



Washington State Medicaid Transformation Project (MTP) demonstration
Section 1115 Waiver Annual Report (DY4)/Quarterly Report (DY4 Q4)
Demonstration Year: 4 (January 1 to December 31, 2020)
Reporting Quarter: 4 (October 1 to December 31, 2020)

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Introduction

On January 9, 2017, the Centers for Medicare & Medicaid Services (CMS) approved Washington State's request for a Section 1115 Medicaid demonstration waiver, titled "Medicaid Transformation Project (MTP)." The activities are targeted to improve the system's capacity to address local health priorities, deliver high-quality, cost-effective, whole-person care, and create a sustainable link between clinical and community-based services.

Over the five-year MTP period, Washington will:

- Integrate physical and behavioral health purchasing and services to provide whole-person care.
- Convert 90 percent of Medicaid provider payments to reward outcomes instead of volume of service.
- Support providers as they adopt new payment and care models.
- Improve health equity by implementing population health strategies.
- Provide targeted services to support the state's aging populations and address social determinants of health (SDOH).

The state will accomplish these goals through these three programs:

- Transformation through Accountable Communities of Health (ACHs) and Delivery System Reform Incentive Payment (DSRIP) program.
- Long-Term Services and Supports (LTSS): Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA).
- Foundational Community Supports (FCS): Community Support Services (CSS) and Supported Employment – Individual Placement and Support (IPS).
- Substance use disorder (SUD) and Mental Health treatment services: expanded and extended services in participating facilities for eligible enrollees.

Vision: a healthier Washington

The Washington State Health Care Authority (HCA) is the lead agency for MTP; however, many agencies and partners play an important role in improving Washington's health and wellness systems. Together, we are working together to create a healthier Washington, where people can receive better health, better care, and at a lower cost.

Annual report: demonstration year 4

In accordance with special terms and conditions (STC) 76 and 42 C.F.R. § 431.428, this report summarizes the activities and accomplishments for the fourth demonstration year of MTP (DY4). It documents accomplishments, project status, and operational updates and challenges.

Visit the [Medicaid Transformation webpage](#) to learn more about HCA's Medicaid transformation work.

Policy and administrative updates

MTP in 2020

2020 was a challenging year and MTP experienced both disruption and resiliency as initiatives worked to achieve their goals while also responding to the COVID-19 pandemic. MTP partners worked diligently to continue implementing initiatives despite stay-at-home orders, revenue disruptions, increases in Medicaid enrollment, and increases in client service needs.

Washington is grateful to both Centers for Medicare & Medicaid Services (CMS) and all partners across the state for their diligent efforts in working to support continued implementation, pandemic response, and increased flexibility.

MTP amendments

- **Mental health IMD waiver:** over the course of DY4, the state continued development of the mental health IMD waiver, formally referred to as the serious mental illness/serious emotional disturbance waiver. An IMD is a facility with more than 16 beds and at least 51 percent of the patients receive mental health or substance use treatment. HCA received CMS approval of the mental health IMD waiver amendment on November 6, 2020 and approval of the implementation plan on December 23, 2020.
- **LTSS and value-based purchasing (VBP) adjustments:** the state developed amendment requests related to presumptive eligibility and transportation services within Initiative 2 and VBP target and improvement score adjustments related to Initiative 1. Submission to CMS will occur Q1 of 2021.

MTP one-year extension request

Over the course of DY4, the state developed a concept and application to request a one-year extension of the MTP Section 1115 demonstration waiver. The COVID-19 pandemic has strained the health care system, essential workers, families, and communities. An extension would allow Washington State to continue its COVID-19 relief efforts through each of the MTP initiatives.

It would also serve to further the continued implementation of the MTP's transformational goals and progress toward value-based care, as well as allowing for additional time to develop strategies for sustainability. The state is not requesting any changes to the current programmatic elements of MTP.

Annual expenditures

DSRIP program expenditures

During the period of January 1 through December 31, 2020, all nine ACHs earned just over **\$115,000,000** in project incentives and integration incentives for demonstrating completion of required VBP, project, and regional integration milestones during DY 4. During DY4, Indian Health Care Providers (IHCPs) earned just over **\$3,500,000** for IHCP-specific projects that advance delivery system reform and whole-person care.

Table 1: DSRIP funding by ACH

	Q1	Q2	Q3	Q4	DY4 total	Funding source
	January 1– March 31	April 1– June 30	July 1– September 30	October 1– December 31	January 1– December 31	Federal financial participation
Better Health Together	\$5,144,786	\$4,852,757	\$0	\$2,674,964	\$12,672,507	\$6,336,254
Cascade Pacific Action Alliance	\$4,677,079	\$4,443,414	\$0	\$2,431,785	\$11,552,278	\$5,776,139
Elevate Health	\$6,547,910	\$6,080,780	\$0	\$2,918,142	\$13,792,733	\$6,896,367
Greater Columbia	\$10,289,572	\$9,355,513	\$0	\$3,404,499	\$16,033,189	\$8,016,595
HealthierHere	\$2,338,539	\$2,396,707	\$0	\$5,349,926	\$24,995,011	\$12,497,506
North Central	\$7,015,618	\$6,490,122	\$0	\$1,215,893	\$5,951,139	\$2,975,570
North Sound	\$1,870,831	\$1,987,366	\$0	\$3,647,677	\$17,153,417	\$8,576,709
Olympic Community of Health	\$5,612,494	\$5,262,097	\$0	\$972,714	\$4,830,911	\$2,415,456
SWACH	\$3,273,955	\$3,215,390	\$0	\$1,702,250	\$8,191,595	\$4,095,798
Indian Health Care Providers	\$1,862,500	\$0	\$0	\$1,660,000	\$3,522,500	\$1,761,250

Table 2: LTSS and FCS service expenditures

	Q1	Q2	Q3	Q4	DY4 total
	January 1– March 31	April 1– June 30	July 1– September 30	October 1– December 31	January 1– December 31
Tailored Supports for Older Adults (TSOA)	\$2,323,728	\$3,684,643	\$66,359	\$4,936,552	\$13,819,232
Medicaid Alternative Care (MAC)	\$56,452	\$79,469	\$2,874,309	\$117,269	\$319,549
MAC and TSOA not eligible	\$465	\$1,236	\$745	\$(14)	\$2,432
FCS	\$2,637,290	\$9,434,315	\$5,788,771	\$5,852,639	\$23,713,015

LTSS data annual summary

Table 3: beneficiary enrollment by program

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of December 31, 2020	293	3001	5725
Number of new enrollees in 2020 by program	95	838	2002
Number of new person-centered service plans in 2020 by program	17	222	860
Number of beneficiaries self-directing services under employer authority	0	0	0

FCS data annual summary

Reports are available on the [MTP resources webpage](#). These reports provide a month-by-month look at Medicaid clients enrolled in IPS and CSS since the programs began in January 2018.

Table 4: FCS client enrollment 2020

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Supported Employment - Individual Placement and Support (IPS)	2,428	2,659	2,675	2,339	2,440	2,464	2,291	2,268	2,345	2,656	2,742	2,700
Community Support Services (CSS)	2,729	2,962	3,036	3,042	3,253	3,246	3,305	3,292	3,340	3,765	3,868	3,778
CSS and IPS	953	1,008	1,038	1,224	1,329	1,329	1,212	1,300	1,332	1,535	1,606	1,582
Total aggregate enrollment	6,110	6,629	6,749	6,605	7,022	7,039	6,808	6,860	7,017	7,956	8,216	8,060

Data represents cumulative enrollment (number of individuals who had been enrolled at least one month during the life of the program). Month to month changes is due to client enrollment mix, not program impact. Some individuals may be enrolled in both IPS and CSS.

Data source: Research and Data Analysis (RDA) administrative reports

MTP evaluation

In 2018, HCA began working with an independent external evaluator, the Center for Health System Effectiveness (CHSE) at Oregon Health and Science University. As part of their contract with HCA, CHSE is responsible for evaluating the overall success and effectiveness of MTP. In DY4, CSHE continued its active engagement.

Notable deliverables for the MTP evaluation in 2020 include:

Baseline Evaluation Report

The evaluator’s final [Baseline Evaluation Report](#) and [Issue Brief](#) were delivered on May 29, 2020. The report described the performance of Washington State’s Medicaid system for its readiness for transformation as of 2019. The final report incorporated individual case summaries for each of the nine ACHs.

The case summaries present descriptive and contextual information about each ACH to help audiences understand health transformation in the state and understand the Baseline Report findings. Prior to report finalization, the evaluator shared draft summaries with representatives of each ACH to collect feedback on factual details and interpretation (a process the evaluator calls “member checking”).

The full report is extensive and included quantitative results, key findings, opportunities, and challenges. It highlighted the following key findings:

- Performance generally improved in the areas of SUD care and opioid use, mortality, and treatment.
- Performance was mixed, with some metrics improving while others remained unchanged or worsened, in the following areas: SDOH; reproductive and maternal health care; prevention and wellness; behavioral health care; and emergency department, hospital and institutional care use.

- Performance was similar or unchanged from 2018 in primary and preventive care, oral health care, and care for people with chronic conditions.

The report also included recommendations improve the potential for the state to meet its MTP goals:

- Provide clarity on sustainability and expectations for ACHs beyond 2021.
- Provide ACHs with specific strategies and guidance on health information exchange and community information exchange.
- Clarify the roles of ACHs in meeting workforce needs.
- Evaluate ways to connect MTP initiatives and facilitate connections.
- Enhance VBP reporting to track dollars directly tied to quality and efficiency.

Note: although this report recognizes that Initiative 4 establishes important milestones for people in SUD treatment, it acknowledges this initiative began later than the other MTP initiatives. As a result, its impact will be presented in future reports.

Draft Interim Evaluation Report

CHSE delivered its draft Interim Evaluation Report on December 29, 2020. The draft presented preliminary evaluation findings and plans for completing the final report, due in December 2021. After some brief technical review and fact checking, HCA received the revised draft report on December 29, 2020.

The report is based on data available through 2019, so it does not include analysis on how the COVID-19 pandemic may have impacted the MTP initiatives. This report builds on the [Baseline Evaluation Report](#) HCA received in May 2020, as well as the quarterly Rapid-cycle Monitoring Reports. [View the full Interim Evaluation Report](#).

Rapid-cycle Monitoring Reports

CHSE produces this report each quarter as part of their evaluation, which highlights their quarterly activities, key findings (as available) from their analyses, and a summary of their activities planned for the coming quarter. These reports also highlight the work and progress across all initiatives as implementation continues. Rapid-cycle Monitoring Reports are available on the [Medicaid Transformation resources page](#).

The reports received in DY4 include the following:

- **Sixth Rapid-cycle Monitoring Report:** delivered on April 13, 2020, this report highlighted key findings for the first three ACHs where site visits and key informant interviews were completed in 2019. Several technical errors were identified in those highlights. CHSE worked directly with leadership from all three of those ACHs to correct errors and a revised report was submitted.
- **Seventh Rapid-cycle Monitoring Report:** this report was delivered on a slightly delayed schedule negotiated by HCA and CHSE to accommodate work impacts because of COVID-19. The report was delivered on April 17, 2020. Highlights from the report included:
 - CHSE finalized data analysis, data visualizations and narrative for the Baseline Evaluation Report.
 - Case summary checking with individual ACH case summaries on the summaries that were delivered with the final Baseline Evaluation Report.
 - CHSE shared its plan for sampling primary care practices and hospitals across the state for participation in qualitative interviews.
 - Qualitative and quantitative teams met to maximize coordination across those two disciplines and research questions.
- **Eighth Rapid-cycle Monitoring Report:** this report was delivered on June 26, 2020. Highlights from the report included:

- Preparation for the Interim Evaluation Report delivered in December 2020. This included detailed analysis plans for MTP Initiatives 1-4.
 - Submission of a study amendment request with the state’s Institutional Review Board to reflect updated data requirements and plans for the next rounds of key informant interviews.
 - Review of ACH-specific information to be prepared for evaluation of ACH project-specific target populations, including outreach to ACHs to obtain their feedback on target populations. This helps to ensure quantitative evaluation reflects the Medicaid populations ACHs are serving with their projects.
 - Development by the evaluator’s qualitative team to develop analytic summaries and contextual information about each of the eight health improvement projects in ACH regions.
 - Began next rounds of key informant interviews representatives of ACHs, state agencies, and managed care organizations (MCOs).
- **Ninth quarterly Rapid-cycle Monitoring Report:** this report was delivered on September 30, 2020. For the first time, this regular report provided key findings for statewide performance metrics. It also provides an in-depth preview of data to be used in the Interim Evaluation Report. Additional highlights in this report included:
 - Interim Evaluation Report activities: continued data collection and analysis necessary to prepare the draft Interim Evaluation Report.
 - Key informant interviews continued.
 - ACH Health Improvement Project Analysis: development of matrices to analyze information about each of the eight ACH project areas. Information was categorized to observe emerging similarities and variation across project areas. The matrices provide context for, and aid interpretation of, performance metrics and in project areas presented in the Interim Evaluation Report.

