DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

April 14, 2023

Charissa Fotinos, MD
Medicaid Director
Washington Health Care Authority
626 8th Avenue
P.O. Box 45502
Olympia, WA 98504-5050

Dear Dr. Fotinos:

The Centers for Medicare & Medicaid Services (CMS) is approving an amendment to the section 1115(a) demonstration titled, "Medicaid Transformation Project" (MTP) (Project Number 11-W-00304/0) (the "demonstration"), in accordance with section 1115(a) of the Social Security Act. Approval of this demonstration amendment will enable the state to change the definition of long-term services and supports (LTSS) transportation, revise the value-based payment (VBP) adoption targets for 2021 and 2022, and implement continuous eligibility for a defined group of children. This amendment is effective as of the date of this approval through June 30, 2023, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire.

CMS's approval of this section 1115(a) demonstration, as amended, is subject to the limitations specified in the attached waiver and expenditure authorities, Special Terms and Conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as waived or not applicable to expenditures under the demonstration.

Extent and Scope of Demonstration

Washington is expanding its definition of transportation for individuals who receive the Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) LTSS benefit packages. The definition is changed to allow transportation in accordance with the participant's service plan. Consistent with the definition of non-medical transportation under 1915(c) waivers, this service is offered in order to enable participants to gain access to community services, activities, and resources, as defined by the service plan.

Washington's Delivery System Reform Incentive Payment (DSRIP) Program includes aggressive alternative payment model (APM) adoption goals for its state procurement of

healthcare services, as well as financial incentives for Accountable Communities of Health (ACHs) and Medicaid managed care organizations (MCOs) to improve their VBP contracting levels. The state has established VBP contracting goals consistent with the Health Care Payment Learning & Action Network (HCP-LAN) APM Framework. Through this demonstration amendment, the 2021 and 2022 VBP adoption targets are adjusted from 90 percent to 85 percent. Washington has not distributed DSRIP incentive payments for the 2021 and 2022 performance years. Washington requests this adjustment in light of the effects of the COVID-19 pandemic on the state's capacity to advance additional risk-based contractual arrangements.

With this approval, the state is able to provide continuous eligibility for Medicaid children from the time of initial eligibility determination until they reach age six, regardless of changes in circumstances that would otherwise cause a loss of eligibility. CMS is authorizing this continuous eligibility with the aim to support consistent coverage and continuity of care by keeping beneficiaries enrolled until they reach age six, regardless of income fluctuations or other changes that otherwise would affect eligibility (except for death or ceasing to be a resident of the state). The continuous eligibility policy is likely to assist in promoting the objectives of Medicaid as it is expected to minimize coverage gaps and to help maintain continuity of access to program benefits for young children, and thereby help improve health outcomes. Continuous coverage is also an important aspect of reducing the rate of uninsured and underinsured individuals.

Requests Not Being Approved at this Time

CMS and Washington are continuing discussions of the state's pending request related to implementing a new presumptive eligibility (PE) process for a defined group of individuals. Washington requested to extend a PE process to individuals who are being discharged from acute care hospitals or psychiatric hospitals, or diverted from these facilities, and need to access home and community-based services (HCBS) under Medicaid state plan and 1915(c) waiver authorities. Under this proposal, the state or qualified entity will determine that the individual appears to meet functional and financial eligibility requirements. CMS is generally supportive of efforts to facilitate access to covered services in the most appropriate and least restrictive setting, and will continue to work with the state on this proposal.

Monitoring and Evaluation

Consistent with CMS requirements for all section 1115 demonstrations, and as outlined in the STCs, the state will be required to conduct comprehensive monitoring and evaluation of the demonstration amendment. The demonstration's monitoring activities must support tracking the state's progress toward meeting the applicable program-specific goals. Specifically, with this amendment, the state must undertake standardized reporting on categories of metrics including, but not limited to: beneficiary enrollment, quality of care, and health outcomes. For example, to monitor the continuous eligibility policy, the state must track and report enrollment and renewal metrics, utilization of preventative services (including vaccinations), and avoidable inpatient hospitalizations and nonemergent use of emergency departments.

With respect to the demonstration evaluation requirements, Washington will submit a revised Evaluation Design to include the amendment components to assess whether the demonstration amendment components are effective in producing the desired outcomes. For example, for the continuous eligibility policy, the state should assess how the continuous eligibility policy affects coverage, enrollment and churn (i.e., temporary loss of coverage in which beneficiaries are disenrolled but then re-enroll within 12 months) as well as population-specific appropriate measures of service utilization and health outcomes. The state must also evaluate how changing the definition of transportation for beneficiaries who receive the MAC and TSOA LTSS benefit packages enables participants to gain access to community services, activities, and resources.

Furthermore, to the best extent feasible, the state must collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes and help inform how the demonstration's various policies might support reducing such disparities. Given that the new components of the demonstration have a limited period of implementation during the current approval period for the state's demonstration, the evaluation design will accommodate as comprehensive an assessment of the demonstration's progress as feasible within this time period.

Consideration of Public Comments

Washington provided public notice for this amendment submission in accordance with the processes described in the September 27, 1994 Federal Register notice (59 FR 49249) as generally acceptable methods of state public notice for demonstration amendments. CMS generally considers a state to have provided acceptable public notice for a demonstration amendment if the state follows one or more (if the state desires) of the processes described in the 1994 Federal Register notice.

The state conducted a 30-day public notice and comment period on the draft amendment proposal from November 12, 2020 to December 13, 2020. The state held two public hearings on the amendment proposal.

The federal comment period was open from April 1, 2021 through April 30, 2021. CMS received three comments. One comment expressed support for the PE and transportation components of the amendment. One commenter suggested modifications to the demonstration to support the needs of American Indian/Alaska Native (AI/AN) people, but they are not related to the amendment requests. The remaining comment was not related to the MTP demonstration.

The continuous eligibility for Medicaid children proposal was included in Washington's extension application submitted on July 15, 2022. In accordance with federal requirements for section 1115 demonstration extension applications, Washington completed its state level public comment period from May 12, 2022 to June 13, 2022. The state held three public hearings on the extension proposal.

The federal comment period for the extension application was open August 1, 2022 through August 31, 2022. No comments were received related to continuous eligibility for children during the federal comment period.

After carefully reviewing the state's requests of the public comments submitted during the federal comment period and the information received from the state, CMS has concluded that the demonstration, as amended, is likely to advance the objectives of Medicaid. This demonstration, as amended, will promote stable health care coverage for Medicaid beneficiaries.

Other Information

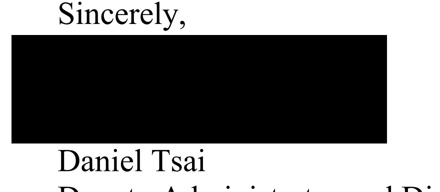
The award is subject to CMS receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Ms. Diona Kristian. She is available to answer any questions concerning your amendment. Ms. Kristian's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Diona.Kristian@cms.hhs.gov

If you have questions regarding this approval, please contact Ms. Mehreen Rashid, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-0938.

Sincerely,



Daniel Tsai
Deputy Administrator and Director

Enclosure

cc: Edwin Walaszek, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER LIST

NUMBER: **11-W-00304/0**

TITLE: **Washington State Medicaid Transformation Project**

AWARDEE: **Washington State Health Care Authority**

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list or identified as not applicable in the accompanying expenditure authorities and/or these Special Terms and Conditions (STC), shall apply to the demonstration project.

The following waivers are granted under the authority of section 1115(a)(1) of the Social Security Act ("the Act") and shall enable the state to implement the Washington State Medicaid Transformation Project (MTP) section 1115 demonstration subject to the approved STCs.

These waivers are effective beginning January 9, 2017 through June 30, 2023 and none of these waivers apply to the Substance Use Disorder, Serious Mental Illness component of this demonstration (see Expenditure Authorities #10 and #11).

1. Statewideness/Uniformity **Section 1902(a)(1)**
42 CFR §431.50

To the extent necessary to enable the state to make delivery system reform incentive payments—based on a regional needs assessment–that vary regionally in amount and purpose.

2. Reasonable Promptness **Section 1902(a)(8)**

To enable the state to limit the number of individuals receiving benefits through the Medicaid Alternative Care (MAC) or Tailored Support for Older Adults (TSOA) program.

To enable the state to limit the number of individuals who receive foundational community supports benefits under the demonstration.

3. **Freedom of Choice** **Section 1902(a)(23)(A)**

To the extent necessary to enable the state to restrict freedom of choice of provider for individuals receiving benefits through the Medicaid Alternative Care (MAC) or Tailored Support for Older Adults (TSOA) program.

To the extent necessary to enable the state to restrict freedom of choice of provider for individuals receiving who receive foundational community supports benefits under the demonstration.

4. Amount, Duration, Scope and Service Section 1902(a)(10)(B)

To permit the state to provide benefits for the Tailored Supports for Older Adults (TSOA) expansion population that are not available in the standard Medicaid benefit package.

To permit the state to provide benefits not available in the standard Medicaid benefit package to individuals who have elected and enrolled to receive Medicaid Alternative Care (MAC) benefits.

To permit the state to provide benefits not available in the standard Medicaid benefit package to populations specified by Accountable Communities of Health (ACH).

To permit the state to offer a varying set of benefits to beneficiaries eligible for the Foundational Community Support program.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00304/0**

TITLE: **Washington State Medicaid Transformation Project**

AWARDEE: **Washington State Health Care Authority**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below (which would not otherwise be included as matchable expenditures under section 1903 of the Act) shall, for the period beginning January 9, 2017 through June 30, 2023, unless otherwise specified, be regarded as matchable expenditures under the state's Medicaid state plan.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable Washington ("state") to operate its section 1115 Medicaid demonstration. These expenditure authorities promote the objectives of title XIX in the following ways:

a. Increase access to, stabilize, and strengthen, providers and provider networks available to serve Medicaid and low-income populations in the state;
b. Improve health outcomes for Medicaid and other low-income populations in the state; and
c. Increase efficiency and quality of care through initiatives to transform service delivery networks.

1. **Delivery System Reform Incentive Payments to Accountable Communities of Health and Partnering Providers**
   Expenditures for performance-based incentive payments to regionally-based Accountable Communities of Health (ACH) and their partnering providers to address health systems and community capacity; financial sustainability through participation in value-based payment; Bi-directional integration of physical and behavioral health; community-based whole person care; improve health equity and reduce health disparities.

2. **Delivery System Reform Incentive Payments to Managed Care Organizations**
   Expenditures for DSRIP payments to managed care organizations.

3. **Medicaid Alternative Care Unpaid Caregiver Supports**
   Expenditures for costs to support unpaid caregivers serving individuals who are receiving MAC benefits.

4. **Medicaid Alternative Care Services for Eligible Individuals**

Expenditures for individuals age 55 and older who are eligible for the standard Medicaid benefit package, meet the functional eligibility criteria for HCBS under the state plan, but elect, instead, to receive MAC services specified in Section VII.

5. **Tailored Support for Older Adults Unpaid Caregiver Supports**
   Expenditures for costs to support unpaid caregivers serving individuals who are receiving TSOA benefits.

6. **Tailored Support for Older Adults for Eligible Individuals**
   Expenditures for services that are an alternative to long-term care services and supports for individuals age 55 or older who are not otherwise eligible for CN or ABP Medicaid, meet functional eligibility criteria for HCBS under the state plan, and have income up to 300 percent of the supplemental security benefit rate established by section 1611(b)(1) of the Act.

7. **Presumptive Eligibility for MAC and TSOA**
   Expenditures for each individual presumptively determined to be eligible for MAC or TSOA services, during the presumptive eligibility period described in STC 59. In the event the state implements a waitlist, the authority for presumptive eligibility terminates.

8. **Designated State Health Programs**
   Expenditures for the Designated State Health Programs (DSHP) specified in STC 91.

9. **Foundational Community Supports**
   Expenditures for home and community-based services (HCBS) and related services as described in Section VIII.

10. **Residential and Inpatient Treatment for Individuals with Substance Use Disorder**
    Effective as of the date of the SUD demonstration amendment approval letter (July 17, 2018) through June 30, 2023, expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

11. **Residential and Inpatient Treatment for Individuals with Serious Mental Illness**
    Effective as of the date of the SMI demonstration amendment approval letter through June 30, 2023, expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment for a serious mental illness (SMI) who are short-term residents in facilities that meet the definition of an institution for mental disease (IMD).

12. **Continuous Eligibility**. Expenditures for continued benefits for children who have been determined eligible as specified in STC 17 for the continuous eligibility period who would otherwise lose coverage during an eligibility determination, except as noted in STC 19.

