.
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	*Current State:* The 2020 Health IT Operational Plan includes the following task: Task 2.10: The State will complete the following: • HCA, Policy and the health information technology section will explore: ○ Medicaid Managed Care coverage and payment policies regarding telehealth. ○ Activities being undertaken by the University of Washington related to telehealth to identify whether there are gaps that need to be filled and options for addressing these gaps. HCA Clinical Quality and Care Transformation Clinical Policy staff will leverage and analyze information emerging via the following workgroups to help inform telehealth coverage policies to support access to high quality services: • National Academy for State Health Policy (NASHP) convened a Telehealth Affinity Group of policymakers and stakeholders to learn about the Patient Centered Outcomes Research Institute (PCORI)'s emerging telehealth research and explore associated policy challenges and solutions. • MED Telehealth workgroup (a forum for state agencies) to discuss telehealth issues facing Medicaidprograms including coverage policies, utilization, expenditures, patient privacy and security, and patient outcomes. The workgroup also explores best practices and evidence related to telehealth and monitors emerging telehealth

	advancements that may be relevant to Medicaid agencies. • Identify, disseminate, and promote information on telehealth, including grant opportunities HCA Clinical Quality and Care Transformation is recruiting a Behavioral Health Telehealth Program Manager who will be responsible for: • Drafting policy guidance about the telehealth technology landscape with a focus on the needs of the behavioral healthcare system. • Reviewing best practice models of telehealth services related to behavioral health care within and outside of Washington State to evaluate effective methods of telehealth clinical consultation and evaluation. • Consulting with representatives from state agencies, payers, provider and other service organizations to identify opportunities and barriers to use, coverage, and payment of telehealth services on behalf of children and adults with behavioral health needs. • Exploring Medicaid managed care coverage and payment policies regarding telehealth. • Participating in the National Academy of State Health Policy and other similar telehealth workgroups. • Identifying, defining, and developing possible funding sources to support existing and planned telehealth initiatives. • Providing a road map for future planning for telehealth implementation within substance use disorder treatment and behavioral healthcare settings.
	Future State: By July 2021, HCA will: • Provide policy guidance about the use tele-behavioral health technology in Washington State. • Include in Managed Care Organization contract language examples of when tele-behavioral technologies could be used to support the integration of physical and mental health services.

	Summary of Actions Needed: Beginning in April 2020, the HCA Clinical Quality and Care Transformation Behavioral Health Telehealth Program Manager will lead, in collaboration with other HCA Sections (e.g., health information technology, Medicaid Program Operations and Integrity), the development of a tele-behavioral health landscape assessment. By December 2020, the HCA Clinical Quality and Care Transformation will draft policy guidance about the tele-behavioral health technology in Washington State. By April 2021, HCA will publicly disseminate policy guidance about the tele-behavioral health technology in Washington State. By January 2021, the HCA Clinical Quality and Care Transformation will submit draft Managed Care Organization contract language that includes examples of when tele-behavioral technologies could be used to support the integration of physical and mental health services. This language will be integrated into Managed Care Organization contract requirements effective July 1, 2021.
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment[5])	*Current State:* **Managed Care Organization Contract Provisions:** Include the several requirements related to supporting the continuity of care including as individuals transition between care settings, ensuring the delivery of needed services and referrals, addressing the needs for persons at risk of re-hospitalization, and provider responsibilities if the individual discontinues treatment. Some of these requirements are listed below: 14 Care Coordination 14.1 Continuity of Care The Contractor shall ensure Continuity of Care for Enrollees in an active course of treatment for a chronic or acute physical or behavioral health condition… The Contractor shall ensure medically necessary care for Enrollees is not interrupted and transitions from one setting or level of care to another are supported with a continuity of care period that is no less than ninety (90) days for all new Enrollees. 14.1.8 The Contractor shall provide for the smooth transition of care for Enrollees who lose Medicaid eligibility while hospitalized in behavioral health inpatient or residential treatment facilities or while incarcerated or in