State legislative developments

The Washington State Legislature’s 2020 session ran from January 13 to March 12, 2020. As anticipated, the operating budget provided continued spending authority for MTP. Due to ongoing budget neutrality corrective action planning in 2020, the Legislature authorized lower DSRIP spending limits than originally authorized by CMS. It is important to note legislative session deadlines and decision-making preceded budget neutrality corrective action approval issued by CMS.

At the request of the Legislature, the state presented MTP updates to multiple legislative committees over the course of the year and responded to targeted questions from legislators and staff as they arose.

MTP Public Forum

On December 11, 2020, HCA held its annual MTP Public Forum as a webinar. During this virtual forum, MTP staff provided an update on all MTP initiatives, shared the state’s COVID-19 response efforts, and talked about next steps for MTP, including amendment and extension application development. At the end of the webinar, attendees had a chance to ask questions. [View the slide deck](#) and [watch the webinar recording](#) for more information.

Summary of public comments received during DY4

The following public comments were received during DY4, organized by program:

DSRIP program public comments

Quarter 1

- ACHs began escalating concerns regarding DSRIP reporting and performance expectations due to COVID-19 impacts.
- FCS providers continued to report issues related to initial claims denials by Amerigroup. HCA continued efforts with Amerigroup, providers, and internal systems to reduce initial denials. Accepted claims were consistently paid by Amerigroup within contract parameters.
- A substantial number of providers began reporting severe financial distress related to the COVID-19 pandemic. HCA worked with providers to offer guidance and flexibility, as appropriate.

Quarter 2

- ACH staff and partners continued to highlight new challenges and opportunities tied to COVID-19. In addition, during the one-on-one discussions with HCA, many ACHs highlighted the need to begin outlining the ACH role post-MTP, recognizing there is a window of opportunity to maintain momentum and sustain critical infrastructure tied to pandemic response and recovery.

Quarter 3

- ACH partners and stakeholders continued to express interest in prioritizing discussions regarding sustainability and the long-term role of ACHs in the state.

Quarter 4

- No MTP stakeholder concerns were reported during Q4.

LTSS program public comments

No comments or concerns were reported in DY4.

FCS program public comments

Quarter 1

- FCS program staff received and responded to questions for program updates from legislative staff and program stakeholders.

Quarter 2

- Questions were raised about how to deliver FCS services during the COVID-19 pandemic. HCA provided guidance on the use of telehealth for FCS services. While previously allowable under FCS, HCA strongly recommended providers transition to telehealth services to protect enrollees and the workforce. The FCS team also surveyed FCS providers to gauge how to best support their needs during the COVID-19 pandemic.

Quarter 3

- HCA continued to respond to inquiries about FCS during the COVID-19 pandemic. FCS providers shared their thoughts on how to address the needs of participants. Suggestions included being able to support enrollees with both funding and mobile devices, as well as allowing providers new to Medicaid services access to the Medicaid database to check enrollment and eligibility status.

Quarter 4

- The FCS program received numerous questions about longer-term sustainability of the program and MTP in general, mostly from the provider community and program stakeholders. FCS program staff participated in the quarterly Advisory Council meeting led by the third-party administrator (TPA) and responded to questions around billing and enrollments in the FCS program. HCA heard numerous public comments supporting the extension of the MTP Section 1115 demonstration waiver and FCS services during the MTP extension application public comment process.

Quarterly report: October 1–December 31, 2020

This quarterly report summarizes MTP activities from the fourth quarter of 2020: October 1 through December 31, 2020. It details MTP implementation, including stakeholder education and engagement, planning and implementation, and development of policies and procedures.

Summary of quarter accomplishments

- During the period of January 1 through December 31, 2020, all nine ACHs earned just over \$115,000,000 in project incentives and integration incentives for demonstrating completion of required milestones during DY4. During DY4, IHCPs earned just over \$3,500,000 for IHCP-specific projects.
- The American Indian Health Commission for Washington State is the Tribal coordinating entity for MTP. In Q4, the commission submitted, and HCA approved, the MTP IHCP Projects Report for January 1 through June 30, 2020.
- New enrollees in LTSS for this reporting period: 40 MAC dyads, 251 TSOA dyads, and 529 TSOA individuals.
- Within FCS, the total aggregate number of people enrolled in services at the end of DY4 Q4 includes 4,282 in IPS and 5,360 in CSS.
- Implementation of the SUD IMD waiver amendment continues to move forward. In DY4 Q4, an action plan to remove barriers to residential care and improve transitions between levels of care for both adults and adolescents was submitted to the Legislature. The action plan was submitted at the beginning of December as required by House Bill 2642.
- Over the course of DY4, the state continued development of the mental health IMD waiver, formally referred to as the serious mental illness/serious emotional disturbance waiver. HCA received approval for the amendment from CMS on November 6, 2020 and approval of the implementation plan on December 23, 2020.
- CHSE delivered its draft Interim Evaluation Report in early December 2020, presenting preliminary evaluation findings and plans for completing the final report, due in December 2021. After some brief technical review and fact checking, HCA received the revised draft report on December 29, 2020. The report is based on data available through 2019, so it does not include any analysis on how the COVID-19 pandemic may have impacted the MTP initiatives. This report builds on the [Baseline Evaluation Report](#) HCA received in May 2020, as well as the quarterly Rapid-cycle Monitoring Reports. [View the full Interim Evaluation Report.](#)

MTP-wide stakeholder engagement

One-year extension application

During the reporting quarter, HCA created a communications plan and strategy for the MTP one-year extension application. As part of this plan, HCA:

- Developed a [dedicated webpage](#).
 - Developed and provided an online survey for people to provide public comment. HCA also offered the option for people to write and mail their comments.
 - Posted draft materials, including the extension application draft and appendices.
- Scheduled and held two public hearing webinars, which included time for attendees to ask questions.

- Sent out announcements about the public hearing webinars and the one-year extension.

New web content

During the reporting period, HCA created a new webpage for [Initiative 4: SUD IMD](#) and [Initiative 5: mental health IMD](#). In addition, HCA created an [FAQ on the mental health IMD](#).

Continuing to update the website

As part of HCA's efforts to sunset the Healthier Washington brand, [shared in an earlier report](#), HCA continues to transition all non-MTP-related content to other parts of the HCA website. Once this work is complete, the [Healthier Washington](#) section will be renamed "Medicaid Transformation Project," and all content will be focused on MTP efforts. As part of this project, HCA is also updating the MTP webpages and documents. HCA expects this work to continue through the rest of this year and well into 2021.

Statewide activities and accountability

VBP

VBP Roadmap and Apple Health Appendix

The VBP Roadmap describes HCA’s VBP goals, purchasing and delivery system transformation strategies, innovation successes to date, and plans to accelerate the transition into value-based payment models. The appendix, in accordance with the STCs, describes how MTP supports providers and MCOs to move along the value-based care continuum. The roadmap establishes targets for VBP attainment and related DSRIP incentives for MCOs and ACHs.

HCA published annual updates to the VBP Roadmap and Apple Health Appendix, delivering the appendix to CMS in early October in accordance with the STCs. HCA posted both documents to the Paying for Value webpage. The update to the VBP Roadmap included HCA’s long-term vision for delivery system transformation from 2021 through 2025.

Validation of financial performance measures

In DY1, HCA contracted with Myers & Stauffer to serve as the independent assessor (IA) for MTP. In this role, the IA is the third-party assessor of financial measures data submitted by MCOs as part of their contracts with HCA. The state maintains contracts with the five Medicaid MCOs. These contracts outline VBP attainment expectations, including the following parameters:

- Financial performance measures.
- Timelines under which MCOs must submit data.
- Review process, which includes third-party validation.

The IA successfully completed the validation of MCO VBP data submissions. Upon completing the validation of MCO VBP performance on VBP adoption and provider incentives metrics, the IA delivered a final report to HCA and began disseminating formal communications to MCOs and ACHs describing respective performance.

The tables below provide details on the MCO and ACH incentives for VBP adoption provider incentives targets. They also include the partial earn-back where MCOs did not achieve the target.

Table 5: MCO achievement of VBP Adoption targets

MCO	% VBP	DY 3 target	Target achieved	Partial earn-back
Apple Health Managed Care (AHMC)				
Amerigroup	76%	75%	Yes	N/A
Community Health Plan	65%	75%	No	87%
Coordinated Care	87%	75%	Yes	N/A
Molina	67%	75%	No	90%
United Healthcare	87%	75%	Yes	N/A
Integrated Managed Care (IMC)				
Amerigroup	75%	75%	Yes	N/A
Community Health Plan	78%	75%	Yes	N/A
Coordinated Care	82%	75%	Yes	N/A

Molina	78%	75%	Yes	N/A
United Healthcare	76%	75%	Yes	N/A
Foster Care (FC)				
Coordinated Care	81%	75%	Yes	N/A

Table 6: MCO achievement of provider incentives targets

MCO	% incentives	DY 3 target	Target achieved	Partial earn-back
AHMC				
Amerigroup	0.33%	1.00%	No	33%
Community Health Plan	1.26%	1.00%	Yes	N/A
Coordinated Care	2.67%	1.00%	Yes	N/A
Molina	4.89%	1.00%	Yes	N/A
United Healthcare	5.86%	1.00%	Yes	N/A
IMC				
Amerigroup	0.86%	1.00%	No	86%
Community Health Plan	2.09%	1.00%	Yes	N/A
Coordinated Care	2.19%	1.00%	Yes	N/A
Molina	3.77%	1.00%	Yes	N/A
United Healthcare	2.66%	1.00%	Yes	N/A
FC				
Coordinated Care	1.24%	1.00%	Yes	N/A

Table 7: DSRIP-funded VBP incentives earned by MCOs and ACHs

	% VBP	DY 3 target	Target achieved	MACRA A-APM*	% incentives earned
MCO					
Amerigroup	76%	75%	Yes	No	95%
Community Health Plan	82%	75%	Yes	Yes	100%
Coordinated Care	76%	75%	Yes	No	95%
Molina	76%	75%	Yes	Yes	100%
United Healthcare	78%	75%	Yes	No	95%
ACH					
Better Health Together	79%	75%	Yes	Yes	100%
Cascade	67%	75%	No	Yes	14%
Elevate Health	79%	75%	Yes	Yes	100%
Greater Columbia	68%	75%	No	Yes	18%
HealthierHere	79%	75%	Yes	Yes	100%

North Central	81%	75%	Yes	Yes	100%
North Sound	81%	75%	Yes	Yes	100%
Olympic	82%	75%	Yes	Yes	100%
SWACH	79%	75%	Yes	Yes	100%

* MACRA A-APM = Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA) Advanced Alternative Payment Model (A-APM) Arrangement

Statewide progress toward VBP targets

HCA sets annual VBP adoptions targets for MCOs and ACH regions in alignment with our state-financed purchasing goals. To track progress, HCA collects financial performance measure data from MCOs by ACH region. In addition to the reported financial data, HCA issued two annual VBP surveys to:

- Track health plan and provider progress toward the state’s goal of paying for health and value.
- Identify barriers to desired progress.

HCA completed the analysis of the health plan and provider paying for value surveys and published the results to the Paying for Value webpage late in Q4.

Technical support and training

There were no activities in Q4.