CENTERS FOR MEDICARE AND MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00304/0

TITLE: Washington State Medicaid Transformation Project

AWARDEE: Washington State Health Care Authority

I. PREFACE

The following are the Special Terms and Conditions (STC) for the Washington State Medicaid Transformation Project (MTP) section 1115(a) Medicaid demonstration (hereafter "MTP" or "demonstration") to enable the Washington State (hereafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of certain Medicaid requirements, and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs further set forth in detail the nature, character, and extent of federal involvement in the demonstration, the state's implementation of the expenditure authorities and the state's obligations to CMS during the demonstration period. The effective date of the demonstration is January 9, 2017 and is approved through June 30, 2023, unless otherwise stated. The Serious Mental Illness (SMI) component of this demonstration is effective November 6, 2020 through June 30, 2023.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Populations Affected by the Demonstration
V. Continuous Eligibility for Children
VI. Delivery System Reform Program
VII. Long Term Services & Supports
VIII. Foundational Community Supports
IX. General Reporting Requirements
X. Substance Use Disorder Program and Benefits
XI. Serious Mental Illness (SMI) Program and Benefits
XII. Designated State Health Programs
XIII. General Financial Requirements
XIV. Monitoring Budget Neutrality
XV. Evaluation of the Demonstration
XVI. Schedule of State Deliverables for the Demonstration Period

Attachment A: Quarterly Report Template

Attachment B: DSHP Claiming Protocol
Attachment C: DSRIP Planning Protocol
Attachment D: DSRIP Program Funding & Mechanics Protocol
Attachment E: Value-Based Roadmap (Original)
Attachment F: Financial Executor Role
Attachment G: Intergovernmental Transfer (IGT) Protocol
Attachment H: Tribal Engagement and Collaboration Protocol
Attachment I: Foundational Community Supports Protocol
Attachment J: Evaluation Design
Attachment K: SUD Implementation Plan Protocol
Attachment L: SUD Monitoring Protocol
Attachment M: Health IT Protocol
Attachment N: Corrective Action Plan
Attachment O: SMI Implementation Plan Protocol
Attachment P: SMI Monitoring Protocol

II. PROGRAM DESCRIPTION AND OBJECTIVES

This demonstration aims to transform the health care delivery system through regional, collaborative efforts led by Accountable Communities of Health (ACH). It will test changes to payment, care delivery models and targeted services.

Over the six-year demonstration period, Washington will:

- Integrate physical and behavioral health purchasing and service delivery to better meet whole person needs;
- Convert 85 percent of Medicaid provider payments to reward outcomes instead of volume;
- Support provider capacity to adopt new payment and care models;
- Implement population health strategies that improve health equity; and
- Provide new targeted services that address the needs of the state's aging populations and address key determinants of health

The demonstration will provide up to $994 million (total computable) in the form of incentive payments to providers tied to projects coordinated by ACHs, based on achievement of milestones and outcomes. Delivery System Reform Incentive Payment (DSRIP) incentives under this demonstration are time-limited and the project design will reflect a priority for financial sustainability beyond the demonstration period.

ACHs are regionally situated, self-governing organizations with non-overlapping geographic boundaries that also align with Washington's regional service areas for Medicaid purchasing. ACHs are composed of managed care, provider, and many other community organizations and are focused on improving health and transforming care delivery for the populations that live within their region. ACHs are not new service delivery organizations and do not provide direct services nor are they a replacement of managed care. ACHs will lead strategies consistent with the transformation objectives based on a regional needs assessment. ACHs will be responsible for certifying achievement of milestones and performance metrics for payment to partnering

providers. Managed care organizations (MCO) will continue to serve the majority of Medicaid enrollees in the provision and coordination of State Plan services and will be incentivized to implement value based payment strategies.

The state will also offer a new Medicaid Alternative Care (MAC) benefit package for individuals eligible for Medicaid but not currently receiving Medicaid-funded long-term services and supports (LTSS). This benefit package will provide another community-based option for clients and their families to choose, which will help them avoid or delay more intensive Medicaid-funded services by supporting their unpaid caregivers. In addition to the MAC benefits, the State will also engage in activities to support unpaid family caregivers who serve MAC beneficiaries. Similar to the MAC benefit package, the state will also establish a new eligibility category and limited benefit package termed Tailored Supports for Older Adults (TSOA). TSOA will be for individuals "at risk" of future Medicaid LTSS use and who do not currently meet Medicaid financial eligibility criteria.

The State will offer a Foundational Community Supports Program to eligible beneficiaries. Under this program, the state will provide a set of HCBS that includes one-time community transition services to individuals moving from institutional to community settings and those at imminent risk of institutional placement, in addition to HCBS that could otherwise be provided to the individual under a 1915(c) waiver or 1915(i) SPA.

In addition, the state will implement initiatives to improve existing SUD services. Initiatives will 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 American Society for Addiction Medicine (ASAM) criteria for assessment and treatment decision making. Other recent approvals include:

- On April 6, 2020, CMS approved a Corrective Action Plan (CAP) which included, among other changes, revised expenditure limits beginning in 2019 (see Section XIII and Attachment N).

- On November 6, 2020, CMS approved an amendment which will allow the state to claim FFP, upon the approval of the Implementation Plan Protocol, for otherwise covered Medicaid services provided to beneficiaries who are short term residents in IMDs primarily to receive treatment for SMI.

- On April 14, 2023, CMS approved an amendment to revise the DSRIP program value-based payment adoption target; expanding transportation services for MAC and TSOA enrollees; and providing continuous eligibility for children ages 0 through 5.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited

to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents (which are a part of these terms and conditions), must apply to the demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, court order, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.

    b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **Changes Subject to the Amendment Process**. Changes related to demonstration features such as eligibility, enrollment, benefits, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The state must not implement changes to these demonstration elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 6 below.

6. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS in writing for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure limit;

c. An explanation of the public process used by the state consistent with the requirements of STC 14; and

d. A description of how the evaluation design will be modified to incorporate the amendment provisions.

7. **Extension of the Demonstration**. States that intend to request a demonstration extension under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the Governor of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 Code of Federal Regulations (CFR) §431.412(c) or a transition and phase-out plan consistent with the requirements of STC 8.

8. **Demonstration Phase Out.** The state may only suspend or terminate this demonstration, in whole or in part, at any time prior to the date of expiration consistent with the following requirements:

   a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the effective date and reason(s) for the suspension or termination. At least six months before the effective date of the demonstration's suspension or termination, the state must submit to CMS its proposed transition and phase-out plan, together with intended notifications to demonstration enrollees. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with the requirements of STC 14. Once the 30-day public comment period has ended, the state must provide a summary of public comments received, the state's response to the comments received, and how the state incorporated the comments received into the transition and phase-out plan submitted to CMS.

   b. Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries whether currently enrolled or determined to be eligible individuals, as well as any community outreach activities, including community resources that are available.

c. Phase-out Plan Approval: The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

d. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, §431.210 and §431.213. In addition, the state must assure all appeal and hearing rights are afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as found in 42 CFR §435.916.

e. Exemption from Public Notice Procedures 42 CFR §431.416(g): CMS may expedite federal and state public notice requirements in accordance with the circumstances described in 42 CFR §431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out: If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended.

g. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

9. **CMS Right to Amend, Suspend, or Terminate.** CMS may amend, suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines, following a hearing, that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the amendment, suspension or termination, together with the effective date.

10. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in an amount up to $5,000,000 per deliverable (federal share) when deliverables are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. The state does not relinquish its rights to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

    a. Thirty days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

    b. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.

c. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Should CMS agree to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

d. When the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in the STCs, the deferral(s) will be released.

e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for extension, amendment or renewal, or for a new demonstration.

f. If applicable, CMS will consider with the state an alternative set of operational steps for implementing the intended deferral associated with this demonstration to align the process with any existing deferral process the state is undergoing (e.g., the quarter the deferral applies to and how the deferral is released).

11. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

12. **Withdrawal of Waiver/Expenditure Authority.** CMS reserves the right to amend or withdraw waiver and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS must promptly notify the state in writing of the determination and the reasons for the amendment or withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn or amended, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems applicable to the demonstration; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

14. **Public Notice, Tribal Consultation and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR §431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the public notice procedures set forth in 42 CFR §447.205 for changes in statewide methods and standards for setting payment rates.

A state with Federally-recognized Indian Tribes, Indian Health Programs, and/or Urban Indian Health Organizations must comply with the tribal consultation requirements set forth in section 1902(a)(73) of the Act and implemented in regulation at 42 CFR §431.408(b) or the tribal consultation requirements contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 6 or extension, are proposed by the state.

15. **Federal Financial Participation (FFP).** No federal matching for administrative or medical assistance payments for services provided under this demonstration will take effect until the effective date identified in the CMS demonstration approval documents.

IV. POPULATIONS AFFECTED BY THE DEMONSTRATION

16. **Eligibility Groups Affected by the Demonstration.** All individuals eligible under the Medicaid State Plan are affected by the demonstration. Such individuals derive their eligibility through the Medicaid State Plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State Plan, except as expressly waived in this demonstration and described in these STCs. In addition, this demonstration extends eligibility to one demonstration expansion population. Specifically, this demonstration affects:

    a. All individuals who are currently eligible under the state's Medicaid State Plan; and

    b. Individuals eligible for Tailored Supports for Older Adults (TSOA) who are not otherwise eligible for CN or ABP Medicaid, age 55 or older, meet functional eligibility criteria for Home and Community Based Services (HCBS) under the state plan or 1915(c), and have income up to 300% of the supplemental security benefit rate established by section 1611(b)(1) of the Act.

    c. Children age 0 through 5 who would otherwise lose coverage during an eligibility determination but are still within the continuous eligibility period.

V. CONTINUOUS ELIGIBILITY FOR CHILDREN

17. **Affected Individuals.** Except as provided in STC 19, and except for the medically needy (as described in section 1902(a)(10)(C) of the Act and 42 CFR 435.301 et seq.), individuals ages zero through five, who enroll in Medicaid shall qualify for continuous eligibility until the end of the month in which their sixth birthday falls.

18. **Continuous Eligibility Period.** The state is authorized to provide continuous eligibility for children ages zero through five, regardless of the delivery system through which these populations receive Medicaid benefits.

    a. This provision shall be effective beginning with enrollments and renewals that are undertaken on or after the date when the continuous coverage requirement authorized by the Families First Coronavirus Response Act (FFCRA) ends.

b. Subject to the effective date, once effective, coverage shall be continuous for children ages 0 through 5 who qualify for continuous eligibility until the end of the month in which their 6th birthday falls. The child's continuous eligibility period begins on the effective date of the child's eligibility under 42 CFR 435.915. The state will redetermine eligibility consistent with 42 CFR 435.916 when the child turns age 6. The state will continue to redetermine eligibility during a period of continuous eligibility in limited circumstances, if appropriate, as described in STC 19.

19. Exceptions. Notwithstanding STC 18, if any of the following circumstances occur during an individual's designated continuous eligibility period, the individual's Medicaid eligibility shall be redetermined or terminated:

a. The individual is no longer a Washington resident;

b. The individual requests termination of eligibility;

c. The individual dies; or

d. The agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual.

20. Beneficiary-Reported Information and Periodic Data Checks. The state must have procedures designed to ensure that beneficiaries can make timely and accurate reports of any change in circumstances that may affect their eligibility as outlined in this demonstration, such as a change in state residency, and are able to report other information relevant to the state's implementation or monitoring and evaluation of this demonstration, such as changes in income. The beneficiary must be able to report this information through any of the modes of submission available at application (online, in person, by telephone, or by mail).

For individuals who qualify for a continuous eligibility period that exceeds 12 months, the state must continue to attempt to verify residency at least once every 12 months. The state should follow its typical processes that it would otherwise use to verify continued residency at renewal if continuous eligibility was not available for these individuals. Additionally, at least once every 12 months, the state must follow its typical processes to attempt to confirm the individual is not deceased, consistent with the data sources outlined in the state's verification plan(s) and/or confirmed by the household per 42 CFR 435.952(d). The state must redetermine eligibility if the state receives information that indicates a change in state residency or that the individual is deceased, verifying the change consistent with 42 CFR 435.916(d) and in accordance with 42 CFR 435.940 through 435.960 and the state's verification plan developed under 42 CFR 435.945(j).

The state is required to provide CMS a narrative update annually on the processes it conducted and a summary of its findings regarding the successes and challenges in conducting such verifications. This information shall be provided in the demonstration's Annual Monitoring Reports (see STC 79).

21. **Annual Updates to Beneficiary Information.** For all continuous eligibility periods longer than 12 months, the state must have procedures and processes in place to accept and update beneficiary contact information, and must attempt to update beneficiary contact information on an annual basis, which may include annually checking data sources and partnering with coordinated care organizations to encourage beneficiaries to update their contact information. The state is reminded that updated contact information obtained from third-party sources with an in-state address is not an indication of a change affecting eligibility. Contact information with an out-of-state or no forwarding address indicates a potential change in circumstance with respect to state residency, but without additional follow up by the state per 42 CFR 435.952(d), the receipt of this third-party data is not sufficient to make a definitive determination that beneficiaries no longer meet state residency requirements.

Each demonstration year, through the Annual Monitoring Reports (see STC 79), the state must submit to CMS a summary of activities and outcomes from efforts to update beneficiary contact information on an annual basis.

VI. DELIVERY SYSTEM REFORM INCENTIVE PAYMENTPROGRAM

This demonstration authorizes Accountable Communities of Health (ACHs) to coordinate and oversee regional projects aimed at improving care for Medicaid beneficiaries with a focus on building health systems capacity, care delivery redesign, prevention, and health promotion, and preparing for value-based payments.