	homeless shelters. The Contractor shall include protocols for coordination with the BH-ASO to facilitate referral for state funded or federal block grant services, when such funds are available, in order to maintain Continuity of Care. 14.6 Care Coordination Services (including): 14.6.6 The Care Coordinator is responsible for: 14.6.6.1 Conducting IHS [Initial Health Screen] or collecting IHS data from providers, to assess Enrollees for unmet health care or social service needs; 14.6.6.2 Communicating utilization patterns to providers and ensuring action by the provider on under or over-utilization patterns requiring action; 14.6.6.3 Ensuring clinical and social service referrals are made to meet identified Enrollee health and community service needs; 14.6.6.4 Ensuring referrals are made and services are delivered, including any follow-up action; 14.6.6.6 Ensuring collaboration with the regional Behavioral Health Administrative Services Organization (BH-ASO), including developing processes to ensure an Enrollee is followed up with within seven (7) calendar days of when the Enrollee has received crisis services. Section. 14.17:Transitional Services 14.17.1 The Contractor shall ensure transitional services described in this Section are provided to all Enrollees who are transferring from one care setting to another or one level of care to another. 14.17.3.1 Development of an individual Enrollee plan to mitigate the risk for re-institutionalization, re-hospitalization or treatment recidivism to include: 14.17.3.1.1 Information that supports discharge care needs, Medication Management, interventions to ensure follow-up appointments are attended, and follow-up for self-management of the Enrollee's chronic or acute conditions, including information on when to seek medical care and emergency care. Formal or informal caregivers shall be included in this process when requested by the Enrollee; 14.17.3.1.2 A written discharge plan, including scheduled follow-up appointments, provided to the Enrollee and all treating providers; 14.17.3.1.3 Systematic follow-up protocol to ensure timely access to follow-up care post discharge and to identify and re-engage Enrollees who do not receive post discharge care; 14.17.3.1.4 Organized post-discharge services, such as home care services, after-treatment services, and occupational and physical therapy services; 14.17.3.1.5 Telephonic reinforcement of the discharge plan and problem-solving two (2) to three (3) business days following Enrollee discharge; 14.17.3.1.6 Information on what to do if a problem arises following discharge;

	14.17.3.1.7 For Enrollees at high risk of re-hospitalization, a visit by the PCP or Care Coordinator at the Facility before discharge to coordinate transition; 14.17.3.1.9 For Enrollees at high risk of re-hospitalization, the Contractor shall ensure the Enrollee has an in- person assessment by the Enrollee's PCP or Care Coordinator for post-discharge support within seven (7) calendar days of hospital discharge. The assessment must include follow-up of: discharge instructions, assessment of environmental safety issues, medication reconciliation, an assessment of support network adequacy and services, and linkage of the Enrollee to appropriate referrals; 14.17.3.1.10 Scheduled outpatient Behavioral Health and/or primary care visits within seven (7) calendar days of discharge and/or physical or mental health home health care services delivered within seven (7) calendar days of discharge; 14.17.3.1.11 Follow-up to ensure the Enrollee saw his/her provider; and 14.17.3.1.12 Planning that actively includes the patient and family caregivers and support network in assessing needs. 14.17.5.3 If the Enrollee discontinues services, the Subcontractor will document as such and attempt to facilitate transition back into the community. 14.17.5.4 If a behavioral health treatment agency discontinues treatment of an Enrollee, the agency must meet all discharge requirements noted in subsections 14.17.5.2 and 14.17.5 above. In addition, MCO contract provisions include the several requirements related to the development and use of Population Health Management Plans and Interventions. 14.2 Population Health Management: Plan The Contractor shall develop a plan to address Enrollee needs across the continuum of care, and ensure services are coordinated for all Enrollees. The plan shall be reviewed by HCA during the annual monitoring review. The Population Health Management plan shall include at a minimum the following focus areas: 14.2.1 Keeping Enrollees healthy; 14.2.2 Managing Enrollees with emerging risk; 14.2.3 Enrollee safety and outcomes across settings; 14.2.4 Managing multiple chronic conditions; and 14.2.5 Managing individuals with multiple service providers (e.g., physical health and behavioral health). The Contractor's Population Health Management plan shall establish methods to identify targeted populations for each focus area and include interventions that meet the requirements of NCQA and the subsections below. The Contractor's Population Health Management plan shall take into account available and needed: (i) data and

	analytic infrastructure, (ii) HIT and HIE infrastructure and tool, and (iii) other resources needed to support population health management activities. 14.3 Population Health Management: Identification and Triage 14.3.6 The Contractor will risk stratify the population to determine the level of intervention enrollees require. 14.4 Population Health Management: Interventions 14.4.1 The Contractor shall work with providers to achieve population health management goals, and shall provide PCPs with clinical information about their patients to improve their care. 14.4.1.1 The Contractor shall make clinical decision support tools available to providers for use at the point of care that follow evidence-based guidelines for: 14.4.1.1.1 Behavioral health conditions. 14.4.1.1.2 Chronic medical conditions. 14.4.1.1.3 Acute conditions. 14.4.1.1.4 Unhealthy behaviors. 14.4.1.1.5 Wellness. 14.4.1.1.6 Overuse/appropriateness issues.
	Future State: MCO contract language will be refined to enhance the identification of and interventions for persons at risk of discontinuing treatment. Contingent on the availability of funds, a closed loop referral tool will be available for piloting by mental health providers. (See Section #1.)