Upcoming activities

- HCA will present findings from the Paying for Value surveys to ACHs on January 11, 2021, and through a public webinar on January 25, 2021.
- HCA will begin preparations for the 2021 MCO VBP validation process.
- HCA will share individual ACH Paying for Value survey results as requested.

IMC progress

In 2014, state legislation directed a transition to integrate the purchasing of medical and behavioral health services for Apple Health (Medicaid) clients through an IMC system no later than January 1, 2020. Below are IMC-related activities for Q4.

- As directed by Substitute Senate Bill (SSB) 6312, statewide integration was achieved in January 2020.
- With the support of ACHs, HCA continues to support behavioral health providers in their transition to managed care.
- Stabilizing the behavioral health provider network has had extra challenges because of the COVID-19 pandemic. To mitigate financial instability due to lower utilization, MCOs provided additional financial support and contracting flexibility to behavioral health providers during the initial months of the COVID-19 pandemic.
- Soon, HCA will refocus attention on opportunities to further advance clinical integration and bi-directional care, as well as ensuring full continuum of services. During this reporting period, the ACHs and MCOs worked together to review methods of collecting clinical integration progress from providers, with the goal of piloting a new approach in 2021.

Health information technology (HIT)

The 2020 HIT Operational Plan includes tasks in several categories, including:

- Electronic health records (EHRs)
- Mental health IMD waiver

- SUD HIT Plan and prescription drug monitoring program enhancements
- Master Person Index (MPI)
- Provider directory
- Payment models and sources
- Data and governance
- Health information exchange functionality
- Registries
- Adding clients to the Clinical Data Repository (CDR)
- Adding CDR users
- Adding CDR functions/quality
- Provider education
- Tribal engagement
- Behavioral health integration

While 2020 brought unforeseen challenges with the onset of the COVID-19 pandemic, the state has advanced work on these tasks and deliverables throughout 2020, including beginning implementation of several of these activities.

Success stories

The HIT team spent Q4 and much of 2020 focused on advancing multi-year initiatives involving HIT. During the past year, the state:

- Advanced its work with the CDR.
- HCA expanded its pre-existing telemedicine policies to cover telehealth services during the time of the COVID-19 pandemic. HCA has held numerous webinars for providers and others describing these services and how Medicaid can cover the use of telehealth technologies.
- The state procured more than 2,000 Zoom for health care licenses and offered them free of charge to Medicaid physical and behavioral health providers to facilitate the use of telehealth services to the most vulnerable populations, while continuing to practice social distancing measures to reduce the spread of COVID-19.
- HCA distributed several hundred HCA-issued loaner laptops to providers to help clients and providers stay connected through online appointments.
- HCA distributed thousands of phones donated by cell phone companies through the State Military Department to Tribes, fee-for-service Medicaid clients, and individuals enrolled in the FCS program and in long-term care facilities. The phones had 400 talk minutes and unlimited data (texting and internet).
- Disseminated quarterly provider feedback reports related to opioid use and prescribing patterns. Conducted the 2020 behavioral health provider survey, which included detailed questions about provider adoption and use of certified EHR technology.
- Completed a proof of concept for the MPI, established a governance process, completed the MPI Roadmap, which documents the proposed phased implementation of the MPI, and contracted with vendor to conduct implementation of phase one (focused on COVID-19-related use cases) of the MPI Roadmap.
- Presented detailed information on broadband access in the state and discussed broadband as a SDOH to various health organizations.

- Continued coordination with the nine ACHs and MCOs to support MTP activities in regions and plans across the state, including the use of HIT.
- Coordinated internally within HCA and with the Department of Health (DOH) to support implementation of the HIT Plan requirements related to the Prescription Drug Monitoring Program (PDMP) and related requirements using funds made available through the Partnership Act/SUPPORT Act.
- Drafted and submitted to CMS its 2021 HIT Operational Plan.

Mental health IMD HIT requirements:

- Staff and leadership met to discuss nine potential projects that could be funded with State Fiscal Year (SFY) 2021 appropriated funds to support the mental health IMD HIT requirements. Leadership requested staff narrow down the options and advance staff recommendations to leadership for decision making.

The state submitted legislative funding requests to support the development of an enterprise MPI and to support the HIT plan requirements included in the mental health IMD waiver. The MPI was not initially included in the Governor’s budget for 2021-2022. If additional funding is not identified for these items, the state will need to identify what work can be completed without additional funding.

HCA has been working to identify areas within the health care system that do not have adequate HIT or health information exchange (HIE) capacity. This includes planning an environmental scan of providers’ electronic health record capacity, exploring community information exchange (CIE), and developing an approach to facilitate Fast Healthcare Interoperability Resources (FHIR)-based information exchange.

To view the 2020 HIT Operational Plan and other related reports, visit the [Washington State Medicaid HIT Plan webpage](#).

DSRIP program implementation accomplishments

ACH project milestone achievement

Semi-annual reporting

ACHs report on their MTP activities, project implementation, and progress on required milestones. This is outlined in the [Project Toolkit](#). Semi-annual reports are submitted every six months. The next set of ACH semi-annual reports (SARs) are due February 1, 2021, for the July 1–December 31, 2020, reporting period.

Next steps

HCA and ACHs are coordinating across the state on scale and sustain strategies. In alignment with the timeline and expectations contained in the Project Toolkit, the upcoming SAR introduces scale and sustain reporting. This information will inform the planning tied to the MTP one-year extension request, along with considerations tied to the potential transition of DSRIP and/or a longer-term renewal application.

ACHs will continue to inform the state about project progress by submitting updated implementation plans and/or project updates that reflect progress, barriers, and opportunities during the reporting period. ACHs will also provide updates related to how ACHs are supporting partnering providers.

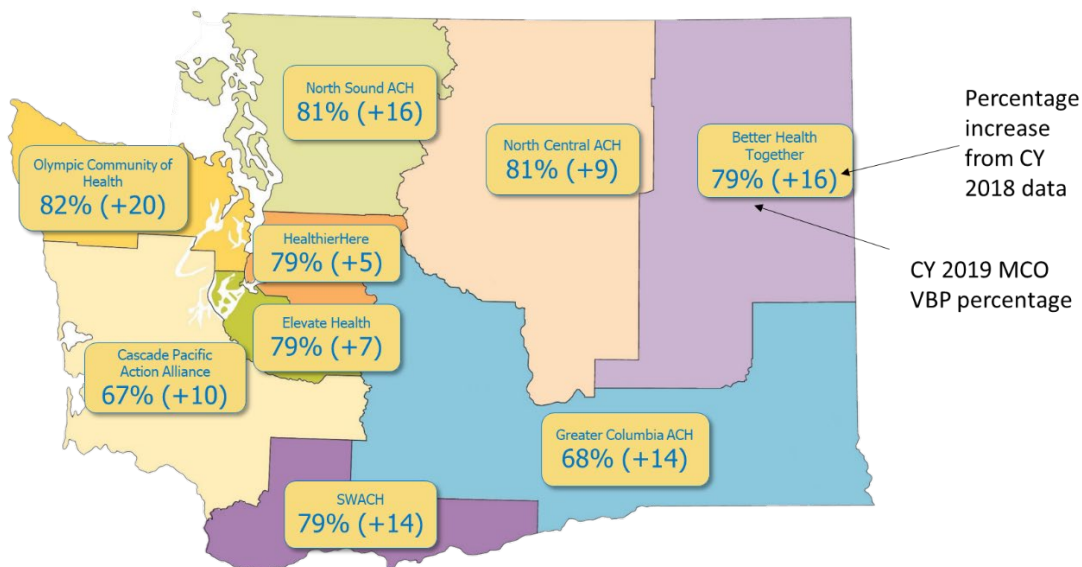
Annual VBP milestone achievement by ACHs

ACHs help assess and support provider VBP readiness and practice transformation by connecting providers to training and resources. ACHs continue to use several strategies to support regional providers in the transition to VBP.

Each ACH was instrumental in promoting and encouraging provider participation in the 2020 provider Paying for Value survey. A total of 170 unique provider organizations responded to the 2020 survey, up from 148 in 2019.

The figure below shows MCO VBP adoption for calendar year (CY) 2019 by ACH region with the change from calendar year 2018 in parenthesis. Seven of the nine ACH regions achieved the VBP adoption target for 2019 of 75 percent.

Figure 1: VBP adoption percentage for CY 2019 by ACH region with percent change from CY 2018



Financial executor (FE) portal activity

ACHs continue to distribute incentive funds to partnering providers through the FE portal. During the reporting quarter, ACHs distributed more than **\$19.4 million to 291** partnering providers and organizations in support of project planning and implementation activities. The state did not distribute any earned incentive funds to IHCPs in Q4 for achievement of IHCP-specific project milestones.

The state's FE, Public Consulting Group, continued to provide direct technical assistance and resources to ACHs as they registered and distributed payments to providers in the portal during this quarter. Appendix B, at the end of this report, provides a detailed account of all funds earned and distributed through the FE portal to date.

DSRIP measurement activities

Since the beginning of MTP, HCA has contracted with Providence Health & Services – Center for Outcomes Research and Education (CORE) to support measure production and visualization of health care transformation measures, in partnership with state measure producers.

As planned, CORE transitioned measure production and visualization work to HCA at the end of 2021. HCA is committed to ongoing rigorous quality assurance and metric evaluation. A new dashboard is in production by HCA with stakeholder input, focusing initially on the DSRIP measures (also known as pay-for-performance (P4P) measures).

DSRIP baseline and performance years are separated by two years to allow for the implementation of DSRIP projects. Improvement targets are prospectively released before the start of the associated performance year. However, metric specifications are updated annually by measure stewards. These updates can be substantial and require recalculation of prior measurement years to ensure consistency in measurement.

HCA and Department of Social and Health Services (DSHS) RDA began updating metric changes between the CY 2017 measurement period and the most recent measurement period available (CY 2019). This ensures consistency across all specifications. HCA, in collaboration with RDA, began updating the technical specifications that sets the boundaries from the National Committee for Quality Assurance (NCQA) national 90th percentile Medicaid metric targets for CY 2020.

HCA completed an update to technical data specifications that allows for the IA under contract to receive category 2 data for ACH achievement value (AV) calculations.

The current Healthier Washington Dashboard will sunset and the new dashboard went live in January 2021.

State measurement support

During Q4, HCA continued to provide technical assistance surrounding project pay-for-reporting (P4R)/P4P metrics, the DSRIP Measurement Guide, and metric technical specifications. HCA released an updated measurement guide supporting new visual metric calculation walk-throughs for gap-to-goal (GTG) and improvement-over-self (IOS) methods, as well as updated the high-performance pool (HPP) quality improvement score overview. Additionally, VBP calculation metrics and baseline and improvement targets for P4P metrics were updated as well.

HCA received and aggregated all ACH project P4P results. The P4P results workbook was sent to the IA in December 2020 to review and complete the AV calculations for earned P4P incentives for ACHs. HCA anticipates receiving the AV results by the end of January 2021 and the project incentive totals by the end of February 2021.

DY3 reflected the first year HCA was required to submit a Statewide Accountability Report. HCA finalized the report to outline DY3 statewide accountability metric results, IMC results, and VBP adoption results.

HCA submitted the Statewide Accountability Report to CMS in November 2020, however, a resubmission is scheduled for the end of February 2021 as there was an update to MCO performance that impacted VBP adoption outcomes.

DSRIP program stakeholder engagement activities

During the reporting period, HCA continued to host weekly Transformation Alignment Calls (TACs) with ACHs, state partners, and others. HCA continued sending a weekly ACH email summarizing COVID-19-related communications HCA has sent out, along with other announcements and information from DOH, the Office of Governor, Department of Commerce, the [Coronavirus.wa.gov](https://www.wa.gov) website, and others.

The annual Medicaid Transformation Learning Symposium was held October 26-28, 2020. This year's event was a virtual conference developed through a partnership between HCA and all nine ACHs. The theme of this year's event was "Community Health Through an Equity Lens" and included many sessions and keynotes that directly addressed the work of ACHs and community partners to address equity and racism, community health improvement, and the COVID-19 pandemic.

Many sessions included community partners from the health and social services sector who worked directly with ACHs. These sessions highlighted the experiences and lessons learned of those implementing MTP work in communities across the state. The event had hundreds of unique attendees over three days, with 954 attendees on day one, 708 on day two, and 574 on day three.