ACHs are self-governing organizations with multiple community representatives defined in STC 24, that address care in regions with non-overlapping boundaries that also align with Washington's regional service areas for Medicaid purchasing. They are focused on improving health and transforming care delivery for the populations that live within the region. ACHs are not new service delivery organizations, do not provide direct services, nor are they a replacement of managed care. ACHs must be headquartered in the region they serve and include in their governing bodies representatives of managed care organizations, health care providers, and other relevant organizations within the region (see STC 24). Managed care organizations (MCOs) will continue in their current roles, serving the majority of Medicaid enrollees in the provision and coordination of State Plan services and will be incentivized to implement value-based payment strategies.

ACHs, through their governing bodies, are responsible for managing and coordinating the partnering providers. The ACHs must meet the qualifications set forth in STCs 22-24 and must meet certain targets to earn incentive payments. In addition, they will certify whether or not the partnering providers have met the milestones as required for earning incentive payments within their region. The ACH will certify to the independent assessor (see STC 22) whether or not partnering providers have achieved the milestones. The independent assessor will review the ACH's certification and make recommendations to the state related to distribution of payment. Once the state affirms the recommendations from the

independent assessor, the state will send them to the financial executor to distribute incentive payments to the partnering ACH providers.

Incentive payments for partnering providers and the ACHs will transition from pay-for-reporting to outcome-based over the course of the demonstration. The performance of this initiative will be measured at the statewide and regional ACH level, and incentive payments will be paid out accordingly. The maximum allowable expenditures available for total ACH incentive payments are enumerated in STC 46 below (see Table 2). The state will allocate total funds across the ACHs based on a CMS-approved methodology to be submitted in the DSRIP Program Funding and Mechanics Protocol (Attachment D). Each regional ACH includes a coalition of partnering providers, and the ACH primary decision-making body will apply on behalf of partnering providers for such incentive payments as a single ACH.

22. **Role of Independent Assessor.** The state will contract with an independent assessor to review ACH project proposals using the state's review tool and consider anticipated project performance. The independent assessor has no affiliation with the ACHs or their partnering providers. The independent assessor shall make recommendations to the state regarding approvals, denials or recommended changes to project plans to make them approvable. This entity (or another entity identified by the state) will also assist with the mid-point assessment and any other ongoing reviews of ACH Project Plan.

    a. **Review tool**. The state will develop a standardized review tool that the independent assessor will use to review ACH Project Plans and ensure compliance with these STCs and associated protocols. The review tool will be available for public comment according to the timeframe specified in the Program Funding and Mechanics Protocol (Attachment D). The review tool will define the relevant factors, assign weights to each factor, and include a scoring for each factor.

    b. **Mid-point assessment.** During DY 3, the state's independent assessor shall assess project performance to determine whether ACH Project Plans merit continued funding and provide recommendations to the state. If the state decides to discontinue specific projects, the project funds may be made available for expanding successful project plans in DY 4 and DY 5, as described in the Program Funding and Mechanics Protocol (Attachment D).

23. **ACH Management.** Each ACH must identify a primary decision-making process, a process for conflict resolution and structure (e.g., a Board or Steering Committee) that is subject to the outlined composition and participation guidelines. The primary decision-making body will be the final decision-maker for the ACH regarding the selection of projects and participants based on the regional needs assessment. Each ACH and the state will collaborate and agree on each ACH's approach to its decision-making structure for purposes of this demonstration. The overall organizational structure established by the ACH must reflect capability to make decisions and be accountable for the following five domains, at a minimum. The ACH must demonstrate compliance with this STC in the ACH Project Plan.

a. *Financial*, including decisions about the allocation methodology, the roles and responsibilities of each partner organization, and budget development.

b. *Clinical*, including appropriate expertise and strategies for monitoring clinical outcomes. The ACH will be responsible for monitoring activities of providers participating in care delivery redesign projects and should incorporate clinical leadership, which reflects both large and small providers and urban and rural providers.

c. *Community*, including an emphasis on health equity and a process to engage the community and consumers.

d. *Data*, including the processes and resources to support data-driven decision making and formative evaluation.

e. *Program management and strategy development.* The ACH must have organizational capacity and administrative support for regional coordination and communication on behalf of the ACH.

24. ACH Composition and Participation. At a minimum, each ACH decision-making body must include voting partners from the following categories:

a. One or more primary care providers, including practices and facilities serving Medicaid beneficiaries;

b. One or more behavioral health providers, including practices and facilities serving Medicaid beneficiaries;

c. One or more health plans, including but not limited to Medicaid Managed Care Organizations; if only one opening is available for a health plan, it must be filled by a Medicaid Managed Care Organization;

d. One or more hospitals or health systems;

e. One or more local public health jurisdiction;

f. One or more representatives from the tribes, IHS facilities, and UIHPs in the region, as further specified in STC 27;

g. Multiple community partners and community-based organizations that provide social and support services reflective of the social determinants of health for a variety of populations in the region. This includes, but is not limited to, transportation, housing, employment services, education, criminal justice, financial assistance, consumers, consumer advocacy organizations, childcare, veteran services, community supports, legal assistance, etc.

The ACHs must create and execute a consumer engagement plan as part of the ACH Project Plan. The consumer engagement plan will detail the multiple levels of the decision-making process to ensure ACHs are accurately assessing local health needs, priorities and inequities. As part of the ACH Project Plan ACHs must provide documentation of at least two public meetings held for purposes of gathering public comment and must also provide details for how their submitted project plan incorporates feedback from the public comment process.

To ensure broad participation in the ACH and prevent one group of ACH partners from dominating decision-making, at least 50 percent of the primary decision-making body must be non-clinic, non-payer participants. In addition to balanced sectoral representation, where multiple counties exist within an ACH, a concerted effort to include a person from each county on the primary decision-making body must be demonstrated.

25. **American Indians/Alaska Natives (AI/AN) Managed Care Protections.** This section 1115 demonstration will not alter the statutory exemption of AI/ANs from requirements to enroll in managed care, or alter the requirements for the state and managed care entities to come into compliance with the Medicaid Managed Care Regulations published April 26, 2016, including the Indian-specific provisions at 42 CFR §438.14.

26. **Indian Health Care Providers.**

    1. The state will assure compliance by the state itself and by any managed care or ACH contractor with the requirements of section 1911 of the Social Security Act and 25 U.S.C. § 1647a(a)(1), to accept an entity that is operated by IHS, an Indian tribe, tribal organization, or urban Indian health program as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program, if the entity attests that it meets generally applicable State or other requirements for participation as a provider of health care services under the program.

    2. The state will assure compliance by the state itself and by any managed care or ACH contractor with the requirements of 25 U.S.C. § 1621t, to licensed health professionals employed by the IHCP shall be exempt from the Washington State licensure requirements if the professionals are licensed in another state and are performing the services described in the contract or compact of the Indian health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

27. **Tribal Engagement and Collaboration Protocol**. The state, with tribes, IHS facilities, and urban Indian Health Programs, must develop and submit to CMS for approval a Tribal Engagement and Collaboration Protocol (Attachment H) no later than 60 calendar days after demonstration approval date. Once approved by CMS, this document will be incorporated as Attachment H of these STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved expenditure and waiver authorities and STCs.

ACHs will be required to adopt either the State's Model ACH Tribal Collaboration or Communication Policy or a policy agreed upon in writing by the ACH and every tribe and Indian Health Care Provider (IHCP) in the ACH's region. The model policy establishes minimum requirements and protocols for the ACH to collaborate and communicate in a timely and equitable manner with tribes and Indian healthcare providers.

In addition to adopting the Model ACH Tribal Collaboration and Communication Policy, ACH governing boards must make reasonable efforts to receive ongoing training on the Indian health care delivery system with a focus on their local tribes and IHCPs and on the needs of both tribal and urban Indian populations.

Further specifications for engagement and collaboration in Medicaid transformation between (a) tribes, IHS facilities, and urban Indian health programs and (b) ACHs and the state, will be described by the Tribal Engagement and Collaboration Protocol (Attachment H). At a minimum, the Tribal Engagement and Collaboration Protocol must include the elements listed below:

a. Outline the objectives that the state and tribes seek to achieve tribal specific interests in Medicaid transformation; and

b. Specify the process, timeline and funding mechanics for any tribal specific activities that will be included as part of this demonstration, including the potential for financing the tribal specific activities through alternative sources of non-federal share.

28. Tribal Coordinating Entity. The federal government and the State have federal trust responsibility to support tribal sovereignty and to provide health care to tribal members and their descendants. Part of this trust responsibility involves assessing this demonstration for impacts, including unintended consequences, on affected IHCPs and AI/AN. The state will facilitate a tribal coordinating entity (TCE) controlled by tribes and Urban Indian Organizations (as defined in 25 U.S.C. § 1603(29)) for purposes of facilitating appropriate engagement and coordination with tribal governments and communicating advice and feedback from Indian Health Care Providers (IHCPs) (as defined in 42 C.F.R. § 438.14(a)) to the state on matters related to this demonstration. The state will work with the TCE:

1. To provide opportunity to review programs and projects implemented through delivery system reform efforts within this demonstration;

2. For the TCE to coordinate with affected tribes and IHCPs to provide an assessment of potential impacts as a result of delivery system reform activities within this demonstration on affected IHCPs and AI/AN populations and report these assessments to CMS, the ACHs, and the State;

3. To coordinate with tribes and IHCPs to establish a cross-walk of statewide common performance measures to the GPRA measures used by tribes and IHCPs; and

4. To support other tribal-specific projects implemented through this demonstration to the extent appropriate.

29. Tribal Specific Projects. Consistent with the government-to-government relationship between the tribes and the State, tribes, IHCPs, or consortia of tribes and IHCPs can apply directly through the State to receive funding for eligible tribal specific projects. Tribes and IHCPs will not be required to apply for tribal specific projects through ACHs or the TCE, and the TCE and ACHs will not participate in the approval process for tribal specific projects.

1. Indian Health Care Provider Health Information Technology Infrastructure. The state will work with the tribes and IHCPs to develop a tribal specific project, subject to CMS approval, that will enhance capacity to: (i) effectively coordinate care between IHCPs and non-IHCPs, (ii) support interoperability with relevant State data systems, and (iii) support tribal patient-centered medical home models (e.g., IHS IPC, NCQA PCMH, etc.).

2. Other Tribal Specific Projects. The state will work with tribes on tribal specific projects, subject to CMS approval, that align with the objectives of this demonstration, including requirements that projects reflect a priority for financial sustainability beyond the demonstration period.

3. The Tribal Engagement and Collaboration Protocol (Attachment H) will provide further specifications for process, timeline and funding mechanics for any tribal specific projects that will be included as part of this demonstration. To the extent applicable, the Tribal Engagement and Collaboration Protocol must align with project requirements set forth in these STCs.

30. Financial Executor. In order to assure consistent management of and accounting for the distribution of DSRIP funds across ACHs, the state shall select through a procurement process a single Financial Executor. The Financial Executor will be responsible for administering the funding distribution plan for the DSRIP that specifies in advance the methodology for distributing funding to providers partnering with the ACHs. The funding methodology will be described in the DSRIP Program Funding and Mechanics Protocol (Attachment D) and submitted to CMS for approval.

1. The Financial Executor will perform the following responsibilities: (a) provide accounting and banking management support for DSRIP incentive dollars; (b) distribute earned funds in a timely manner to participating providers in accordance with the state approved funding distribution plans; (c) submit scheduled reports to the state on the actual distribution of transformation project payments, fund balances and reconciliations; and (d) develop and distribute budget forms to participating providers for receipt of incentive funds (see Attachment G).[1] Financial Executor performance will be subject to audit by the state.

[1] For a comprehensive description of the Financial Executor role, see Attachment G.

2. The distribution of funds must comply with all applicable laws and regulations, including, but not limited to, the following federal fraud and abuse authorities: the anti-kickback statute (sections 1128B(b)(1) and (2) of the Act); the physician self-referral prohibition (section 1903(s) of the Act); the gainsharing civil monetary penalty (CMP) provisions (sections 1128A(b)(1) and (2) of the Act); and the beneficiary inducement CMP (section 1128A(a)(5) of the Act). State approval of an ACH funding distribution plan does not alter the responsibility of ACHs to comply with all federal fraud and abuse requirements of the Medicaid program.

31. **Attribution Based On Residence**. The state will use defined regional service areas, which do not have overlapping boundaries, to determine populations for each ACH. Determination will be made based on beneficiary residence. There is only one ACH per regional service area, as described in the DSRIP Program Funding and Mechanics Protocol (Attachment D).

32. **ACH Provider Agreements under DSRIP.** In addition to the requirements specified in the DSRIP Program Funding and Mechanics Protocol (Attachment D), ACHs must establish a partnership agreement between the providers participating in projects.