	Summary of Actions Needed: HCA/DBHR staff will lead a workgroup to identify methods to reduce the risk of patients discontinuing/stopping treatment. The workgroup will include HCA staff (i.e., staff from HCA Clinical Quality and Care Transformation (including clinical; analytics research and measurement; and health information technology, and Medicaid Program Operations and Integrity staff). The workgroup will: • Take into account the written documents and closed loop referral tool developed under Section 1 (Closed Loop Referrals and e-Referrals). • Consider whether and if so, how Managed Care Organization Population Health Management Plans, identification, and interventions could be enhanced to identify and intervene on behalf of individuals at risk discontinuing/stopping treatment. Consider other needed enhancements to Managed Care Organization contract language to better identify patients at risk for discontinuing or stopping treatment, and intervene on behalf of these individuals (including notifying their care teams to ensure continuation or resumption of treatment). The workgroup will convene beginning in September 2020, develop a charter describing the scope and focus of its activities, and develop recommendations to enhance the identification of and interventions for persons at risk of discontinuing treatment. The workgroup will present its charter, progress reports, and recommendations to the: • HCA/DBHR leadership; • HCA Medicaid Steering Committee; and; • Mental Health Institute of Mental Disease Waiver Workgroup. • Enhancements to Managed Care Organizations contract language will be advanced in January and September 2021.

5 Interdepartmental Serious Mental Illness Coordinating Committee. (2017). *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers*. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf

6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis	*Current State:* **Evidence-based Specialty Care Programs: Early Identification and Intervention for Individuals Experiencing Psychosis:** The state recently increased funding to develop a statewide plan to implement evidence-based specialty care programs that provide early identification and intervention for individuals experiencing psychosis. This includes funding to increase the number of teams providing these services from five to ten by October 1, 2020. **New Journeys:** New Journeys is a collaborative effort of HCA (The State Medicaid Agency and Mental Health Authority), the University of Washington, and Washington State University. New Journeys is a program focusing on first episode psychosis. **The 2020 Health IT Operational Plan requires that the State complete the following:** • The health information technology section, Policy, and Medicaid Program Operations and Integrity will collaborate to identify health IT/health information exchange tools that could support care coordination workflow of HCA, payers, and providers and options for developing needed tools; and • The health information technology section and DBHR will identify the providers involved in caring for persons experiencing their first episode of psychosis, the workflow involved, and the technical tools needed to support care coordination on behalf of these individuals.
	Future State: Contingent on the availability of funds, mental health providers providing services to persons experiencing their first episode of psychosis will pilot health IT tools that support: • Interoperable intake, screenings, and assessments; • Electronic and interoperable care plans; and • E-closed loop referrals. See Sections 1, 2, and 4 above.

	Summary of Actions Needed: *See Sections 1, 2, and 4 above.* HCA staff (DBHR, health information technology section, Policy, and Medicaid Program Operations and Integrity) and staff from the University of Washington and Washington State University will collaborate to identify any additional health IT/health information exchange tools that could support caring for and care coordination on behalf of persons experiencing their first episode of psychosis. DBHR staff will take the lead in initiating these conversations, no later than September 2020. If additional health IT tools are identified as needed, in January 2021, HCA/DBHR will present recommendations to: • DBHR leadership; • HCA Medicaid Steering Committee; and • Mental Health Institute of Mental Disease Waiver Workgroup.
Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records	*Current State:* Currently, the state is in the planning phase to create a multi-agency master person index that will facilitate identity management across multiple agencies and programs. The state's health and human service agencies (Department of Health, Department of Social and Health Services, Health Care Authority, Department of Children, Youth and Families and the Health Benefit Exchange) are partnering to pursue this effort. We are currently in the planning phase and are working to develop a proof of concept and a roadmap for implementation

	Future State: Contingent on funding, technical solutions to match a child's electronic medical records to a parent's electronic medical records, the use of an agency master person index, and implementation of needed data governance policies; the state envisions a future where a child's and parent's electronic medical records could be linked to provide safe and efficient care.
	Summary of Actions Needed: The following high-level deliverables will be needed to achieve the stated goal of tag or linking a child's medical records with their respective parent/caretaker's medical record: • Issue a request for proposal for master person index expert consultants to develop a roadmap. • Develop implementation roadmap. • Identify funding sources for implementation. • Establish system and data governance processes. • If necessary, procure tools to implement the identified solution. • Implement the identified solution per the guidance of the master person index roadmap. • Connect electronic health record or other health information technology to the master person index via FHIR transactions.
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	*Current State:* The state continues to support and expand the use of and content in the statewide clinical data repository. The state is exploring the feasibility of a statewide electronic health record/rural HER particularly for providers that do not have/use certified electronic health records (e.g., behavioral health providers). As described above, contingent on funding, the state is supporting enhancements to its Health IT information infrastructure that will support the capture of additional clinical information and work to develop and use a master person index.

	Future State: Contingent on funding, the state envisions a future where information across all episodes of care is linked to the correct patient and available when and where needed to support and improve service delivery at the point of care.
	Summary of Actions Needed: See actions needed described above.

Section 3: Relevant documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.

HCA 2020 Health IT Operational Plan: https://www.hca.wa.gov/about-hca/health-information-technology/washington-state-medicaid-hit-plan (Click on the 2020 Operational Plan.)

Draft 2020 Behavioral Health Provider Survey (BHPS) questionnaire
"Sharing Substance Use Disorder Information: A Guide for Washington State"
https://www.hca.wa.gov/assets/billers-and-providers/60-0015-sharing-substance-use-disorder-information-guide.pdf