According to the post-event feedback survey, 92 percent of respondents rated the event as "good" or "very good." All sessions were recorded and can be accessed on the [Washington ACH Learning Symposium webpage](#).

DSRIP stakeholder concerns

No stakeholder concerns were reported during the reporting period in the context of DSRIP. ACHs continued to hear from providers concerning telehealth limitations, billing and rate questions, and other new operational challenges emerging during the COVID-19 pandemic. HCA uses regular touchpoints with ACHs to offer guidance and ensure communication and technical assistance is making it to providers and community partners. In this way, ACHs have provided a new avenue for identifying and addressing emerging issues.

Upcoming DSRIP activities

HCA and ACHs have been engaged in conversations about the future role of ACHs beyond the scope of DSRIP. These discussions include topics, such as innovative funding strategies to continue supporting the regional ACH functions, along with the continued advancement of paying for health and SDOH interventions. These discussions have also provided an opportunity to look ahead to new initiatives and COVID-19 recovery activities that may require ACH leadership in the future.

DY3 reflected the first performance year tied to statewide accountability. HCA is required to submit a Statewide Accountability Report following the availability of metric results and VBP performance. This report was submitted to CMS in Q4 of DY4 and is currently being reviewed by CMS. Along with the report, HCA highlighted a methodology issue related to the VBP improvement score calculation that could be improved ahead of future reporting.

In anticipation of the finalized Statewide Accountability Report, HCA is coordinating with the IA to finalize ACH regional P4P and HPP results. These results and corresponding regional earned incentives are expected to go out in Q2 DY4.

Tribal project implementation activities

Primary milestone: the American Indian Health Commission for Washington State is the Tribal coordinating entity for MTP. In Q4, the commission submitted, and HCA approved, the MTP IHCP Projects Report, for the period covering January 1 through June 30, 2020. This prompted HCA to draw down half of DY4 funds for distribution.

Secondary milestone: HCA and DSHS hosted three Roundtables and one Tribal Consultation on the MTP one-year extension application and amendment request. These forums made space for thoughtful and meaningful contributions relating to the IHCP-specific projects in the extension application from Tribal partners and IHCPs.

Tribal partner engagement timeline

- October 5: consulted on the Community Health and Rural Transformation (CHART) grant opportunity
- October 9: participated in the Behavioral Health Aide (BHA) Advisory Workgroup
- October 12: participated in the Learning Symposium Content Advisory Group
- October 13: participated in a meeting regarding HIT initiatives
- October 16: participated in an event hosted by the Northwest Portland Area Indian Health Board (NPAIHB) titled Gathering of NW Elders, Knowledge Holders, and Culture Keepers on how traditional knowledge and elders will be incorporated into the Community Health Aide Program (CHAP)
- October 19, 21 and 23: participated in a Better Health Together training on race
- October 26, 27, and 28: participated in and presented at the Learning Symposium
- October 28: hosted the first Roundtable for the MTP one-year extension application
- November 5 and 6: participated in the commission's State-Tribal Leaders Summit
- November 10: hosted the second Roundtable for the MTP one-year extension application
- November 16 and 17: participated in the breakout sessions of the commission's State-Tribal Leaders Summit
- November 17: presented to the Master of Health Administration program at University of Washington
- November 18: hosted the third Roundtable for the MTP one-year extension application

- November 25: met with NPAIHB regarding CHAP and Medicaid reimbursement
- December 2: participated in the commission's delegates meeting to provide an update on MTP
- December 9: hosted Tribal Consultation for the MTP one-year extension application
- December 14: provided input to Washington's interoperability strategy
- December 16: participated in development of Washington's interoperability strategy

LTSS implementation accomplishments

This section summarizes LTSS program development and implementation activities from October 1 through December 31, 2020. Key accomplishments for this quarter include:

- A new statewide vendor was successfully procured for translation of client documents with contract effective date of January 1, 2021.
- October 22: Annual Senior Lobby Conference (virtual) highlighted updates for family caregiver programs, including MAC and TSOA.
- Implementation and refinement activities continued for the TCARE application into the GetCare system.

Network adequacy for MAC and TSOA

Some Area Agencies on Aging (AAAs) have obtained contracts with new service providers, as well as re-contracting with previous providers. AAAs report it continues to be a challenge to locate providers for massage therapy and acupuncture in some areas of the state. It was reported that a few potential community-based providers were hesitant to use ProviderOne, the state's Medicaid payment system, or are not willing to accept the established state rate.

Assessment and systems update

As reported last quarter, the integration of the TCARE application, the evidence-based caregiver assessment tool, into the GetCare case management and assessment system was deployed on September 17, 2020. The system integration streamlined the caregiver and care receiver screening and assessment processes for case managers.

During the last quarter of DY4, the state continued to provide training and supports to case management staff and supervisors on the use of the integrated tool. Home and Community Services (HCS) program managers have been pleased with the positive feedback from case managers and the overall success of the transition. User guides and assessment policies were created and/or revised as needed.

Staff training

MAC and TSOA program managers for HCS committed to providing monthly statewide training webinars on requested/needed topics to field staff during 2020. Below are the webinar trainings that occurred during this quarter:

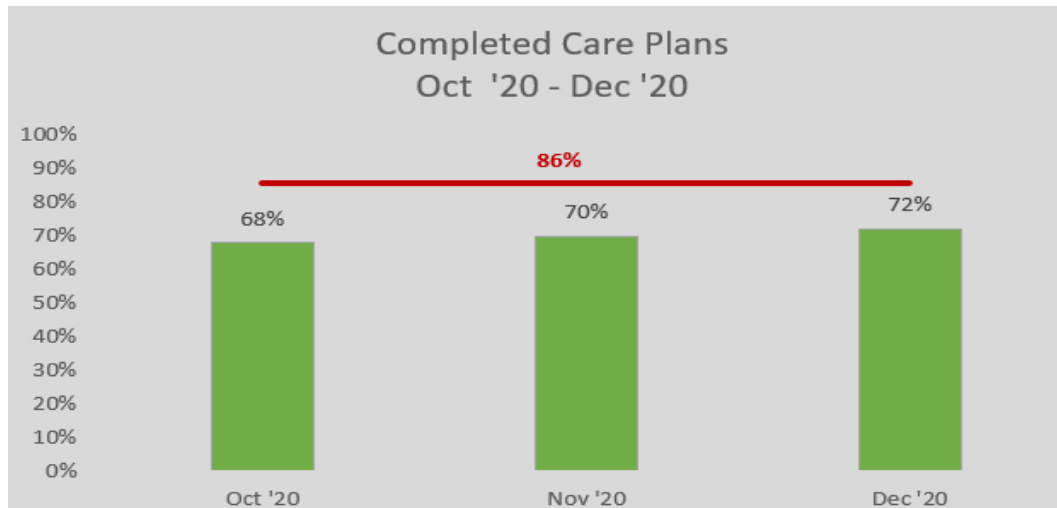
- October: GetCare and TCARE Care Plan policy training; overview of TCARE in GetCare session.
- November: statewide virtual workshop was held with MTP field supervisors and program managers regarding use of existing reports to monitor care plan proficiency at the local level.
- December: no formal training sessions; training team completed revisions to user manual and training aids.

Upcoming webinars include:

- February: Review of TCARE assessments and care plans.
- March: Service enrollments and authorizations in GetCare.

Data and reporting

Figure 2: beneficiary enrollment by program



*30 of the new enrollees does not require a care plan because they are still in the care planning phase and services have yet to be authorized.

**186 of the new enrollees do not require a care plan because they are still in the care planning phase and services have yet to be authorized.

***259 of the new enrollees do not require a care plan because they are still in the care planning phase and services have yet to be authorized.

The state continues to monitor and assist AAAs with compliance in timely completion of care plans for enrollees.

Table 8: completed care plans

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of December 31, 2020	293	3001	5725
Number of new enrollees in quarter by program	40	251	529
Number of new person-centered service plans in quarter by program	0*	5**	187***
Number of beneficiaries self-directing services under employer authority	0	0	0

Outreach and engagement

Outreach activities this quarter were primarily virtual meetings and presentations as well as dissemination of program publications/flyers. The volume and type of outreach activities continue to be impacted by the COVID-19 pandemic.

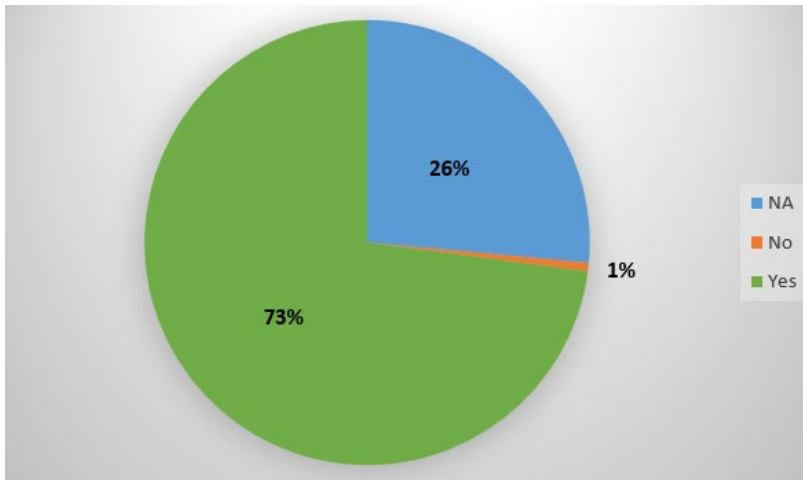
Table 9: outreach and engagement activities by AAA

	October	November	December
	Number of events held		
Community presentations and information sharing	9	6	4

Quality assurance

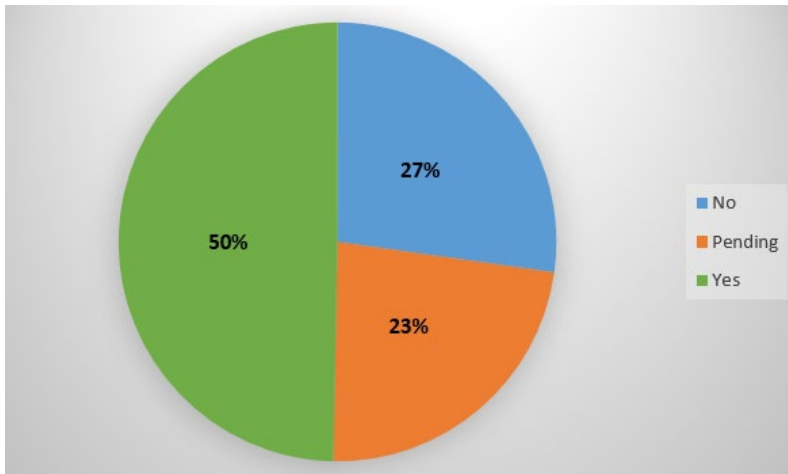
Results of the quarterly presumptive eligibility (PE) quality assurance review

Figure 3: Question 1: was the client appropriately determined to be nursing facility level of care eligible for PE?



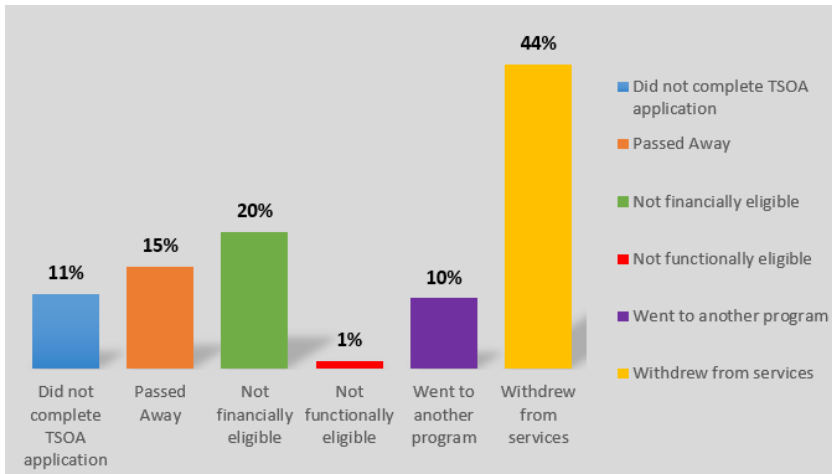
Note: The N/A represents clients who were part of the last quarter's review and the response to question #1 was "yes," but the response to question #2a was "pending."