33. **Project Objectives**. ACHs will design and implement projects that further the objectives, which are elaborated further in the DSRIP Planning Protocol (Attachment C).

    a. *Health Systems and Community Capacity.* Creating appropriate health systems capacity in order to expand effective community based-treatment models; reduce unnecessary use of intensive services and settings without impairing health outcomes; and support prevention through screening, early intervention, and population health management initiatives.

    b. *Financial Sustainability through Participation in Value-based Payment.* Medicaid transformation efforts must contribute meaningfully to moving the state forward on value-based payment (VBP). Paying for value across the continuum of Medicaid services is necessary to assure the sustainability of the transformation projects undertaken through the Medicaid Transformation Demonstration. For this reason, ACHs will be required to design project plan activities that enable the success of Alternative Payment Models required by the state for Medicaid managed care plans (see Table 1 under STC 44 for the APM goals per DY).

    c. *Bi-directional Integration of physical and behavioral health.* Requiring comprehensive integration of physical and behavioral health services through new care models, consistent with the state's path to fully integrated managed care by January 2020. Projects may include: co-location of providers; adoption of evidence-based standards of integrated care; and use of team-based approaches to care delivery that address physical, behavioral and social barriers to improved outcomes for all populations with behavioral health needs. Along with directly promoting integration of care, the projects will promote infrastructure changes by supporting the IT capacity and protocols needed for integration of care, offering training to providers on how to adopt the required changes; and creating integrated care delivery protocols and models. The state will provide increased

incentives for regions that commit to and implement fully integrated managed care prior to January 2020.

d. *Community-based Whole-person Care.* Use or enhance existing services in the community to promote care coordination across the continuum of health for beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health. In addition, develop linkages between providers of care coordination by utilizing a common platform that improves communication, standardizes use of evidence-based care coordination protocols across providers, and to promote accountable tracking of those beneficiaries being served. Projects will be designed and implemented to promote evidence-based practices that meet the needs of a region's identified high-risk, high-needs target populations.

e. *Improve Health Equity and Reduce Health Disparities.* Implement prevention and health promotion strategies for targeted populations to address health disparities and achieve health equity. Projects will require the full engagement of traditional and non-traditional providers, and project areas may include: chronic disease prevention, maternal and child health, and access to oral health services, and the promotion of strategies to address the opioid epidemic.

34. Project Milestones. Progress towards achieving the goals specified above will be assessed based on achievement of specific milestones and measured by specific metrics that are further defined in the DSRIP Planning Protocol (Attachment C). These milestones are to be developed by the state in consultation with stakeholders and members of the public and approved by CMS. Generally, progress milestones will be organized into the following categories:

1. Project planning progress milestones. This includes plans for investments in technology, tools, stakeholder engagement, and human resources that will allow ACHs to build capacity to serve target populations and pursue ACH project goals in accordance with community-based priorities. Performance will be measured by a common set of process milestones that include project development plans, consistency with statewide goals and metrics, and demonstrated engagement from relevant providers who commit to participate in project plan activities.

2. Project implementation progress milestones. This includes milestones that demonstrate progress towards process-based improvements, as established by the state, in the implementation of projects consistent with the demonstration's objectives of building health and community systems capacity; promoting care delivery redesign through bi-directional integration of care and care coordination; and fostering health equity through prevention and health promotion. Examples of progress milestones include: identify number of providers and practices implementing evidence-based and promising practices for integration; complete a plan for regional implementation of fully integrated managed care. In addition, performance will be monitored by project-

level and system-wide outcome measures consistent with the objectives of the demonstration outlined in STC 33 and specific project area.

3. *Scale and sustain progress milestones.* This includes milestones that demonstrate project implementation progress, as established by the state, related to efforts to scale and sustain project activities in pursuit of the demonstration objectives. Performance will be monitored by project-level and system-wide outcome measures consistent with the objectives of the demonstration outlined in STC 33 and specific project areas. The state will identify a sub-set of project-level and system-wide measures that will transition to pay for performance. The identification of measures that transition and the timing of transition to pay for performance will be outlined in the DSRIP Planning Protocol (Attachment C).

35. ACH Performance Indicators and Outcome Measures. The state will choose performance indicators and outcome measures that are connected to the achievement of the goals identified in STC 33 and in the DSRIP Planning Protocol (Attachment C). The DSRIP performance indicators and outcome measures will comprise the list of reporting measures that the state will be required to report under each of the DSRIP projects.

The state and CMS will accept GPRA measures in lieu of comparable statewide common performance measures when such substitution will reduce duplicative reporting and avoid excessive administrative burdens on tribes and IHCPs.

36. MCO Role in DSRIP. Managed care organizations are expected to serve in leadership or supportive capacity in every ACH. This ensures that delivery system reform efforts funded under this demonstration are coordinated from the beginning across all necessary sectors – those providing payment, those delivering services and those providing critical, community-based supports. Managed care organizations have the following roles and responsibilities under this demonstration:

a. Continue to meet all contractual requirements for the provision and coordination of Medicaid state plan services, including utilization management, care coordination and any new requirements consistent with the Medicaid transformation demonstration.

b. Participate in the design and implementation of delivery system reform projects

c. Actively provide leadership in every Accountable Community of Health where a MCO is providing services, whether through participation in governance or other supportive capacity.

d. Collaborate with provider networks to implement value-based payment models, aligned to the HCP-LAN framework and report on the status of those arrangements to the state when requested,

e. Ensure business approaches evolve to sustain new models of care delivery and population health management, during and beyond the six-year demonstration.

MCOs are expected to participate in delivery system reform efforts as a matter of business interest and contractual obligation to the state, and for this reason, do not receive incentive payments for participation in ACH-led transformation projects, with one exception. A portion of delivery system reform incentives is uniquely set aside to reward managed care plan attainment of value-based payment models, consistent with STC 45a). The incentive amounts are further defined in the DSRIP Planning Protocol (Attachment C), the DSRIP Program Funding and Mechanics Protocol (Attachment D) and the Roadmap (Attachment F).

37. **DSRIP Planning Protocol.** The state must develop and submit to CMS for approval a DSRIP Planning Protocol no later than 60 calendar days after the demonstration approval date. CMS has 60 calendar days to review and approve the protocol. Once approved by CMS, this document will be incorporated as Attachment C of these STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved expenditure authorities and STCs. Changes to the protocol will apply prospectively unless otherwise indicated in the protocols. The DSRIP Planning Protocol must:

    a. Outline the global context, goals and outcomes that the state seeks to achieve through the combined implementation of individual projects by ACHs;

    b. Detail the requirements of the ACH Project Plans, consistent with STC 39, which must include timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance;

    c. Specify a set of outcome measures that must be reported at the ACH level, regardless of the specific projects that they choose to undertake;

    d. Include required baseline and ongoing data reporting, assessment protocols, and monitoring/evaluation criteria aligned with the evaluation design and the monitoring requirements in section XV of the STCs.

    e. Include a process that allows for potential ACH Project Plan modification (including possible reclamation, or redistribution, pending state and CMS approval) and an identification of circumstances under which a plan modification may be considered, which shall stipulate that the state or CMS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved.

    f. When developing the DSRIP Planning Protocol, the state should consider ways to structure the different projects and demonstrate that it will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in section XV of the STCs. Participating ACHs will use the same metrics for similar projects to enhance evaluation and learning experience between ACHs.

38. **DSRIP Program Funding and Mechanics Protocol**. The state must develop a DSRIP Program Funding and Mechanics Protocol to be submitted to CMS for approval no later than

60 days after the demonstration approval date. CMS has 60 days to review and approve the protocol. Once approved by CMS, this document will be incorporated as Attachment D of these STCs and, once incorporated, may be altered only with CMS approval, and only to the extent consistent with the approved expenditure authorities and STCs. Changes to the protocol will apply prospectively, unless otherwise indicated in the protocols. DSRIP payments for each ACH partnering provider are contingent on the partnering providers fully meeting project metrics defined in the approved ACH Project Plan. In order for providers to receive incentive funding relating to any metric, the ACH must submit all required reporting, as outlined in the DSRIP Program Funding and Mechanics Protocol (Attachment D). In addition, the DSRIP Program Funding and Mechanics Protocol must:

1. Describe and specify the role and function of a standardized ACH report to be submitted to the state on a quarterly basis that outlines a status update on the ACH Project Plan, as well as any data or reports that ACHs may be required to submit baseline information and substantiate progress. The state must develop a standardized reporting form for the ACHs to document their progress.

2. Specify an allocation formula across ACHs based on covered Medicaid lives per ACH, scale of project, type of project, level of impact on beneficiaries, number of providers, and other factors;

3. Specify parameters for an incentive payment formula to determine DSRIP incentive payments commensurate with the value, impact, and level of effort required, to be included in the ACH budget plan.

4. Specify that an ACH failure to fully meet a performance metric or non-compliance under its ACH Project Plan within the time frame specified will result in a forfeiture of the associated incentive payment.

5. Include a description of the state's process to develop an evaluation plan for DSRIP as a component of the draft evaluation design as required by STC 126.

6. Ensure that payment of funds allocated in an ACH Project Plan to outcome measures will be contingent on the ACH certifying and reporting DSRIP performance indicators to the state via the independent assessor and on the ACH meeting a target level of improvement in the DSRIP performance indicator relative to baseline. A portion of the funds allocated in DSRIP Year 3 and DSRIP Year 4, and a majority of funds allocated in DSRIP Year 5, must be contingent on meeting a target level of improvement. ACH partnering providers may not receive credit for metrics achieved prior to approval of their ACH Project Plans.

7. Require that, for DSRIP years 4 and 5, all incentive dollars are contingent upon the state achieving fully integrated managed care by January 2020 for physical and behavioral health services. The state will report on progress toward this outcome on its annual report.

8. Include criteria and methodology for project valuation, including a range of available incentive funding per project.

9. Include pre-project plan milestones for capacity-building incentive payments.

39. ACH Project Plans. ACHs must develop a Project Plan that is consistent with the transformation objectives of this demonstration and describes the steps the ACH will take to achieve those objectives. The plan must be based on the DSRIP Planning Protocol (Attachment C), and further developed by the ACH to be directly responsive to the needs and characteristics of the communities that it serves. In developing its ACH Project Plan, an ACH must solicit and incorporate community and consumer input to ensure it reflects the specific needs of its region. ACH Project Plans must be approved by the state and may be subject to additional review by CMS. In accordance with the schedule outlined in these STCs and the process described further in the DSRIP Program Funding and Mechanics Protocol (Attachment D), the state and the assigned independent assessor must review and approve ACH Project Plans in order to authorize DSRIP funding for DY1 and DY 2 and must conduct ongoing reviews of ACH Project Plans as part of a mid-point assessment in order to authorize DSRIP funding for DY 3-5. The state is responsible for conducting these reviews for compliance with approved protocols. The independent assessor recommendations should be considered final and not subject to CMS review. The DSRIP Planning Protocol (Attachment C) will provide a structured format for ACHs to use in developing their ACH Project Plan submission for approval. At a minimum, it will include the elements listed below.

a. Each ACH Project Plan must identify the target populations, projects, and specific milestones for the proposed project, which must be chosen from the options described in the approved DSRIP Planning Protocol (Attachment C).

b. Goals of the ACH Project Plan should be aligned with each of the objectives as described in STC 33 of this section.

c. Milestones should be organized as described above in STCs 34-35 of this section reflecting the overall goals of the demonstration and subparts for each goal as necessary.

d. The ACH Project Plan must describe the needs being addressed and the proposed period of performance, beginning after January 9, 2017.

e. Based on the proposed period of performance, the ACH must describe its expected outcome for each of the projects chosen. ACHs must also describe why the ACH selected the project drawing on evidence for the potential for the interventions to achieve these changes.

f. The ACH Project Plan must include a description of the processes used by the ACH to engage and reach out to stakeholders including a plan for ongoing engagement with the public, based on the process described in the DSRIP Planning Protocol (Attachment C).

g. ACHs must demonstrate how the projects support sustainable delivery system transformation for the target populations. The projects must implement new, or significantly enhance existing, health care initiatives.

h. For each stated goal or objective of a project, there must be an associated outcome metric that must be reported in all years. The initial ACH Project Plan must include baseline data on all applicable quality improvement and outcome measures.

i. ACH Project Plans must include an ACH Budget Plan, which specifies the allocation of funding proposed for each metric and milestone. ACHs may not receive credit for metrics achieved prior to approval of their ACH Project Plans.

40. Monitoring. The independent assessor and the state will be actively involved in ongoing monitoring of ACH projects, including but not limited to the following activities.

a. **Review of milestone achievement.** At least two times per year, ACHs seeking payment for providers under the DSRIP program shall submit reports to the state demonstrating progress on each of their projects as measured by project-specific milestones and metrics achieved during the reporting period. The reports shall be submitted using the standardized reporting form approved by the state. Based on the reports, the Independent Assessor will calculate the incentive payments for the progress achieved according to the approved ACH Project Plan. The Independent Assessor's determination shall be considered final. The ACH shall have available for review by the state, upon request, all supporting data and back-up documentation. These reports will serve as the basis for authorizing incentive payments to providers for achievement of DSRIP milestones.

b. **Quarterly DSRIP Operational Protocol Report**. The state shall provide quarterly updates to CMS and the public on the operation of the DSRIP program. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration and whether there has been progress toward the goals of the demonstration. The reports will document key operational and other challenges, to what they attribute the challenges and how the challenges are being addressed, as well as key achievements and to what conditions and efforts they attribute the successes.

c. **Learning collaboratives.** With funding available through this demonstration, the state will support regular learning collaboratives, which will be a required activity for all ACHs.

d. **Additional progress milestones for at risk projects**. Based on the information contained in the ACH semi-annual report or other monitoring and evaluation information collected, the state may identify particular projects as being "at risk" of not successfully completing its ACH project in a manner that will result in meaningful delivery system transformation. Projects that remain "at risk" are likely to be discontinued at the midpoint assessment.

e. **Annual discussion.** In addition to regular monitoring calls, the State shall on an annual basis present to and participate in a discussion with CMS on implementation progress of the demonstration including progress toward the goals, and key challenges, achievements and lessons learned.