Figure 4: Question 2a: did the client remain eligible after the PE period?



Note: "Pending" means the client was still in PE period during the quality assurance review.

Figure 5: Question 2b: if “No” to question #2a, why?



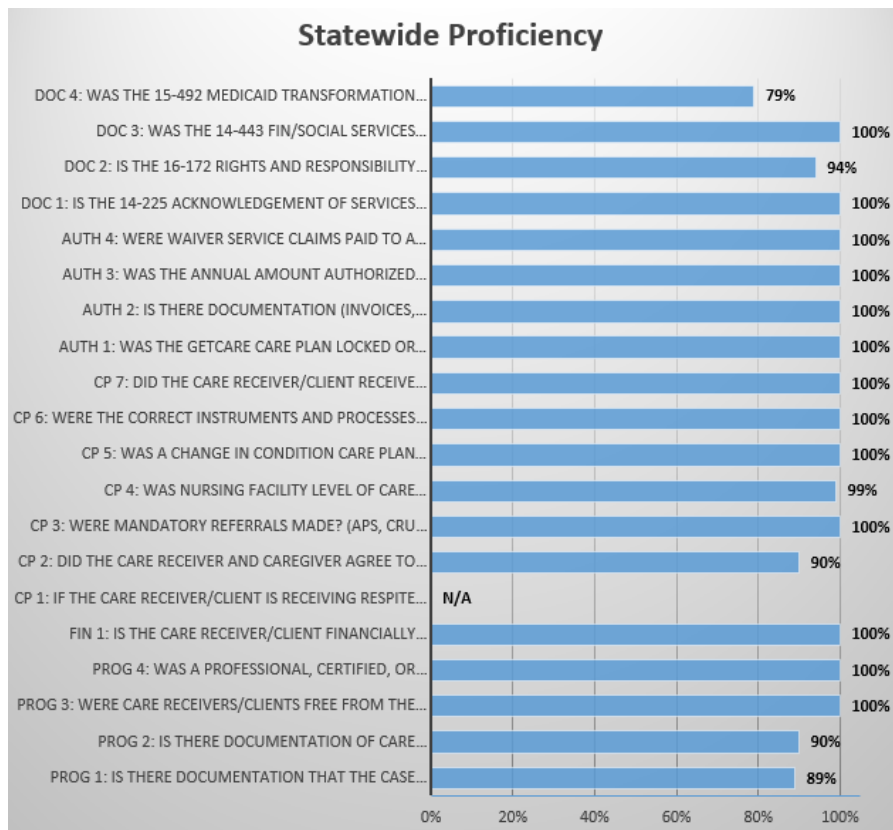
2020 quality assurance results to date

HCS' Quality Assurance (QA) unit began the 2020 audit cycle in January and ended in October. The state's 2020 QA cycle was paused as of March 25, 2020 because of COVID-19 pandemic impacts but resumed June 1, 2020. The results from all 13 AAAs were included in this report.

The statewide compliance review is conducted with all 13 AAAs. An identical review process is used in each AAA Planning and Service Area (PSA), using the same QA tool and the same [QA questions](#). The QA unit reviewed a statistically valid sample of case records (the sample size was 337 cases).

This methodology is the same one used for the state's 1915(c) waivers and meets the CMS requirements for sampling. Each PSA's sample was determined by multiplying the percent of the total program population in that area by the sample size.

Figure 6: statewide proficiency to date



Note: "N/A" means this question did not pertain to anyone in the sample.

State rulemaking

There were no rulemaking activities this quarter.

Upcoming activities

- Continue planning for 2021 training sessions
- Update Long Term Care Policy Manual – MTP Chapter 30bLTSS

Stakeholder concerns

Stakeholders did not submit any concerns this quarter.

FCS implementation accomplishments

This section summarizes the FCS program development and implementation activities from October 1 through December 31, 2020. Key accomplishments for the quarter include:

- Total aggregate number of people enrolled in FCS services at the end of DY4 Q4:
 - CSS: 5,360
 - IPS: 4,282
- There were 162 providers under contract with Amerigroup at the end of DY4 Q4, representing 458 sites throughout the state.

Note: CSS and IPS enrollment totals include 1,582 participants enrolled in both programs. The total unduplicated number of enrollments at the end of Q4 was 8,060.

Network adequacy for FCS

Table 10: FCS provider network development

FCS service type	October		November		December	
	Contracts	Service locations	Contracts	Service locations	Contracts	Service locations
Supported Employment – Individual Placement Support (IPS)	39	83	39	83	39	83
Community Support Services (CSS)	19	46	18	44	18	44
CSS and IPS	104	329	105	331	105	331
Total	162	458	162	458	162	458

The number of FCS providers remained stable through Q4, with one CSS provider terminating their contract in November, and one new provider onboarded that same month who will provide both CSS and IPS support services. HCA completed its first incentive program to assist SUD providers to join the FCS network, which saw 10 new SUD providers start FCS IPS services in DY4.

Substance Abuse Mental Health Services Administration (SAMHSA) block grant funds are being used to provide the infrastructure and capacity building for agencies to add FCS to their book of business.

Client enrollment

Table 11: FCS client enrollment

	October	November	December
Supported Employment – Individual Placement and Support (IPS)	2,656	2,742	2,700
Community Support Services (CSS)	3,765	3,868	3,778
CSS and IPS	1,535	1,606	1,582
Total aggregate enrollment	7,956	8,216	8,060

Data source: RDA administrative reports

Enrollment in the FCS program continued strong growth in Q4, particularly for individuals enrolling in CSS and IPS services simultaneously. The FCS team continued to monitor enrollments and program spend, in partnership with HCA Finance Division and RDA. The program has room to expand in 2021, and HCA's goal is to enroll more individuals with SUD in need of CSS services. HCA is monitoring enrollments closely with the TPA to ensure access to and availability of services statewide.

Table 12: FCS client risk profile

		Met HUD chronic homeless criteria	Avg. PRISM risk score	Serious mental illness
October	IPS	754 (18%)	.99	3,097 (74%)
	CSS	1,501 (28%)	1.39	3,698 (70%)
November	IPS	766 (18%)	1.	3,252 (75%)
	CSS	1,521 (28%)	1.38	3,838 (70%)
December	IPS	763 (18%)	.98	3,206 (75%)
	CSS	1,493 (28%)	1.36	3,723 (69%)

HUD = Housing and Urban Development

PRISM = Predictive Risk Intelligence System (Risk ≥ 1.5 identifies top 10 percent of high-cost Medicaid adults; Risk ≥ 1.0 identifies top 19 percent of high-cost Medicaid adults)

Note: month-to-month changes are due to client enrollment mix, not program impact

Data source: RDA administrative reports

Table 13: FCS client risk profile continued

		Medicaid-only enrollees*	MH treatment need	SUD treatment need	Co-occurring MH + SUD treatment needs flags
October	IPS	3,629	3,434 (95%)	2,287 (63%)	2,184 (60%)
	CSS	4,477	4,179 (93%)	3,398 (76%)	3,209 (72%)
November	IPS	3,757	3,556 (95%)	2,366 (63%)	2,263 (60%)
	CSS	4,623	4,295 (93%)	3,497 (76%)	3,291 (71%)
December	IPS	3,701	3,500 (95%)	2,313 (62%)	2,211 (60%)
	CSS	4,516	4,189 (93%)	3,389 (75%)	3,181 (70%)

MH = Mental health

Data source: RDA administrative reports

*Does not include individuals who are dual-enrolled.

Table 14: FCS client service utilization

		Medicaid-only enrollees*	Long-term Services and Supports	Mental health services	SUD services (received in last 12 months)	Care + MH or SUD services
October	IPS	3,629	335 (9%)	2,904 (80%)	1,472 (41%)	304 (8%)
	CSS	4,477	572 (13%)	3,212 (72%)	2,067 (46%)	500 (11%)

November	IPS	3,757	358 (10%)	2,997 (80%)	1,520 (40%)	326 (9%)
	CSS	4,623	611 (13%)	3,305 (71%)	2,099 (45%)	532 (12%)
December	IPS	3,701	362 (10%)	2,900 (78%)	1,475 (40%)	325 (9%)
	CSS	4,516	612 (14%)	3,164 (70%)	2,020 (45%)	523 (12%)

(Aging CARE assessment in last 15 months)

Data source: RDA administrative reports

*Does not include individuals who are dual-enrolled.

Table 15: FCS client Medicaid eligibility

		CN blind/disabled (Medicaid-only & full dual-eligible)	CN aged (Medicaid-only & full dual-eligible)	CN family & pregnant woman	ACA expansion adults (nonadults presumptive)	Adults (nonadults presumptive) ACA expansion adults (SSI presumptive)	CN & CHIP children
October	IPS	1156 (28%)	73 (2%)	502 (12%)	1863 (44%)	497 (12%)	100 (2%)
	CSS	1776 (34%)	249 (5%)	691 (13%)	1703 (32%)	825 (16%)	56 (1%)
November	IPS	1210 (28%)	76 (2%)	530 (12%)	1927 (44%)	504 (12%)	101 (2%)
	CSS	1838 (34%)	257 (5%)	713 (13%)	1777 (32%)	838 (15%)	51 (1%)
December	IPS	1199 (28%)	78 (2%)	532 (12%)	1899 (44%)	477 (11%)	97 (2%)
	CSS	1822 (34%)	254 (5%)	707 (13%)	1729 (32%)	802 (15%)	46 (1%)

ACA = Affordable Care Act

CHIP = Children’s Health Insurance Program

CN = Categorically needy

Data source: RDA administrative reports

Quality assurance and monitoring activity

FCS staff continued to work with the TPA to monitor the growth of the provider network and enrollments in the program. The TPA conducted quarterly provider outcome and capacity surveys, as well as an annual participant satisfaction survey.

The FCS training staff completed eight fidelity reviews of contracted FCS providers. These reviews were completed virtually over two days with a review team made up of HCA staff and FCS providers. These reviews were designed to assess how well a provider aligns their services with the evidence-based practices of IPS and Permanent Supportive Housing (PSH). FCS staff also held six virtual fidelity reviewers training events that teach FCS providers on the evidence-based practices and prepare their participation on review panels.

During Q4, HCA and DSHS’ Aging and Long-Term Support Administration (ALTSA) presented information about FCS at four state conferences (NAMI, Co-Occurring Disorder and Treatment, Medicaid Transformation Learning Symposium, and Conference on Ending Homelessness). At the Conference on Ending Homelessness, HCA presented the results of a qualitative interview project called Photovoice, in which FCS participants took photos that documented their experiences working with their FCS provider, landlord, or employer.

Photovoice is a process by which people identify, represent, and enhance their lives and communities through a specific photographic approach. Cameras are given to people directly affected by policies, practices, or conditions and they then can act as recorders and potential catalysts for social action and change in their lives and communities. Photovoice uses visual images and accompanying stories to promote an effective and participatory means of sharing expertise and creating proactive public policy.

Other FCS program activity

HCA is actively pursuing the bulk purchase of mobile devices for FCS enrollees. A work group has been created to explore different avenues of purchasing and distributing these devices to FCS providers and participants, as well as developing ongoing policies and procedures. ACHs have agreed to distribute the mobile devices to contracted FCS providers. FCS providers commit to including mobile devices on care plans, as required by CMS. The TPA will incorporate mobile device protocol reviews into their process for quality assurance and monitoring.

After CMS approval allowing FCS to provide CSS services within IMD settings, a cross-initiative work group was established to identify the policies and processes needed to align FCS with MTP Initiatives 4 and 5. The goal of these services is to assist individuals as they transition out of a residential facility, facilitating a higher degree of success in obtaining housing and employment. FCS services would be provided in IMD settings that meet the average length of stay requirement of 30 days or less established under MTP Initiatives 4 and 5. This work will continue in DY5 Q1 with the goal of launching services during DY5 Q2.

Upcoming activities

- HCA’s Division of Behavioral Health and Recovery (DBHR) will launch a request for applications (RFA) that will incentivize SUD treatment providers to become contracted FCS providers. Last year, this project was legislatively mandated to focus specifically on CSS services. In DY5, these SAMHSA block grant funds will be distributed to up to ten providers to assist them in contracting with the TPA, hiring staff, and completing trainings on either IPS or CSS services.
- DBHR started the recruitment process of the FCS program manager position (previously held by the current FCS program administrator), with the goal of that position being filled early in DY5 Q1. This position provides critical support in participant enrollment, data quality and reporting, and external communications.
- DBHR training staff launched the 2021 fidelity review incentive program that aims to complete 20 baseline fidelity reviews (first time reviews of FCS providers) and 20 additional follow-up reviews of providers who will be receiving their second fidelity review.

FCS program stakeholder engagement activities

During the reporting quarter, staff from HCA, AL TSA, and Amerigroup supported a variety of stakeholder engagement activities.

Table 16: FCS program stakeholder engagement activities

	October	November	December
	Number of events held		
Training and assistance provided to individual organizations	33	28	31
Community and regional presentations and training events	13	3	5
Informational webinars	5	11	11

Stakeholder engagement meetings	5	7	8
Total activities	56	49	55

Regularly scheduled webinars inform, educate, and coordinate resources for FCS providers serving people who need housing and employment services, resources, and supports. Q4 topics included:

- Forensic: breaking down stigma
- Changing careers in the middle of upheaval
- Golden thread and psych rehab
- Adolescents transitioning out of youth systems
- Hoarding in housing
- Determining accommodations
- Restorative supervision
- Managing personal information
- Monthly supportive housing supervisor’s learning collaborative
- Job developers training for SUD and supported employment
- Joint problem solving with landlords
- Best practices for clinical supervision
- Earned income tax credit in WA
- Trauma-informed supported employment services
- Enhancing services through concurrent documentation

Although the COVID-19 pandemic has posed significant challenges to the FCS program, total attendance for HCA-led technical assistance activities reached 11,061 for the year. This is nearly twice the number of attendees who registered in DY3 (6,345).

FCS stakeholder concerns

During Q4, FCS staff received only a few stakeholder concerns about the program. These concerns were focused on the future of the program, primarily from providers who had invested significant time and staff resources into FCS. All concerns were from stakeholders who want to see the program succeed and continue past the initial five-year waiver period.

SUD program implementation accomplishments

This section summarizes SUD program development and implementation activities from October 1 through December 31, 2020. Accomplishments for the quarter include:

- An action plan to remove barriers to residential care and improve transitions between levels of care for adults and adolescents was submitted to the Legislature. The action plan was submitted at the beginning of December as required by House Bill 2642.

Key outcomes of the action plan included recommendations for:

- Adoption of American Society of Addiction Medicine (ASAM) criteria to determine medical necessity for SUD treatment across business lines.
- Improving facilitation of transfers between levels of care.
- Facilitating direct transfers to SUD treatment from hospitals and jails.
- Establishing the minimum amount of medical information necessary for plan utilization reviews in withdrawal management settings.

Work continues following the publication of this action plan and further communications regarding the January 1, 2021, implementation of the standard set of admissions criteria will be shared with the SUD treatment field.

SUD mid-point assessment

The Center for Health Systems Effectiveness at Oregon Health & Science University (CHSE) completed its draft of the mid-point assessment and it was submitted to CMS on December 30, 2020.

CHSE noted that state has completed the majority of the actions outlined in the SUD Implementation Plan Protocol for implementing the SUD waiver's six milestones. Actions for milestones 1, 2, 4, and 5 have been completed. The remaining work to complete milestones 3 and 6 involves updating the Washington Administrative Code, a process which the state has begun.

A variety of measures of access and quality for SUD prevention and treatment, assessed using administrative data, showed overall movement in the desired direction and suggested significant progress in expanding access and provider capacity, increasing treatment availability, and improving care coordination.

Among 25 measures, 19 improved, and the others showed no change or slightly worse performance. In addition, the number of licensed SUD residential IMD facilities did not change in the year following the waiver's implementation, while budget neutrality was maintained.

Interviews with stakeholders revealed concern and optimism. According to many providers, the state's managed care integration transition created delays in payment and adversely affected provider financial stability. Disagreements between payers and providers about the role of residential care in SUD treatment were noted. However, stakeholders also pointed to the financial benefits of the waiver and the greater flexibility afforded in meeting Medicaid beneficiaries' needs for residential treatment. The midpoint assessment can be found [here](#).

Implementation plan

In accordance with the amended STCs, the state is required to submit an implementation plan for the SUD program, incorporating six key milestones outlined by CMS. At the time of the waiver application, the state met a number of these milestones in its provision of SUD services. Where the state did not meet the milestones, CMS was engaged to confirm appropriate adjustments.

No changes to the state's SUD implementation plan to report for this reporting period.

Evaluation design

No updates for this reporting period.

Monitoring protocol

The State updated the Monitoring Protocol template to Version 5.0 as requested by CMS. With the update to Version 5.0, the reporting of one of the state-defined Health IT metrics has changed format. Metric Q1: Statewide Overdose Deaths was previously reported as one metric with several sub metrics. In Version 5.0, this metric is reported as multiple state defined metrics (due to the underlying formatting of the Monitoring Protocol template Version 5.0). There were no specification changes, only formatting changes.

CMS requested additional information about previously submitted Monitoring Protocol workbooks. State responses to these questions are below.

CMS question: metric #3 (beneficiaries with SUD diagnosis) seems to have had a large jump between September 2019 (65,338) and October 2019 (102,776), which appears to coincide with the change from v2.0 to v3.0 of the tech specs.

State response: the state identified and corrected the issue for metric #3. The table below contains the updated data for metric #3 for October 2019–March 2020.

**Table 17: metric #3 (Medicaid beneficiaries with an SUD diagnosis)
October 2019–March 2020**

Measurement Period	WA	OUD subpopulation	Age < 18	Age 18-64	Age 65+	Dual	Medicaid-only	Pregnant	Not pregnant	Criminally involved	Not criminally involved
10/01/2019 - 10/31/2019	67,334	42,723	2,331	64,203	800	3,407	63,927	163	67,171	15,426	51,908
11/01/2019 - 11/30/2019	67,024	42,724	2,286	63,938	800	3,389	63,635	168	66,859	15,238	51,786
12/01/2019 - 12/31/2019	67,027	42,901	2,244	93,979	804	3,373	63,654	180	66,847	15,184	51,843
01/01/2020 - 01/31/2020	68,143	43,733	2,207	65,125	811	3,408	64,735	177	67,966	15,315	52,828
02/01/2020 - 02/28/2020	68,690	44,140	2,300	65,583	807	3,437	65,253	177	68,513	15,228	53,462
03/01/2020 - 03/31/2020	68,936	44,434	2,320	65,814	802	3,439	65,497	175	68,761	14,915	54,021

CMS question: metric #6 – criminal subpopulation (beneficiaries receiving any SUD treatment), shows that approximately 20 percent of beneficiaries receiving any SUD treatment are criminally involved. This is strikingly higher than the level seen in other states (which are closer to ~two percent), so we’d appreciate some conversation on this. For example, we would appreciate hearing more about the methodology used to identify the criminally involved subpopulation, and if there are any state- or demonstration-specific situations that might explain the difference.

State response: as submitted as part of the approved monitoring protocol materials, the state uses data from the Washington State Identification System arrest database maintained by the Washington State Patrol. An individual will be counted as “criminally involved” during the measurement period if they were arrested in the reference month or within the prior six months. An individual will be counted as “not criminally involved” during the measurement period if they were not arrested in the reference month or within the prior six months. This is likely a much broader definition of criminal justice involvement than other states have. For additional information about this metric, please see the [Healthier Washington Measures Dashboard](#).

CMS question: for metric #13 and #14, the SUD DY2Q2 report (broader DY3 Q4), there is a note regarding difficulty in reconciling the list of providers eligible to prescribe MAT with the broader SUD provider list. While this note hasn’t appeared in subsequent reports, we’d like to hear any insight the state may have on this issue and what the resolution was.

State response: initially, the list of providers eligible to prescribe MOUD and the list of broader SUD providers were distinct. At the outset of reporting, the state did not have an established process for merging the two lists and de-duplicating providers as necessary. The state has since established a process to merge and de-duplicate the lists so that MOUD providers are a subset of all SUD providers.

Upcoming activities

Rapid response calls are ongoing to assist providers in implementing recommendations resulting from House Bill 2642.

Quarterly expenditures

The following table reflects quarterly expenditures for DSRIP, LTSS, and FCS during DY4 (2020).

Table 18: DSRIP expenditures

	Q1	Q2	Q3	Q4	DY4 Total	Funding source
	January 1– March 31	April 1– June 30	July 1– September 30	October 1– December 31	January 1– December 31	Federal financial participation
Better Health Together	\$5,144,786	\$4,852,757	\$0	\$2,674,964	\$12,672,507	\$6,336,254
Cascade Pacific Action Alliance	\$4,677,079	\$4,443,414	\$0	\$2,431,785	\$11,552,278	\$5,776,139
Elevate Health	\$6,547,910	\$6,080,780	\$0	\$2,918,142	\$13,792,733	\$6,896,367
Greater Columbia	\$10,289,572	\$9,355,513	\$0	\$3,404,499	\$16,033,189	\$8,016,595
HealthierHere	\$2,338,539	\$2,396,707	\$0	\$5,349,926	\$24,995,011	\$12,497,506
North Central	\$7,015,618	\$6,490,122	\$0	\$1,215,893	\$5,951,139	\$2,975,570
North Sound	\$1,870,831	\$1,987,366	\$0	\$3,647,677	\$17,153,417	\$8,576,709
Olympic Community of Health	\$5,612,494	\$5,262,097	\$0	\$972,714	\$4,830,911	\$2,415,456
SWACH	\$3,273,955	\$3,215,390	\$0	\$1,702,250	\$8,191,595	\$4,095,798
Indian Health Care Providers	\$1,862,500	\$0	\$0	\$1,660,000	\$3,522,500	\$1,761,250

Table 19: LTSS and FCS service expenditures

	Q1	Q2	Q3	Q4	DY4 Total
	January 1– March 31	April 1– June 30	July 1– September 30	October 1– December 31	January 1– December 31
Tailored Supports for Older Adults (TSOA)	\$2,323,728	\$3,684,643	\$2,874,309	\$4,936,552	\$13,819,232
Medicaid Alternative Care (MAC)	\$56,452	\$79,469	\$66,359	\$117,269	\$319,549
MAC and TSOA not eligible	\$465	\$1,236	\$745	\$(14)	\$2,432
FCS	\$2,637,290	\$9,434,315	\$5,788,771	\$5,852,639	\$23,713,015

Financial and budget neutrality development issues

Financial

Below are the counts of member months eligible to receive services under MTP. Member months for non-expansion adults are updated retrospectively, based on the current caseload forecast council (CFC) medical caseload data. Actual caseload data for non-expansion adults is available through October 2020. November 2020 and December 2020 member months for non-expansion adults are forecasted caseload figures from CFC. Actual member months data for the SUD populations is currently available through June 2020.