41. Data. The state shall make the necessary arrangements to assure that the data required from the ACHs and from other sources, are available as required by the CMS approved DSRIP Planning Protocol (Attachment C).

42. Health IT. The state will use Health Information Technology ("Health IT") to link services and core providers across the continuum of care to the greatest extent possible. The state is expected to achieve minimum standards in foundational areas of Health IT and to develop its own goals for the transformational areas of Health IT use. The state will discuss how it plans to meet the Health IT goals/milestones outlined below in the DSRIP Planning Protocol (see STC 37 and Attachment C). Through quarterly reporting, the state will further enumerate how it has, or intends to, meet the stated goals.

1. The state must have plans with achievable milestones for Health IT adoption or health information exchange for providers both eligible and ineligible for the Medicaid Electronic Health Records (EHR) Incentive Programs and execute upon that plan.

2. The state shall create a pathway, or a plan, for the exchange of clinical health information for Medicaid consumers statewide to support the demonstration's program objectives.

3. The state shall advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing state policies—and in all applicable state procurements (e.g. including managed care contracts).

    1. Where there are opportunities at the state and provider level to leverage federal Medicaid funds that could use a standard referenced in 45 CFR §170, the state must adopt it.

    2. Where there are opportunities at the state and provider level to leverage federal Medicaid funds that could use a standard not already referenced in 45 CFR §170 but are included in the ISA, the state should attempt to use the federally-recognized ISA standards barring no other compelling state interest.

4. The state shall require the electronic exchange of clinical health information, utilizing the Consolidated Clinical Document Architecture (C-CDA), with all members of the interdisciplinary care. The state will provide a Health IT strategy by April 1, 2017 that details existing HIT capabilities that support this goal, and develop a mutually-agreed upon timeframe between CMS and the state for any identified enhancements.

5. The state shall ensure a comprehensive Medicaid enterprise master patient index that supports the programmatic objectives of the demonstration. The state will provide a Health IT strategy by April 1, 2017 that details existing HIT capabilities that support this goal, and develop a mutually-agreed upon timeframe between CMS and the state for any identified enhancements.

6. The state shall ensure a comprehensive provider directory strategy that supports the programmatic objectives of the demonstration. The state will provide a Health IT strategy by April 1, 2017 that details existing HIT capabilities that support this goal, and develop a mutually-agreed upon timeframe between CMS and the state for any identified enhancements.

7. The state will pursue improved coordination and improved integration between Behavioral Health, Physical Health, Home and Community Based Providers and community-level collaborators for Improved Care Coordination (as applicable) through the adoption of provider-level Health IT infrastructure and software—to facilitate and improve integration and coordination to support the programmatic objectives of the demonstration. The state will provide a Health IT strategy by April 1, 2017 that details existing HIT capabilities which support this goal, and develop a mutually-agreed upon timeframe between CMS and the state for any identified enhancements.

8. The State shall ensure a comprehensive Health IT-enabled quality measurement strategy that support the programmatic objectives of the demonstration. The state will provide a Health IT strategy by April 1, 2017 that details existing HIT capabilities which support this goal, and develop a mutually-agreed upon timeframe between CMS and the state for any identified enhancements.

43. Value-Based Roadmap. Recognizing that the DSRIP investments must be sustained through new payment methods, and that managed care plans will play a critical role in the long-term sustainability of this effort, the state must take steps to plan for and reflect the impact of DSRIP in managed care business approaches.

Within 60 days of STC approval, and subsequently, by October 1st of each demonstration year, the state must submit an updated Value-based Roadmap ("Roadmap") which establishes targets for VBP attainment, related incentives under DSRIP for MCOs and ACHs, a description of how managed care is transforming to support new models of care, and Medicaid MCO contract changes being made to align with the Medicaid Transformation Demonstration project. The state will also address the payment mechanism, including an implementation plan detailing when the state will submit any required documentation in order to meet payment timelines.

The Roadmap will be updated annually to ensure that best practices and lessons learned can be incorporated into the state's overall vision of delivery system reform. This Roadmap will describe what the state and its stakeholders consider the payment reforms required for a high quality and a financially sustainable Medicaid delivery system.

Recognizing the need to formulate this plan to align with the stages of DSRIP, this will be a multi-year plan. It will necessarily be flexible to properly reflect future DSRIP progress and accomplishments. Progress on the Roadmap will also be included in the quarterly DSRIP report.

The Roadmap shall address the following:

a. Targets for regional ACH and statewide MCO attainment of VBP Goals, per STC 44.

b. Approaches that MCOs and the state will use with providers to encourage practices consistent with DSRIP objectives and metrics and the VBP targets.

c. Use of DSRIP measures and objectives by the state in their contracting strategy approach for managed care plans.

d. MCO contract amendments to include any necessary reporting of DSRIP objectives and measures.

e. Alternative payment models deployed between MCOs and providers to reward performance consistent with DSRIP objectives and measures.

f. Measurement of MCOs based on utilization and quality in a manner consistent with DSRIP objectives and measures, including incorporating DSRIP objectives into their annual utilization and quality management plans.

g. Evolution toward further alignment with MACRA and other advanced APMs.

44. Models of Value-Based Payment. The state has established VBP goals consistent with the HCP-LAN *Alternative Payment Models* (APM) Framework[2] and the Quality Payment Program (QPP) under MACRA, further defined in Table 1. The goals are in alignment with broader U.S. Department of Health and Human Services' (HHS) delivery system reform goals.

Under DSRIP, regional and managed care plan-level incentives will be established. Specifically, the state agrees to VBP target thresholds at or above which incentive payments can be earned by partnering ACH providers and MCOs. *See Table 1*. The state will ensure both improvement from baseline and attainment are taken into consideration in the development of the VBP incentive program. The thresholds will be further defined in the DSRIP planning protocol (Attachment C) and Roadmap (Attachment F).

Table 1: Percentage of Provider Payments in HCP-LAN APM Categories at or above which Incentives Are Provided to Providers and MCOs under DSRIP

[2] Available at https://hcp-lan.org/groups/apm-fpt/apm-framework/

VBP Goals (consistent with HCP-LAN Framework)*						
	DY1	DY2	DY3	DY4	DY5	DY6
HCP LAN Category 2C – 4B	30%	50%	75%	85%	85%	85%
Subset of goal above: HCP LAN Category 3A-4B	-	10%	20%	30%	50%	50%
Payments in Advanced APMs			TBD*	TBD*	TBD*	

a. Starting in DY 1, VBP incentives will be based on the percentage of provider payments in categories 2C-4B of the HCP-LAN Framework, with progressive targets throughout the demonstration.

b. By DY 2, the state will implement in its Roadmap (Attachment F) additional criteria that incentivizes ACH and MCO attainment of upside/downside provider risk arrangements (HCP-LAN categories 3A-4B). The incentive structure will be further defined in the DSRIP Planning Protocol (Attachment C) and Roadmap (Attachment F).

c. By DY 3, the additional targets (*) outlined in Table 1 above to be defined in the Roadmap, will incentivize implementation of MACRA Advanced APMs in provider contracts.

d. Beginning in DY 4, to be eligible for any region or plan-level incentives under the Roadmap, at least 30 percent of all provider payments must meet or exceed category 3A of the HCP-LAN framework with additional incentives provided for meeting categories 3B through 4B with the following elements:

   i. Shared upside and downside risk (where entities will be required to bear more than a nominal risk for monetary losses)

   ii. Payment tied to provider improvement and attainment of quality performance metrics from the Washington Statewide Common Measure set, using HCA Quality Improvement Model or similar tool.

   iii. Care transformation requirements consistent with ACH-led DSRIP activities, including appropriate recognition of state level best practice recommendations, such as the Bree Collaborative.[3]

[3] Bree Collaborative is a public-private consortium established in 2011 by the Washington State Legislature "to provide a mechanism through which public and private health care stakeholders can work together to improve

iv. Use of certified EHR technology and health information exchange services in support of VBP methods.

e. The state will submit annually, by no later than October 1 of each demonstration year, an updated Roadmap (Attachment F) to meet the specifications of this section and to ensure the roadmap aligns with evolving MACRA and other state-based payment models. All thresholds for VBP incentive payments exclude payments for services provided by or through Indian health care providers.

f. The Roadmap will describe how the state will validate and categorize value-based arrangements using a third-party validator.

g. Contractual obligations for MCOs are integral to this demonstration, including requirements that MCOs attain defined levels of value-based payment with their provider networks while achieving quality improvement across a core set of quality metrics to be included in the managed care contracts. A premium withhold has been established to incentivize improved quality performance, and that withhold will increase over the first five years of the demonstration. The withhold for DY6 will be at or above the DY5 level. These value-based purchasing targets and quality measures align to the DSRIP program structure and will change to adapt to future requirements and protocols developed throughout this demonstration.

45. Challenge and Reinvestment Pools. Under DSRIP, the state will set aside no more than 15 percent of annually available DSRIP funds to reward MCO and ACH partnering providers for provider-level attainment of VBP targets stipulated in STC 44. Two pools are created to facilitate incentive payments:

a. *Challenge Pool.* An annual budget, not to exceed 5 percent of total available DSRIP funding, is established as incentive payments for MCO attainment and progression toward VBP targets. In addition, if unearned incentives from the MCO premium withholds and DSRIP funding for MCO VBP attainment (see STC 44(g)) remain after the annual performance period, any remaining funds will be used for incentive payments for MCOs meeting exceptional standards of quality and patient experience, based on a subset of measures to be defined in the DSRIP planning protocol (Attachment C) and Roadmap (Attachment F).

b. *Reinvestment Pool*. An annual budget, not to exceed 10 percent of total available DSRIP funding, is established to reward ACH partnering providers (regional) attainment and progression toward VBP targets. To the extent unearned incentives

quality, health outcomes, and cost effectiveness of care in Washington State." Annually, the Bree identifies up to three areas where there is substantial variation in practice patterns and/or high utilization trends that do not produce better care outcomes. Recommendations from the Bree are sent to the Health Care Authority to guide state purchasing for programs such as Medicaid and Public Employees Benefits Board (PEBB).

remain after the annual performance period from ACH Projects or VBP unearned incentives, any remaining funds will be used for incentive payments to the ACH for performance against a core subset of measures to be defined the DSRIP planning protocol (Attachment C) and Roadmap (Attachment F). These funds must be spent on demonstration objectives.

46. **Federal Financial Participation (FFP) for DSRIP.** The state may claim, as authorized expenditures under the demonstration, up to $994 million total computable for six years, performance-based incentive payments to ACH partnering providers or MCOs that support change in how care is provided to Medicaid beneficiaries through payment and delivery system reforms. DSRIP payments are an incentive for successfully meeting associated metrics and outcomes rather than payment of claims for the provision of medical care. For this reason, DSRIP payments shall not be considered patient care revenue for purposes of offsetting allowable uncompensated care costs under the DSRIP Funding and Mechanics Protocol under demonstration authority.

    1. DSRIP payments are not direct reimbursement for expenditures or payments for services. DSRIP payments are intended to support and reward ACHs and their partnering providers for delivery system transformation efforts and are eligible for federal matching at the administrative rate and not as medical assistance. DSRIP payments are not considered patient care revenue, and shall not be offset against disproportionate share, MCO expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) or other allowable administrative expenses.

    2. The state may not claim FFP for DSRIP until after CMS has approved the DSRIP Planning Protocol (Attachment C) and DSRIP Funding and Mechanics Protocol (Attachment D). Once approved, the state may receive FFP for expenditures beginning January 1, 2017.

    3. The state may not claim FFP for DSRIP payments in each year for DSRIP Year 1 through DSRIP Year 6 until the state has concluded whether or not the ACHs, MCOs, and partnering providers have met the performance indicated for each payment. The state must inform CMS of the funding of all DSRIP payments through a quarterly payment report to be submitted to CMS within 60 days after the end of each quarter. ACH and MCO reports must contain sufficient data and documentation to allow the state and CMS to determine if the ACH, MCO, and partnering providers have fully met the specified metric or VBP goal, and ACHs and MCOs must have available for review by the state or CMS, upon request, all supporting data and back-up documentation. FFP will be available only for payments related to approved DSRIP activities.

    4. The non-federal share of payments to ACHs, MCOs, and partnering providers may be funded by state general revenue funds, intergovernmental transfers, designated state health programs, or any other allowable source of non-federal share consistent with

federal law. The funding will flow to the participating providers according to the methodology specified in the DSRIP Funding and Mechanics Protocol.

5. The state must inform CMS of the funding of all DSRIP payments to providers through quarterly reports submitted to CMS within 60 calendar days after the end of each quarter, as required in STC 77. This report must identify the funding sources associated with each type of payment received by each provider.

47. DSRIP Funding. The amount of demonstration funds available for the DSRIP Program is shown in Table 2 below.

Table 2: DSRIP Funding and At-Risk Percentages

	DY1 **01/01/17-12/31/17**	**DY2** **01/01/18-12/31/2018**	**DY3** **01/01/19 – 12/31/19**	**DY4** **01/01/20 – 12/31/20**	**DY5** **01/01/21 – 12/31/21**	**DY6** **01/01/22 – 12/31/2022**
Maximum Allowable Funds*	$242,100,000	$240,600,000	$187,180,434	$151,510,022	$71,250,000	$101,679,588
Percent at Risk for Performance	0%	0%	5%	0%	20%	20%
Dollar Amount at Risk for Performance	N/A	N/A	$9,359,022	$0	$14,250,000	$20,335,918

*These amounts reflect actual spending in DY1 – DY5.

<u>*Funding At Risk for VBP and Quality Improvement Goals under DSRIP*.</u> A share of total DSRIP funding will be at risk if the state fails to demonstrate progress toward meeting the demonstration's VBP goals as outlined in STC 44, Table 1 and quality measures to be defined in the DSRIP Planning Protocol (Attachment C). The percentage at risk will gradually increase from 0 percent in DY 1-2 to 5 percent in DY 3 and 20 percent in DY 5 and DY 6. The at risk for DY 4 is waived due to COVID-19 performance implications. The at-risk outcome measures will be developed by the state and included in the DSRIP Planning Protocol for approval by CMS. They must be statewide and measure progress toward the state's Medicaid transformation goals.

48. Life Cycle of the Six-Year DSRIP Program. Synopsis of anticipated activities planned for this demonstration and the corresponding flow of funds.

1. ***Demonstration Year 1- Planning and Design:*** In the first year of the demonstration, the state will undertake implementation activities, including the following:

   i. <u>*Submit the DSRIP Planning Protocol (Attachment C) and* DSRIP *Program Funding and Mechanics Protocol (Attachment D)*</u>. Working closely with

stakeholders and CMS, the state will submit the two required protocols in accordance with STCs 37 and 38 by March 9, 2017.

ii. *Develop and oversee certification process for ACHs*. The state will develop a process for ACHs to be certified to lead Medicaid transformation projects. Certification will require, among other things, that the ACHs: (1) describe their governance plan and process to ensure compliance with principles outlined in the STCs; and (2) describe the stakeholder, tribal engagement, and public processes that will be used to solicit community input.

iii. *Develop and oversee project plan application process for ACHs*. The state will develop a project plan application in accordance with the approved DSRIP Planning Protocol (Attachment C) and the DSRIP Program Funding and Mechanics Protocol (Attachment D). The ACHs must complete the project plan applications within the timeframe determined by the state.

iv. *Review and approve project plans submitted by ACHs.* Once the ACHs submit project plans and they are reviewed by the independent assessor, the state will approve applications in accordance with the DSRIP Funding and Mechanics Protocol (Attachment D).

v. *Establish Statewide Resources To Support ACHs.* The demonstration will also support ACHs with statewide resources. Specifically, ACHs will be provided with technical assistance and the opportunity to participate in learning collaboratives that facilitate the sharing of best practices and lessons learned across ACHs. The statewide resources will be developed to coordinate with other ongoing and emerging delivery system reform efforts in the state.

2. ***Demonstration Years 2-4: Implementation, Performance Measurement and Outcomes*:**

   i. In these years, the state will move the distribution of DSRIP payments to more outcome-based measures, making them available over time only to those ACH partnering providers that meet performance metrics.

3. ***Demonstration Years 5 and 6: Performance Measurement and Sustainability:***

   i. DSRIP investments that meet the demonstrations objectives will continue through value-based payment objectives, led by MCOs and supported by ACHs and the provider community.

VII. LONG TERM SERVICES AND SUPPORTS

49. Medicaid Alternative Care (MAC). Currently eligible Medicaid beneficiaries who are eligible for, but have chosen not to receive, Medicaid-funded LTSS will be eligible for a new Medicaid Alternative Care (MAC) benefit package. These individuals *do not* constitute a

new MEG. The demonstration allows them a benefits choice that will enable them to remain in their homes for a longer period. Eligibility criteria include:

a. Age 55 or older;

b. Eligible for Categorically Needy (CN) or Alternative Benefit Plan (ABP) services; and

c. Eligible to receive the LTSS Medicaid benefit currently available under optional State Plan 1915(k) or HCBS authorities—but have chosen to receive services under MAC instead.

The state will not apply post-eligibility treatment of income to the MAC population because they will not be receiving LTSS.

50. MAC Benefits Package. Administered by the state, or its delegate, the MAC benefit package will be offered through a person-centered planning process where services from one or more of the service categories in STC 50(a) through (d) are identified in a plan of care—up to a specified limit as defined in state rule—to individuals who are age 55 or older and eligible for CN or ABP coverage—and not currently receiving Medicaid-funded LTSS. Beneficiaries receiving MAC would also be eligible for Medicaid medical services but would not be eligible for other Medicaid optional state plan or 1915(c) LTSS benefits at the same time. MAC is an alternate benefit package that individuals may choose so they can remain in their home with care provided through their unpaid family caregiver. If an eligible individual chooses to access state plan or 1915(c) LTSS benefits, they would no longer be eligible to receive MAC services. With the exception of services authorized under presumptive eligibility, services offered under this benefit will not duplicate services covered under the state plan, Medicare or private insurance, or through other federal or state programs. The following are the MAC benefits with corresponding descriptions:

a. Caregiver Assistance Services. Services that take the place of those typically performed by the unpaid caregiver in support of unmet needs the care receiver has for assistance with activities of daily living (ADL) and instrumental ADL. Services include:

i. Housework/errands/yardwork

ii. Transportation (in accordance with the participant's service plan)

iii. Respite (in home and out of home)

iv. Home delivered meals

v. Home safety evaluation

vi. Minor home modifications and repairs required to maintain a safe environment

b. Training and Education. Services and supports to assist caregivers with gaining skills and knowledge to implement services and supports needed by the care receiver to remain at home or skills needed by the caregiver to remain in their role. Services include:

i. Support groups

ii. Group training

iii. Caregiver coping/skill building training

iv. Consultation on supported decision making

v. Caregiver training to meet the needs of the care receiver

vi. Financial or legal consultation

vii. Health and wellness consultation

c. Specialized Medical Equipment & Supplies. Goods and supplies needed by the care receiver. Goods and supplies include:

i. Supplies

ii. Specialized Medical Equipment (includes durable medical equipment and adaptive equipment)

iii. Personal emergency response system

iv. Assistive Technology

d. Health Maintenance & Therapy Supports. Clinical or therapeutic services that assist the care receiver to remain in their home or the caregiver to remain in their caregiving role and provide high quality care. Services are provided for the purpose of preventing further deterioration, improving or maintaining current level of functioning. Supports and services categorized here include those typically performed or provided by people with specialized skill, certification or licenses. Services include:

i. Adult day health

ii. RDAD and EB exercise programs

iii. Health Promotion and Wellness Services

iv. Counseling

51. **Tailored Supports for Older Adults.** The demonstration also establishes a new eligibility expansion category for individuals who are "at risk" of becoming eligible for Medicaid in order to access LTSS. This "At Risk" or "Tailored Supports for Older Adults" (TSOA) eligibility group is comprised of individuals that could receive Medicaid State Plan benefits under 42 CFR §435.236 and §435.217. Under the Demonstration, these individuals may access a new LTSS benefit package that will preserve their quality of life while delaying their need (and the financial impoverishment) for full Medicaid benefits. The individuals must:

    a. Be age 55 or older;

    b. Be a U.S. citizen or in eligible immigration status;

    c. Not be currently eligible for CN or ABP Medicaid;

    d. Meet functional eligibility criteria for NFLOC as determined through an eligibility assessment; and

    e. Have income up to 300% of the SSI Federal Benefit Rate.

        i. To determine eligibility for TSOA services, the state will consider the income of the applicant, not their spouse/dependents, when determining if gross income is at or below the 300% SSI Federal Benefit Rate limit; and

        ii. To determine income, Washington will use the Social Security Income (SSI)-related income methodologies currently in use for determining eligibility for Medicaid LTSS. No post-eligibility treatment of income will apply and eligibility will be determined using only the applicant's income. Like the MAC population, Washington will not apply post-eligibility treatment of income to the TSOA populations.

        iii. The individual's separate non-excluded resources are at or below $53,100 or, for a married couple, that non-excluded resources (calculated as of the first point at which the individual is deemed to have the status of an "institutionalized spouse") are at or below a combination of $53,100 plus the current state Community Spouse Resource Allowance, based on the individual's verified household resources.

            1. To determine resources, the State will us the Social Security Income (SSI)-related resource rules currently in use for determining eligibility for Medicaid LTSS with the following exceptions:

            2. Transfer of asset penalties do not apply

            3. Excess home equity provisions do not apply

52. **TSOA Benefits Package.** Administered by the state or its delegate, the TSOA benefit package will be offered to individuals determined to be "at risk" for Medicaid (as described in the previous section) will be offered through a person-centered planning process where services from one or more of the service categories are identified in a plan of care up to a specified limit as defined in state rule. Individuals receiving TSOA services will not be eligible for CN or ABP Medicaid-funded medical services or other Medicaid-funded optional State Plan or 1915(c) LTSS benefits. Individuals who later become CN or ABP Medicaid-eligible will no longer be eligible for TSOA services. Individuals receiving MN Medicaid-funded medical services or are eligible for a Medicare Savings Program (MSP) are eligible for TSOA services. With the exception of services authorized under presumptive eligibility, services offered under this benefit will not duplicate services covered under the state plan, Medicare or private insurance, or through other federal or state programs. The following are the TSOA benefits with corresponding descriptions:

    a. TSOA Benefits. The TSOA benefits include all the same benefits outlined in STC 50(a)(i), (b), (c) andh (d).

    b. Personal Assistance Services. Supports involving the labor of another person to help demonstration participants carry out everyday activities they are unable to perform independently. Services may be provided in the person's home or to access community resources. Services include but are not limited to:

        i. Personal Care

        ii. Nursing delegation

        iii. Adult day care

        iv. Transportation (in accordance with the participant's service plan)

        v. Home delivered meals

        vi. Home safety evaluation

        vii. Home modifications and repairs (associated with the home modifications) required to maintain a safe environment

53. **Person Centered Planning.** The state agrees to use person-centered planning processes to identify participants', applicants' and unpaid caregivers' LTSS needs, the resources available to meet those needs, and to provide access to additional service and support options as needed. The state assures that it will use person centered planning tools that will be in compliance with the characteristics set forth in 42 CFR 441.301(c)(1)-(3).

54. **Self-Directed Supports.** The state agrees to provide resources to support participants or their proxies (e.g., a surrogate, parent or legal guardian/representative) in directing their own care when that care is provided by an individual provider. This support assures, but is not limited to, participants' compliance with laws pertaining to employer responsibilities and

provision for back-up attendants as needs arise. The state agrees to assure that background checks on employees and their results are available to participants. State policies and guidelines will include, but not be limited to: criteria for who is eligible to self-direct, a fiscal agent/intermediary, and training materials to assist participants with learning their roles and responsibilities as an 'employer' and to ensure that services are consistent with care plan needs and allocations.

a. Program enrollees will have full informed choice on the requirements and options to: self-direct services; have a qualified designated representative direct services on their behalf, or select traditional agency-based service delivery. State and provider staff will receive training on these options.

55. **Conflict of Interest.** The state agrees that the entity responsible for assisting the individual with development of the person-centered service plan may not be an LTSS service provider, unless that service planning entity is the only qualified and willing entity available to conduct the service. If a service planning entity is the only willing and qualified entity to conduct the service, the state must establish firewalls between the service provision and planning functions to ensure conflict of interest protections. The state assures that conflict of interest protections will be in compliance with the characteristics set forth in 42 CFR 441.301(c)(1)(v)(vi). The state also assures that the independent evaluation and determination of eligibility for LTSS is performed by an agent that is independent and qualified as defined in 42 CFR 441.730.

56. **Home and Community-Based Setting Requirements.** The state will assure compliance with the characteristics of home and community-based settings in accordance with 42 CFR 441.301(c)(4), for those services that could be authorized under sections 1915(c) and 1915(i).

57. **Quality Measures.** The state will develop a Quality Improvement System (QIS) that includes:

a. Performance measurement and reporting in accordance with the quality reporting and review standards outlined in *Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers* guidance issued March 12, 2014, and reporting timelines outlined in *Revised Interim Procedural Guidance* issued February 6, 2007.

1. Performance measures should address the following areas:

   i. Identification of needs and goals, and access to services (Level of Care/Functional assessment and Person-Centered Plan of Care at least annually);

   ii. Services are delivered in accordance with the Person-Centered Plan of Care

   iii. Providers meet required qualifications;

iv. Settings meet the home and community-based setting requirements for those services that could be authorized under 1915(c) and 1915(i);

v. Number of substantiated incidents of neglect, exploitation or abuse and average time to resolution;

vi. The State Medicaid Agency (SMA) retains authority and responsibility for program operations and oversight; and

vii. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1115 participants by qualified providers.

b. Ongoing quarterly/annual reporting that includes:

i. Number of LTSS beneficiaries broken out by program (MAC and TSOA);

ii. Number of new MAC and TSOA person-centered service plans;

iii. Percent of MAC and TSOA level of care re-assessments annually; and

iv. Number of people self-directing services under employer authority

58. Critical Incident Reporting. The state has a system as well as policies and procedures in place through which providers must identify, report and investigate critical incidents that occur within the delivery of MAC and TSOA. Provider contracts reflect the requirements of this system. The state also has a system as well as policies and procedures in place through which to detect, report, investigate, and remediate abuse, neglect, and exploitation. Providers and participants are educated about this system. Provider obligations include specific action steps that providers must take in the event of known or suspected abuse, neglect or exploitation.