Table 20: member months eligible to receive services

Calendar month	Non-expansion adults only	SUD Medicaid disabled	SUD Medicaid non-disabled	SUD newly eligible	SUD American Indian/Alaska Native
Jan-17	376,322	0	0	0	0
Feb-17	375,219	0	0	0	0
Mar-17	374,752	0	0	0	0
Apr-17	373,608	0	0	0	0
May-17	373,151	0	0	0	0
Jun-17	373,055	0	0	0	0
Jul-17	372,148	0	0	0	0
Aug-17	371,882	0	0	0	0
Sep-17	370,615	0	0	0	0
Oct-17	370,417	0	0	0	0
Nov-17	370,220	0	0	0	0
Dec-17	370,206	0	0	0	0
Jan-18	370,226	0	0	0	0
Feb-18	368,794	0	0	0	0
Mar-18	368,573	0	0	0	0
Apr-18	367,280	0	0	0	0
May-18	367,588	0	0	0	0
Jun-18	366,838	0	0	0	0
Jul-18	366,536	2	3	11	8
Aug-18	365,907	6	1	18	17
Sept-18	364,881	3	3	11	18
Oct-18	364,824	4	3	9	24
Nov-18	364,358	2	1	17	27

Dec-18	363,786	4	4	12	15
Jan-19	363,712	4	18	65	22
Feb-19	361,969	13	23	110	27
Mar-19	361,605	7	25	96	29
Apr-19	361,127	6	29	92	35
May-19	360,595	4	29	82	42
June-19	359,804	5	25	57	31
Jul-19	360,240	2	22	57	34
Aug-19	359,802	1	29	28	32
Sep-19	359,380	10	32	77	26
Oct-19	358,845	0	0	0	0
Nov-19	357,969	0	0	0	0
Dec-19	358,272	0	0	0	0
Jan-20	358,668	2	31	83	27
Feb-20	358,540	3	28	60	25
Mar-20	360,181	0	0	0	0
Apr-20	363,530	0	0	0	0
May-20	365,744	0	0	0	0
Jun-20	368,408	0	0	0	0
Jul-20	370,228	0	0	0	0
Aug-20	372,547	0	0	0	0
Sep-20	374,872	0	0	0	0
Oct-20	379,103	0	0	0	0
Nov-20	380,309	0	0	0	0
Dec-20	381,828	0	0	0	0
Total	17,640,220	498	1,696	6,296	9,981

Budget neutrality

HCA adopted CMS's budget neutrality monitoring tool and has been using Performance Management Database and Analytics system to upload quarterly spreadsheets.

A CMS-64 process has been implemented to identify SUD costs and expenditures will be reported for those populations on the Schedule C Q1/FFY21 report.

Designated state health programs (DSHP)

HCA has extended its contract with the IA to perform an independent audit based on agreed-upon procedures to validate the accuracy of DSHP claims reported on the CMS-64 for CY 2019. The state anticipates the audit and final report will be completed by June 2021.

Overall MTP development and issues

Operational/policy issues

During Q4, 2020 HCA and DSHS continued to prepare the appropriate materials tied to the one-year extension request. These activities included engagement of legislative staff and members concerning legislative authorization necessary to support the one-year extension, in anticipation of CMS approval. This engagement also included discussion regarding the timeline and process tied to the extension as compared to a longer-term renewal, and how the extension will provide an additional “runway” for the renewal preparation and related strategic planning.

HCA continued to coordinate with CMS over the course of this reporting period on the topic of statewide accountability and related adjustments due to COVID-19 impacts. The state will continue to work with CMS on finalizing performance flexibility within the funding and mechanics protocol and is pursuing an STC amendment to align the MTP VBP adoption target for DY5 with the target in managed care contracts. The target within contracts was adjusted to 85 percent (down from 90 percent) for DY5.

Consumer issues

The state has not experienced any major consumer issues for DSRIP, FCS, LTSS, or SUD programs during this reporting quarter, except general inquiries about benefits available through MTP.

The state is researching closed captioning services that might permit a hearing-impaired behavioral health counselor to resume group counseling over Zoom. When barriers like this are identified, state expertise is needed to achieve equity.

MTP evaluation

CHSE delivered its [draft Interim Evaluation Report](#), presenting preliminary evaluation findings and plans for completing the final report, due in December 2021. The report is based on data available through 2019, so it does not include any analysis on how the COVID-19 pandemic may have impacted the MTP initiatives.

This report builds on the [Baseline Evaluation Report](#) HCA received in May 2020, as well as the quarterly Rapid-cycle Monitoring Reports. All reports are available on the [Medicaid Transformation resources webpage](#).

Highlights of the draft interim evaluation report included:

- By early 2020, the state had achieved important milestones for structural change. These include transforming payment mechanisms for behavioral health; introducing new options for meeting the needs for LTSS, supportive housing, and supported employment; accelerating adoption of value-based payments; and spurring regional action on a range of population health efforts led by ACHs.
- There were early signs of success. There have been meaningful improvements in SUD treatment, care for people with chronic conditions—and in some cases— mental health quality and utilization. New employment supports for people with complex needs show early signs of success, increasing employment and improving health outcomes.
- Initiatives focused on SDOH, homelessness, or health promotion have not yet shown strong evidence of change. ACHs have made investments in workforce and other infrastructure necessary to implement interventions in these areas. Additional efforts will be necessary to address the structural factors that currently limit access to and the quality of care for underserved groups. More substantial improvements in these outcomes may take longer.

Key findings:

- There were substantial improvements in statewide measures related to SUD and chronic conditions.

- Racial and ethnic disparities were evident.
- Early results of ACH Health Improvement Projects were mixed.
- There was a variety of improvements in measures for projects to integrate behavioral health and physical health care and to address the opioid crisis.
- There were fewer detectable improvements in analyses of other projects. Workforce has progressed toward value-based payment and IMC.
- Workforce shortages were a top challenge in implementing MTP initiatives.
- Stakeholders desired a statewide HIT and HIE strategy to promote standardization and interoperability.
- MAC and TSOA may have reduced statewide utilization of traditional Medicaid LTSS.
- Early results from FCS are promising.
- Access to and quality of SUD treatment in the year following implementation of Initiative 4. There was evidence of increased capacity for SUD treatment across the state.

Specific recommendations for Washington State and HCA:

- Address health disparities.
- Strengthen engagement of non-clinical partners in MTP.
- Support the recruitment and retention of key workers necessary for MTP success.
- Provide clear guidance regarding Washington State’s vision for CIE.
- Continue to monitor progress on ACH health improvement projects.
- Explore options to ensure benefit packages are clearly understood across TSOA, MAC, and traditional LTSS so individuals can make the choice that best meets their needs.
- Build on early positive results from the FCS IPS program.
- Continue to assess the entire system of substance use prevention, treatment, and recovery, and ensure that the SUD IMD does not create incentives for unnecessary residential stays.
- Monitor challenges identified in MCO payments made to behavioral health and SUD treatment providers, including timeliness of payments and appropriateness of prior authorization requirements.

Many of the findings in the Interim Evaluation Report relate to early successes and challenges in implementation. Evaluation of MTP is ongoing, with additional data collection and analysis slated to occur. Interim findings will continue to be reported in quarterly Rapid-cycle Monitoring Reports. A Final Evaluation Report planned in 2022 will present summative evaluation findings for the demonstration.

Summary of additional resources, enclosures, and attachments

Additional resources

To learn more about Washington's MTP, [visit the HCA website](#). Receive notifications about MTP-related activities, new materials, and other information through HCA's [email subscription list](#).

Summary of attachments

- Attachment A: [state contacts](#)
- Attachment B: [Financial Executor Portal Dashboard, Q4 2020](#)
- Attachment C: [1115 SUD Demonstration Monitoring Report – Part B](#)

Attachment A: state contacts

Contact these individuals for questions within the following MTP-specific areas.

Area	Name	Title	Phone
MTP and quarterly reports	Chase Napier	Manager, Medicaid Transformation	360-725-0868
DSRIP program	Chase Napier	Manager, Medicaid Transformation	360-725-0868
LTSS program	Kelli Emans	Integration unit manager, DSHS	360-725-3213
FCS program	Melodie Pazolt	Behavioral Health Programs and Recovery Support Services section manager, DBHR	360-725-0487
SUD program	David Johnson	Federal programs manager, DBHR	360-725-9404

For mail delivery, use the following address:

Washington State Health Care Authority
Policy Division
Mail Stop 45502
628 8th Avenue SE
Olympia, WA 98501

Attachment B: Financial Executor Portal Dashboard, Q4 2020

[View this table on the HCA website](#) which shows all funds earned and distributed through the FE portal through December 31, 2020.

Attachment C: 1115 SUD Demonstration Monitoring Report – Part B

1. Title Page for the State’s SUD Demonstration or SUD Components of Broader Demonstration

State	Washington State
Demonstration name	Washington State Medicaid Transformation Project No. 11-W-00304/0
Approval date for demonstration	January 9, 2017
Approval period for SUD	July 1, 2018-December 31, 2021
Approval date for SUD, if different from above	July 17, 2018
Implementation date of SUD, if different from above	July 1, 2018
SUD (or if broader demonstration, then SUD - related) demonstration goals and objectives	<p>Under Washington’s 1115 demonstration waiver, the SUD program allows the state to receive Federal Financial Participation (FFP) for Medicaid recipients residing in institutions for mental disease (IMDs) under the terms of this demonstration for coverage of medical assistance including opioid use disorder (OUD)/substance use disorder (SUD) benefits that would otherwise be matchable if the beneficiary were not residing in an IMD.</p> <p>Under this demonstration, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to ongoing chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.</p> <p>Expenditure authority will allow the state to improve existing SUD services and ensure the appropriate level of treatment is provided, increase the availability of medication assisted treatment (MAT), and enhance coordination between levels of care. The state will continue offering a full range of SUD treatment options using the American Society for Addiction Medicine (ASAM) criteria for assessment and treatment decision making.</p>

2. Executive Summary

Metrics submitted with this reporting period include data from April through June of 2020. COVID-19 likely impacted service delivery in a variety of ways—including challenges to service delivery brought about by infection control and social distancing measures. However, caution is advised when interpreting, as the full impact is still unclear as the pandemic continues.

Service decreases were observed in early intervention services, outpatient services, residential and inpatient services, withdrawal management, and medication-assisted treatment, and it is not unreasonable to infer that the COVID-19 pandemic may have influenced trends and lead to “chop” in the data as individuals and providers reacted to COVID-19.

Outside of the waiver, recently passed legislation (HB 2642) will directly impact substance use disorder treatment services. Its intent is to require uniform medical necessity and placement criteria, improve transitions of care, and reduce access barriers due to prior authorization requirements. Work to effectively implement this legislation occurred throughout Q4.

3. Narrative Information on Implementation, by Milestone and Reporting Topic

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
1.2 Assessment of Need and Qualification for SUD Services			
1.2.1 Metric Trends			
<p><input checked="" type="checkbox"/> The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.</p>	<p>The monthly number of Medicaid beneficiaries with an SUD diagnosis has remained stable. However, there has been a slight increase in the number of Medicaid beneficiaries with an OUD diagnosis. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.</p>	<p>04/01/2019 – 06/30/2019</p>	<p>#3: Medicaid beneficiaries with SUD diagnosis (monthly)</p>
	<p>The annual number of Medicaid beneficiaries with an SUD diagnosis has increased over the last year. This appears to be driven by an increase in the OUD subpopulation. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.</p>	<p>07/01/2018 – 06/30/2019</p>	<p>#4: Medicaid beneficiaries with SUD diagnosis (annual)</p>
	<p>There has been a slight increase in the number of Medicaid beneficiaries treated in an IMD for SUD. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.</p>	<p>07/01/2018 – 06/30/2019</p>	<p>#5: Medicaid beneficiaries treated in an IMD for SUD</p>

<input type="checkbox"/> The state has no metrics trends to report for this reporting topic.			
1.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to:			
<input type="checkbox"/> i) The target population(s) of the demonstration			
<input type="checkbox"/> ii) The clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The state expects to make other program changes that may affect metrics related to assessment of need and qualification for SUD services			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
2.2 Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)			
2.2.1 Metric Trends			
<input checked="" type="checkbox"/> The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1	The number of Medicaid beneficiaries received any SUD treatment has decreased from the previous measurement period. This decreased can be seen across all subpopulation. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#6: Any SUD Treatment
	Consistent with other service categories, the number of early intervention services has decreased from the previous measurement period. Research within the state has highlighted some barriers to billing for SBIRT, including but not limited to staff turnover and uncertainty around reimbursement. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on	04/01/2019 – 06/30/2019	#7: Early Intervention

	the receipt of these services is unknown. Any changes in trends should be interpreted with caution.		
	Consistent with other service categories, the number of outpatient services has decreased from the previous measurement period. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#8: Outpatient Services
	Consistent with other service categories, the number of residential and inpatient services has decreased from the previous measurement period. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#10: Residential and Inpatient Services
	Consistent with other service categories, the number of withdrawal management services has decreased from the previous measurement period. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#11: Withdrawal Managemen t
	Consistent with other service categories, the number of medication-assisted treatment services has decreased from the previous measurement period. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#12: Medication Assisted Treatment
	The overall average length of stay has decreased from the previous measurement period (16.42 days to 15.48 days). However, for the OUD subpopulation, the average length of stay has increased from the previous measurement period (16.57 days to 18.07 days). Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	07/01/2018 – 06/30/2019	#36: Average Length of Stay in IMDs

<input type="checkbox"/> The state has no metrics trends to report for this reporting topic.			
2.2.2 Implementation Update			
<p>Compared to the demonstration design and operational details, the state expects to make the following changes to:</p> <p><input type="checkbox"/> i) Planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g. outpatient services, intensive outpatient services, medication assisted treatment, services in intensive residential and inpatient settings, medically supervised withdrawal management)</p> <p><input type="checkbox"/> ii) SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and medication assisted treatment services provided to individuals in IMDs</p>			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The state expects to make other program changes that may affect metrics related to Milestone 1			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
3.2 Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)			
3.2.1 Metric Trends			
<input type="checkbox"/> The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 2			
<input checked="" type="checkbox"/> The state has no trends to report for this reporting topic.			