59. Presumptive Eligibility. The state will provide the MAC and TSOA services outlined in STCs 50 and 52 to individuals during a presumptive eligibility (PE) period following a determination by the state or a qualified entity—on the basis of preliminary information—that the individual appears to meet functional and financial eligibility requirements, using simplified methodology prescribed by the state and approved by CMS. In the event the state implements a waitlist, the authority for presumptive eligibility terminates.

a. *Qualified entity* – Presumptive eligibility will be determined by both the state and state designated qualified entities. A qualified entity is an entity that:

i. Participates with the Department of Social and Health Services (DSHS) as an Area Agency on Aging (AAA), subcontractor of an AAA or as a state designated tribal entity to provide limited eligibility functions and other administrative functions as delegated in contract;

ii. Notifies the DSHS of its election to make presumptive eligibility determinations under this section, and agrees to make presumptive eligibility determinations consistent with State policies and procedures; and

iii. The state will include language specific to presumptive eligibility requirements to its existing contracts with qualified entities who shall conduct presumptive eligibility determinations.

b. *Qualified staff* – Presumptive eligibility shall be determined by staff of qualified entities who have met at least the following qualifications imposed by the state.

i. A College degree and at least two years of social service experience or an equivalent level of education plus relevant experience;

ii. Complete PE training prior to determining PE; and

iii. The state will provide CMS the initial training curriculum and PE determination form for review and approval prior to program implementation. Subsequent content changes will be submitted to CMS for review at the time the change is made.

c. *Quality Assurance and Monitoring* – The state will monitor both state staff and qualified entities for adherence to policies applicable to presumptive eligibility determinations through contract monitoring and quality assurance reviews.

i. Post implementation the state will conduct a targeted review of implementation to validate PE determinations are being made in accordance with established criteria; and

ii. As part of the state's Quality Improvement Strategy, a sample of PE determinations will be reviewed yearly to determine that PE was established appropriately.

d. *Presumptive Functional Eligibility* – The following information will be collected as part of the presumptive functional eligibility assessment to determine if the individual appears to meet nursing facility level of care as defined in state rule. Indicators include:

i. Does the individual need daily care provided or supervised by a registered nurse (RN) or licensed practical nurse (LPN); or

ii. Does the individual have an unmet or partially met for assistance with 3 or more qualifying ADLs; or

iii. Does the individual have a cognitive impairment and require supervision due to one or more of the following: Disorientation, memory impairment,

impaired decision making, or wandering and a need for assistance with 1 or more qualifying ADLs; or

iv. Does the individual have an unmet or partially met need for assistance with 2 or more qualifying ADLs; and

v. Functional eligibility shall be confirmed by the State for ongoing program eligibility.

e. *Presumptive Financial Eligibility* – Presumptive financial eligibility will be determined by a financial screen, based on application attestation, to determine if the applicant meets the following requirements:

i. For TSOA:

1. State resident;
2. Social Security Number (SSN);[4]
3. The individual's separate non-excluded income is equal to or less than the Special Income Level (SIL).
4. The individual's separate non-excluded resources are at or below $53,100 or, for a married couple, that non-excluded resources (calculated as of the first point at which the individual is deemed to have the status of an "institutionalized spouse") are at or below a combination of $53,100 plus the current state Community Spouse Resource Allowance, based on the individual's self-attested statement of their household resources.

ii. For MAC:

1. The state or qualified entity will confirm the individual is presumptively eligible in a categorically needy or alternative benefit plan program that offers healthcare coverage to the target population using the state's eligibility and enrollment data system.

f. *Period of Presumptive Eligibility* – Period of presumptive eligibility means a period that begins on the date on which a qualified entity determines that an applicant is presumptively eligible[5] and ends with the earlier of:

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[4] If an applicant does not have a SSN established it will not preclude the applicant from applying for TSOA or MAC, the state shall provide the individual with assistance applying for an SSN or getting the person's SSN.

[5] To receive services past the PE period, the state must have completed a full financial eligibility determination and/or a NFLOC assessment.

i. In the case of an individual on whose behalf a Medicaid or TSOA application has been filed, the day on which a decision is made on that application; or

ii. In the case of an individual on whose behalf a Medicaid or TSOA application has not been filed, the last day of the month following the month in which the determination of presumptive eligibility was made.

g. *Presumptive Eligibility Service Level* –As part of the presumptive eligibility determination the state shall assess the individual for both functional eligibility (NFLOC) and financial eligibility concurrently.

60. Estate Recovery. Participants in MAC and TSOA are exempted from Medicaid estate recovery requirements due to:

a. Scope of Medicaid estate recovery;

b. Limitation on access to Medicaid-funded state plan or demonstration HCBS for MAC participants;

c. Services available to MAC participants are outside the scope of services generally defined by CMS as HCBS; and

d. TSOA is a non-Medicaid population.

61. Wait List. The state may institute a waitlist for those who are eligible for MAC or TSOA services but are unable to access the services because funding for services under the demonstration is not available. If the state determines expenditures for this program will exceed the expenditure authorities 3-6 within a given demonstration year, the state may impose a wait list. The state will implement the waitlist and ensure that no existing beneficiaries lose services as a result of the waitlist. In the event the state implements a waitlist, the authority for presumptive eligibility terminates.

VIII. FOUNDATIONAL COMMUNITY SUPPORTS

62. Foundational Community Supports Program. Under this program, the state will provide a set of HCBS for eligible individuals.

63. Foundational Community Supports Services 1. One-time community transition services to individuals moving from institutional to community settings and those at imminent risk of institutional placement.

64. Foundational Community Supports Eligibility 1. Eligible individuals include those who would be eligible under a section 1915(c) waiver program who, but for the Foundational Community Supports Program, would be in an institutional placement. (For example, those at imminent risk of institutionalization include those individuals with a disabling condition who meet an institutional level of care.)

65. **Post Approval Protocol 1**. The post-approval protocol (Attachment I), which will be subject to CMS approval, will include the service definitions for the one-time transition services and payment methodologies.

66. **Foundational Community Supports Services 2**. HCBS that could be provided to the individual under a 1915(c) waiver or 1915(i) SPA.

67. **Foundational Community Supports Eligibility 2.** Eligibility for these services include individuals who could be eligible under a section 1915(c) waiver or 1915(i) SPA program.

68. **Post Approval Protocol 2.** The post-approval protocol (Attachment I), which will be subject to CMS approval, will include the content that would otherwise be documented in a 1915(c) waiver and/or 1915(i) SPA, and will include service definitions, payment methodologies, and the administrative approach.

69. **Submission of Post Approval Protocol**. The state will submit the protocol for services identified in STC 65 and STC 68 above to CMS for review within 60 days following demonstration approval, and will not provide services under the program until receiving CMS approval.

70. **Wait List.** The state may institute a waitlist for those who are eligible for the Foundational Community Supports Program but are unable to access the services because funding for services under the demonstration is not available. If the state determines expenditures for this program will exceed the expenditure authority within a given demonstration year, the state may impose a wait list. The state will implement the waitlist and ensure that no existing beneficiaries lose services as a result of the waitlist.

IX. GENERAL REPORTING REQUIREMENTS

71. **General Financial Reporting Requirements.** The state must comply with all general financial requirements under title XIX of the Act in section XIII of the STCs.

72. **Electronic Submission of Reports.** The state must submit all monitoring and evaluation report deliverables required in these STCs (e.g., quarterly reports, annual reports, evaluation reports) electronically, through CMS' designated electronic system.

73. **Compliance with Managed Care Reporting Requirements.** The state must comply with all managed care reporting regulations at 42 CFR §438 et. seq. except as expressly waived or identified as not applicable in the expenditure authorities incorporated into these STCs.

74. **Reporting Requirements Relating to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality as set forth in section XIV of the STCs, including the submission of corrected budget neutrality data upon request.

75. **Monthly Monitoring Calls.** CMS will convene monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration, including planning for future changes in the program. CMS will

provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda prior to the calls. Topics to be discussed include, but are not limited to:

a. Operations and performance;

b. Stakeholder concerns, audits, and lawsuits;

c. Related legislative developments in the state; and

d. Any demonstration changes or amendments the state is considering.

76. Annual Discussion with CMS. In addition to regular monitoring calls, the state will hold an annual discussion with CMS during which it will present information on the implementation progress of the demonstration, progress toward the Medicaid goals, key challenges, achievements, and lessons learned. The call may also include a discussion regarding issues that CMS may raise.

77. Quarterly Operational Reports. The state must submit progress reports in the format specified by CMS, as per the prescribed schedule in Section XVI. The intent of these reports is to present the state's analysis and the status of the various operational areas in reaching the goals of the demonstration activities. The fourth quarter information that would ordinarily be provided in a separate report should be incorporated within the annual report (described in STC 79). These quarterly reports, using the quarterly report guideline outlined in Attachment A, must include, but are not limited to the following reporting elements:

a. Summary of quarterly expenditures related to ACHs, ACH Project Plans, and the DSRIP Funds;

b. Updated budget neutrality spreadsheets

c. Summary of all public engagement activities, including, but not limited to the activities required by CMS;

d. Summary of activities associated with the ACHs, ACH Project Plans, and the DSRIP Fund. This shall include, but is not limited to, reporting requirements in STC 35 of this section and the DSRIP Planning Protocol (Attachment C):

e. Updates on state activities, such as changes to state policy and procedures, to support the administration of the DSRIP Funds,

f. Updates on provider progress towards the pre-defined set of activities and associated milestones that collectively aim towards addressing the state's goals;

g. Summary of state's analysis of ACH Project Plans;

h. Summary of state analysis of barriers and obstacles in meeting milestones;

i. Summary of activities that have been achieved through the DSRIP Fund;

j. Summary of transformation and clinical improvement milestones and that have been achieved; and

k. Evaluation activities and interim findings.

l. SUD Health IT. The state will include a summary of progress made in regards to SUD Health IT requirements outlined in STC 83(f).

m. Performance metrics for continuous eligibility: The state should report enrollment and renewal metrics that support tracking Medicaid churn, utilization of preventive care services (e.g. vaccinations), and utilization of costlier and potentially avoidable services, such as inpatient hospitalizations and non-emergent use of emergency department.

78. **Rapid Cycle Assessments.** The state shall specify for CMS approval a set of performance and outcome metrics, including their specifications, reporting cycles, level of reporting (e.g. the state, health plan and provider level, and segmentation by population) to support rapid cycle assessment of ACH projects, performance indicators and outcomes, and for monitoring and evaluation of the demonstration.

79. **Annual Report**. The state must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the demonstration. This report must also contain a discussion of the items that must be included in the quarterly operational reports required under STC 77. The state must submit the draft annual report no later than March 31 of each year (90 days after the end of the 4th quarter). Within 60 calendar days of receipt of comments from CMS, a final annual report must be submitted.

80. **Final Report.** Within 120 calendar days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 calendar days after receipt of CMS' comments.

81. **Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones.** Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Protocol and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

82. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

X. SUBSTANCE USE DISORDER PROGRAM AND BENEFITS

83. **Opioid Use Disorder/Substance Use Disorder Program.** Effective upon CMS' approval of the OUD/SUD Implementation Plan Protocol, the demonstration benefit package for Washington Medicaid recipients will include OUD/SUD treatment services, including short term residential services provided in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD), which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for Washington Medicaid recipients residing in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD benefits that would otherwise be matchable if the beneficiary were not residing in an IMD. Washington will aim for a statewide average length of stay of 30 days in residential treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in Section IX, to ensure short-term residential treatment stays. 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 on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.

    The extension of coverage to services for all recipients while they are in short-term residential treatment for OUD/SUD will expand the available settings and allow the state to offer a full continuum of care for recipients with OUD/SUD (see Table 3). Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

Table 3: Washington OUD/SUD Benefits Coverage with Expenditure Authority

SUD Benefit	Medicaid Authority	Expenditure Authority
Outpatient Services	*State plan (Individual services covered)*	Services provided to individuals in an IMD
Intensive Outpatient Services	*State plan (Individual services covered)*	Services provided to individuals in an IMD
Residential Treatment	*State plan (Individual services covered)*	Services provided to individuals in an IMD
Medically Supervised Withdrawal Management	*State plan*	Services provided to individuals in an IMD

Screening, Brief Intervention, and Referral to Treatment (SBIRT)	*State Plan*	N/A
Medication-Assisted Treatment (MAT)	*State plan*	Services provided to individuals in an IMD

The state attests that the services indicated in Table 3, above, as being covered under the Medicaid state plan authority are currently covered in the Washington Medicaid state plan.

a. **SUD Implementation Plan Protocol.** The state must submit an OUD/SUD Implementation Plan Protocol within 90 calendar days after approval of the SUD program under this demonstration. The state may not claim FFP for services provided in IMDs until CMS has approved the Implementation Plan Protocol. Once approved, the SUD Implementation Plan Protocol will be incorporated into the STCs, as Attachment K, and once incorporated, may be altered only with CMS approval. After approval of the Implementation Plan Protocol, FFP will be available prospectively, not retrospectively. Failure to submit an Implementation Plan Protocol will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the OUD/SUD program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral.