<input type="checkbox"/> The state is not reporting metrics related to Milestone 2.			
3.2.2 Implementation Update			
<p>Compared to the demonstration design and operational details, the state expects to make the following changes to:</p> <p><input type="checkbox"/> i) Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria</p> <p><input type="checkbox"/> ii) Implementation of a utilization management approach to ensure (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, or (c) use of independent process for reviewing placement in residential treatment settings</p>			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The state expects to make other program changes that may affect metrics related to Milestone 2			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The state is not reporting metrics related to Milestone 2.			
4.2 Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)			
4.2.1 Metric Trends			
<input type="checkbox"/> The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 3			
<input checked="" type="checkbox"/> The state has no trends to report for this reporting topic.			
<input type="checkbox"/> The state is not reporting metrics related to Milestone 3.			

4.2.2 Implementation Update			
<p>Compared to the demonstration design and operational details, the state expects to make the following changes to:</p> <ul style="list-style-type: none"> <input type="checkbox"/> i) Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards <input type="checkbox"/> ii) State review process for residential treatment providers' compliance with qualifications standards <input type="checkbox"/> iii) Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site 			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The state expects to make other program changes that may affect metrics related to Milestone 3			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The state is not reporting metrics related to Milestone 3.			
5.2 Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)			
5.2.1 Metric Trends			
<input checked="" type="checkbox"/> The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4	As previously noted, during the initial measurement period, the state had an incomplete list of SUD providers. Thus, the dramatic change in the number of reported providers is due to more complete data. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	07/01/2018 – 06/30/2019	#13: SUD provider availability

	<p>The number of providers who are eligible to provide MAT has increased from the previous measurement period from 2,885 eligible prescribers to 3,357 eligible prescribers. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.</p>	07/01/2018 – 06/30/2019	#14: SUD provider availability – MAT
<input type="checkbox"/> The state has no trends to report for this reporting topic.			
5.2.2 Implementation Update			
<p>Compared to the demonstration design and operational details, the state expects to make the following changes to:</p> <input type="checkbox"/> Planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The state expects to make other program changes that may affect metrics related to Milestone 4			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
6.2 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)			
6.2.1 Metric Trends			
<input type="checkbox"/> The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 5			

<input checked="" type="checkbox"/> The state has no trends to report for this reporting topic.			
6.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to:			
<input type="checkbox"/> i) Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD			
<input type="checkbox"/> ii) Expansion of coverage for and access to naloxone			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The state expects to make other program changes that may affect metrics related to Milestone 5			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
7.2 Improved Care Coordination and Transitions between Levels of Care (Milestone 6)			
7.2.1 Metric Trends			
<input type="checkbox"/> The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 6			
<input checked="" type="checkbox"/> The state has no trends to report for this reporting topic.			
7.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to:			

<input type="checkbox"/> Implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input checked="" type="checkbox"/> The state expects to make other program changes that may affect metrics related to Milestone 6			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
8.2 SUD Health Information Technology (Health IT)			
8.2.1 Metric Trends			
<input checked="" type="checkbox"/> The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its Health IT metrics	<p>Compared to the previous measurement period, there was an increase in the number of fatal drug overdoses for all Washington residents (not Medicaid specific). Among opioid related overdose deaths, there was a significant increases in overdose deaths due to prescription opioids. Note: Due to the data lag in finalizing death certificate information, this metric is reported with a one year lag.</p>	<p>07/01/2017 – 06/30/2018</p>	<p>Q1: PDMP Statewide Fatal Drug Overdoses – All, All Opioids, Heroin, Prescription Opioids (excluding synthetic opioids), Synthetic Opioids (not Methadone)</p>
	<p>Compared to the previous measurement period, there was an increase in the SUD treatment penetration rate (36.49% to 39.19%). In addition, there was an increase in the absolute number of those with an identified SUD treatment need (49,765 to 54,449). Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on</p>	<p>07/01/2018 – 06/30/2019</p>	<p>Q2: Substance Use Disorder Treatment Penetration Rate</p>

	<p>the receipt of these services is unknown. Any changes in trends should be interpreted with caution.</p>		
	<p>Compared to the previous measurement period, the number of FCS beneficiaries with an inpatient or residential SUD service almost doubled. This is likely due to the growth of the FCS program during this measurement period. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.</p>	<p>07/01/2018 – 06/30/2019</p>	<p>Q3: Foundational Community Supports Beneficiaries with Inpatient or Residential SUD Services</p>
<p><input type="checkbox"/> The state has no trends to report for this reporting topic.</p>			
<p>8.2.2 Implementation Update</p>			
<p>Compared to the demonstration design and operational details, the state expects to make the following changes to:</p> <ul style="list-style-type: none"> <input type="checkbox"/> i) How health IT is being used to slow down the rate of growth of individuals identified with SUD <input type="checkbox"/> ii) How health IT is being used to treat effectively individuals identified with SUD <input type="checkbox"/> iii) How health IT is being used to effectively monitor “recovery” supports and services for individuals identified with SUD <input type="checkbox"/> iv) Other aspects of the state’s plan to develop the health IT infrastructure/capabilities at the state, delivery system, health plan/MCO, and individual provider levels 			

<input type="checkbox"/> v) Other aspects of the state’s health IT implementation milestones <input type="checkbox"/> vi) The timeline for achieving health IT implementation milestones <input type="checkbox"/> vii) Planned activities to increase use and functionality of the state’s prescription drug monitoring program			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The state expects to make other program changes that may affect metrics related to Health IT			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
9.2 Other SUD-Related Metrics			
9.2.1 Metric Trends			
<input checked="" type="checkbox"/> The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to other SUD-related metrics	After a brief dip in April 2020 (likely due to COVID-19), the rate of Emergency Department Utilization for SUD increased in May and June 2020. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#23: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries
	After a brief dip in April 2020 (likely due to COVID-19), the rate of Inpatient stays for SUD increased in May and June 2020 to levels consistent with prior reporting periods. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries

	Compared to the previous measurement period, readmissions among beneficiaries with an SUD increased by almost 2 percentage points from 16.26% to 18.25%. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	07/01/2018 – 06/30/2019	#25: Readmissions Among Beneficiaries with SUD
	The number of overdose deaths among Medicaid beneficiaries increased from 568 in SFY 2018 to 661 in SFY 2019. Note: Due to the data lag in finalizing death certificate information, this metric is reported with a one year lag.	07/01/2017 – 06/30/2018	#26: Overdose Deaths (count)
	The rate of overdose deaths among Medicaid beneficiaries increase from SFY 2018 to SFY 2019. Note: Due to the data lag in finalizing death certificate information, this metric is reported with a one year lag.	07/01/2017 – 06/30/2018	#27: Overdose Deaths (Rate)
<input type="checkbox"/> The state has no trends to report for this reporting topic.			
9.2.2 Implementation Update			
<input type="checkbox"/> The state expects to make other program changes that may affect metrics related to other SUD-related metrics			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
10.2 Budget Neutrality			
10.2.1 Current status and analysis			

<input type="checkbox"/> If the SUD component is part of a broader demonstration, the state should provide an analysis of the SUD-related budget neutrality and an analysis of budget neutrality as a whole. Describe the current status of budget neutrality and an analysis of the budget neutrality to date.			
10.2.2 Implementation Update			
<input type="checkbox"/> The state expects to make other program changes that may affect budget neutrality			
<input type="checkbox"/> The state has no implementation update to report for this reporting topic.			
11.1 SUD-Related Demonstration Operations and Policy			
11.1.1 Considerations			
<input checked="" type="checkbox"/> States should highlight significant SUD (or if broader demonstration, then SUD-related) demonstration operations or policy considerations that could positively or negatively affect beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD demonstration’s approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.	<p>HB-2642 was signed into law earlier in 2020. House Bill 2642, also referred to as the “No Wrong Door” bill, addresses health coverage barriers for Washingtonians seeking SUD treatment. The law’s key provisions will become effective January 2021, and explicitly prohibit Medicaid MCOs and other health plans from requiring prior authorization for withdrawal management and residential treatment services. Plans must cover a minimum of two days of residential treatment or three days of withdrawal management before conducting a utilization review. If the utilization review indicates that the residential admission was not medically necessary, the health plan is not required to continue paying for residential services. The new law includes additional refinements to SUD service delivery and patient assessment.</p> <p>Through this legislation the state is adopting a single standard set of criteria based on ASAM to define medical necessity for substance use disorder and define substance use levels of care. Both the Health Care Authority and the Office of the Insurance Commissioner must independently review regulations and practices to achieve this goal.</p> <p>Additionally the related action plan completed in December of</p>	<p>N/A</p>	

	2020 also includes recommendations for improving the facilitation of transfers between levels of care, facilitating direct transfers to SUD treatment from hospitals and jails, and establishing the minimum amount of medical information necessary for plan utilization reviews in withdrawal management settings.		
<input type="checkbox"/> The state has no related considerations to report for this reporting topic.			
11.1.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to:			
<input type="checkbox"/> i) How the delivery system operates under the demonstration (e.g. through the managed care system or fee for service)			
<input type="checkbox"/> ii) Delivery models affecting demonstration participants (e.g. Accountable Care Organizations, Patient Centered Medical Homes)			
<input type="checkbox"/> iii) Partners involved in service delivery			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The state is working on other initiatives related to SUD or OUD			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The initiatives described above are related to the SUD or OUD demonstration (States			

should note similarities and differences from the SUD demonstration)			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
12. SUD Demonstration Evaluation Update			
12.1. Narrative Information			
<input type="checkbox"/> Provide updates on SUD evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. See report template instructions for more details.			
<input checked="" type="checkbox"/> The state has no SUD demonstration evaluation update to report for this reporting topic.			
<input type="checkbox"/> Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.			
<input checked="" type="checkbox"/> The state has no SUD demonstration evaluation update to report for this reporting topic.			
<input type="checkbox"/> List anticipated evaluation-related deliverables related to this demonstration and their due dates.			
<input checked="" type="checkbox"/> The state has no SUD demonstration evaluation update to report for this reporting topic.			
13.1 Other Demonstration Reporting			
13.1.1 General Reporting Requirements			
<input type="checkbox"/> The state reports changes in its implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol			
<input checked="" type="checkbox"/> The state has no updates on general requirements to report for this reporting topic.			

<input type="checkbox"/> The state anticipates the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes			
<input checked="" type="checkbox"/> The state has no updates on general requirements to report for this reporting topic.			
<p>Compared to the demonstration design and operational details, the state expects to make the following changes to:</p> <input type="checkbox"/> i) The schedule for completing and submitting monitoring reports <input type="checkbox"/> ii) The content or completeness of submitted reports and/or future reports			
<input checked="" type="checkbox"/> The state has no updates on general requirements to report for this reporting topic.			
<input type="checkbox"/> The state identified real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation			
<input checked="" type="checkbox"/> The state has no updates on general requirements to report for this reporting topic.			
13.1.2 Post-Award Public Forum			
<input type="checkbox"/> If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual report.			
<input checked="" type="checkbox"/> No post-award public forum was held during this reporting period and this is not an annual report, so the state has no post-award public forum update to report for this topic.			
14.1 Notable State Achievements and/or Innovations			

14.1 Narrative Information

Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD (or if broader demonstration, then SUD related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.

The state has no notable achievements or innovations to report for this reporting topic.