At a minimum, the SUD Implementation Plan Protocol will describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of the SUD component of this demonstration program:

i. **Access to Critical Levels of Care for OUD and other SUDs:** Service delivery for new benefits, including residential treatment and withdrawal management, within 12-24 months of OUD/SUD program demonstration approval;

ii. **Use of Evidence-based SUD-specific Patient Placement Criteria:** Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other comparable assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of OUD/SUD program demonstration approval;

iii. **Patient Placement:** Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of SUD program demonstration approval;

iv. **Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities:** Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in Washington Administrative Code regulations: WAC

388-877.[6] The state will establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other comparable, nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of OUD/SUD program demonstration approval;

v. **Standards of Care:** Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of SUD program demonstration approval;

vi. **Standards of Care:** Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of SUD program demonstration approval;

vii. **Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for OUD:** An assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of SUD program demonstration approval;

viii. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD:** Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

ix. **SUD Health IT Plan:** Implementation of the milestones and metrics as detailed in STC 83(f) and Attachment M; and

x. **Improved Care Coordination and Transitions between levels of care:** Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports, including tribal services and supports, following stays in these facilities within 24 months of SUD program demonstration approval.

b. **SUD Monitoring Protocol.** The state must submit a SUD Monitoring Protocol within 150 calendar days after approval of SUD program under this demonstration. The SUD Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment L. At a minimum, the SUD Monitoring Plan Protocol will include reporting relevant to each of the program implementation areas listed in STC 83(a). The protocol will also describe the

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[6] http://apps.leg.wa.gov/wac/default.aspx?cite=388-877

data collection, reporting and analytic methodologies for performance measures identified by the state and CMS for inclusion. The SUD Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in STC 77 of the demonstration. In addition, for each performance measure, the SUD Monitoring Protocol will identify a baseline, a target to be achieved by the end of the demonstration and an annual goal for closing the gap between baseline and target expressed as percentage points.

Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings. CMS will closely monitor demonstration spending on services in IMDs to ensure adherence to budget neutrality requirements. Progress on the performance measures identified in the Monitoring Protocol will be reported via the quarterly and annual monitoring reports.

c. **Mid-Point Assessment.** The state must conduct an independent mid-point assessment (December 31, 2020 of the SUD component of this demonstration. The assessor must collaborate with tribes and key stakeholders, including representatives of MCOs, SUD treatment providers, beneficiaries, and other key partners in the design, planning and conducting of the mid-point assessment. The assessment will include an examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Protocol, and toward closing the gap between baseline and target each year in performance measures as approved in the SUD Monitoring Protocol. The assessment will also include a determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date, and a determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and about the risk of possibly missing those milestones and performance targets. The mid-point assessment will also provide a status update of budget neutrality requirements. For each milestone or measure target at medium to high risk of not being met, the assessor will provide, for consideration by the state, recommendations for adjustments in the state's implementation plan or to pertinent factors that the state can influence that will support improvement. The assessor will provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. A copy of the report will be provided to CMS. CMS will be briefed on the report.

For milestones and measure targets at medium to high risk of not being achieved, the state will submit to CMS modifications to the SUD Implementation Protocol and SUD Monitoring Plan Protocols for ameliorating these risks subject to CMS approval.

d. **SUD Evaluation.** The OUD/SUD Evaluation will be subject to the same requirements as the overall demonstration evaluation, as listed in sections IX (General Reporting Requirements) and Section XV (Evaluation of the Demonstration of the STCs).

e. **SUD Evaluation Design.** The state must submit, for CMS comment and approval, a revision to the Evaluation Design to include the SUD program with implementation timeline, no later than one hundred eighty (180) days after the effective date of these amended STCs. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if

applicable. The state must use an independent evaluator to develop the draft Evaluation Design.

i. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Quarterly and Annual Reports, including any required Rapid Cycle Assessments specified in these STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

ii. **Evaluation Questions and Hypotheses Specific to OUD/SUD Program.** The evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

f. **SUD Health Information Technology (Health IT).** The state will provide CMS with an assurance that it has a sufficient health IT infrastructure/"ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration—or it will submit to CMS a plan to develop the infrastructure/capabilities. This "SUD Health IT Plan," or assurance, will be included as a section of the state's "Implementation Plan Protocol" (see STC 83(a)) to be approved by CMS. The SUD Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan will also be used to identify areas of SUD health IT ecosystem improvement.

i. The SUD Health IT section of the Implementation plan will include implementation milestones and dates for achieving them (see Attachment K).

ii. The SUD Health IT Plan must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) "Health IT" Plan.

iii. The SUD Health IT Plan will describe the state's goals, each DY, to enhance the state's prescription drug monitoring program's (PDMP)[7]

[7] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.

iv. The SUD Health IT Plan will address how the state's PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[8] This will also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan will describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.

v. The SUD Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the SUD Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

vi. The SUD Health IT Plan will describe how the activities described in (a) through (e) above will support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.[9]

vii. In developing the Health IT Plan, states should use the following resources.

1. States may use resources at Health IT.Gov (https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/) in "Section 4: Opioid Epidemic and Health IT."

2. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

3. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP plans and, more generally, to meet the goals of the demonstration.

g. The state will include in its Monitoring Plan (see STC 83(b)) an approach to monitoring its SUD Health IT Plan which will include performance metrics provided by CMS or State defined metrics to be approved in advance by CMS.

h. The state will monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Reports (see STC 79).

[8] *Ibid*.

[9] Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

i. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

    1. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.

    2. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.

XI. SERIOUS MENTAL ILLNESS PROGRAM AND BENEFITS

84. SMI Program Benefits. Under this demonstration, beneficiaries will have access to, the full range of otherwise covered Medicaid services, including evidence-based SMI treatment services. These SMI services will range in intensity from short-term acute care in inpatient settings for SMI, to ongoing chronic care for such conditions in cost-effective community-based settings. The state will work to improve care coordination and care for co-occurring physical and behavioral health conditions. The state must achieve a statewide average length of stay of no more than 30 days in IMD treatment settings for beneficiaries receiving coverage through this demonstration's SMI Program, to be monitored pursuant to the SMI Monitoring Plan as outlined in STCs 85-88 below.

85. SMI Implementation Plan.

a. The state must submit the SMI Implementation Plan within 90 calendar days after approval of the demonstration for CMS review and comment. If applicable, the state must submit a revised SMI Implementation Plan within sixty (60) calendar days after receipt of CMS's comments. The state may not claim FFP for services provided to beneficiaries residing in IMDs primarily to receive treatment for SMI under expenditure authority #11 until CMS has approved the SMI implementation plan and the SMI financing plan described in STC 85(e). After approval of the required implementation plan and financing plan, FFP will be available prospectively, but not retrospectively.

b. Once approved, the SMI Implementation Plan will be incorporated into the STCs as Attachment O, and once incorporated, may be altered only with CMS approval. Failure to submit an SMI Implementation Plan, within 90 calendar days after approval of the demonstration, will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 10

c. At a minimum, the SMI Implementation Plan must describe the strategic approach, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:

i. **Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.**

A. Participating hospitals must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and either: a) be certified by the state agency as being in compliance with those conditions through a state agency survey, or b) have deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.

B. Participating residential treatment providers must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD.

C. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements as well as a national accrediting entity's accreditation requirements;

D. Use of a utilization review entity (for example, a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;

E. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet applicable federal program integrity requirements, and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidation of existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);

F. Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen beneficiaries for co-morbid physical health conditions and SUDs and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings

(e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).

ii. **Improving Care Coordination and Transitions to Community-Based Care.**

A. Implementation of a process to ensure that psychiatric hospitals and residential treatment facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services, including requirements that facilitate participation of community-based providers in transition efforts (e.g., by allowing beneficiaries to receive initial services from a community-based provider while the beneficiary is still residing in these settings and/or by engaging peer support specialists to help beneficiaries make connections with available community-based providers and, where applicable, make plans for employment);

B. Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who may experience homelessness upon discharge or who would be discharged to unsuitable or unstable housing with community providers that coordinate housing services, where available;

C. Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to help ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and, as appropriate, by contacting the community-based provider they were referred to;

D. Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI or SED (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers);

E. Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED.

iii. **Increasing Access to Continuum of Care Including Crisis Stabilization Services.**

A. Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability;

B. Commitment to implementation of the SMI/SED financing plan described in STC 85(e);

C. Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible;

D. Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association (e.g., LOCUS or CASII) to determine appropriate level of care and length of stay.

iv. **Earlier Identification and Engagement in Treatment and Increased Integration**

A. Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI/SED in treatment sooner, including through supported employment and supported education programs;

B. Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI/SED conditions sooner and improve awareness of and linkages to specialty treatment providers;

C. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

d. **SMI Health Information Technology (Health IT) Plan.** The Health IT plan is intended to apply only to those State Health IT functionalities impacting beneficiaries within this demonstration and providers directly funded by this demonstration. The state will provide CMS with an assurance that it has a sufficient health IT infrastructure/ "ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If the state is unable to provide such an assurance, it will submit to CMS a Health IT Plan, to be included as a section of the applicable Implementation Plan (see STC 85), to develop the infrastructure/capabilities of the state's health IT infrastructure.

The Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SMI goals of the demonstration. The plan(s) will also be used to identify areas of health IT ecosystem improvement. The Plan must include implementation milestones and projected dates for achieving them (see Attachment [X]), and must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) IT Health Plan.

The state will include in its Monitoring Plans (see STC 86) an approach to monitoring its SMI Health IT Plan which will include performance metrics to be approved in advance by CMS.

The state will monitor progress, each DY, on the implementation of its SMI Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Report (see STC 79).

As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SMI Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.

Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.

Components of the Health IT Plan include:

i. The Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of *SED/SMI* care delivery. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

ii. The Health IT Plan will describe the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: 1) Referrals, 2) Electronic care plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7) Identity management.

iii. In developing the Health IT Plan, states should use the following resources:

A. States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and *"Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information-exchange/)*.

B. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

C. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

e. **SMI Financing Plan.** As part of the SMI implementation plan referred to in STC 85(c), the state must submit, within 90 calendar days after approval of the demonstration, a financing plan for approval by CMS. Once approved, the Financing Plan will be incorporated into the STCs as part of the implementation plan in Attachment O and, once incorporated, may only be altered with CMS approval. Failure to submit an SMI Financing Plan within 90 days of approval of the demonstration will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be

grounds for termination or suspension of the SMI program under this demonstration. Components of the financing plan must include:

i. A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers; and

ii. A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings;

iii. A plan to ensure the on-going maintenance of effort (MOE) on funding outpatient community-based services to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services.

86. SMI Monitoring Protocol(s). The state must submit a Monitoring Protocol for the SMI program authorized by this demonstration within 150 calendar days after approval of the implementation plan. The Monitoring Protocol Template must be developed in cooperation with CMS and is subject to CMS approval. The state must submit a revised Monitoring Protocol within sixty (60) calendar days after receipt of CMS' comments, if any. Once approved, the SMI Monitoring Protocol will be incorporated into the STCs, as Attachment O. Progress on the performance measures identified in the Monitoring Protocol must be reported via the quarterly and annual monitoring reports (as required by STC 77 and 79, respectively). Components of the Monitoring Protocol must include:

a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in STC 85(c), information relevant to the state's SMI financing plan described in Attachment C, and information relevant to the state's Health IT plans described in STC 85(d);

b. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section IX of the demonstration; and

c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

87. Monitoring, Reporting, and Evaluation. The SMI Evaluation will be subject to the same requirements as the overall demonstration evaluation, as described in Sections IX (Monitoring and Reporting Requirements) and XV (Evaluation of the Demonstration) of these STCs. The state will follow CMS guidelines to ensure the evaluation design is amended to provide a rigorous evaluation of the SMI component of the demonstration.

88. Availability of FFP for the SMI Services Under Expenditure Authority #11. Federal Financial Participation is only available for services provided to beneficiaries during short term stays for acute care in IMDs. The state may claim FFP for services furnished to beneficiaries during IMD stays of up to 60

days, as long as the state shows at its midpoint assessment that it is meeting the requirement of a 30 day or less average length of stay (ALOS). Demonstration services furnished to beneficiaries whose stays in IMDs exceed 60 days are not eligible for FFP under this demonstration. If the state cannot show that it is meeting the 30 day or less ALOS requirement within one standard deviation at the mid-point assessment, the state may only claim FFP for stays up to 45 days until such time that the state can demonstrate that it is meeting the 30 day or less ALOS requirement. The state will ensure that medically necessary services are provided to beneficiaries that have stays in excess of 60 days—or 45 days, as relevant.

89. **SMI Mid-Point Assessment.** The state must conduct an independent mid-point assessment by September 30, 2023, whether or not the demonstration is renewed. If the demonstration is not renewed or is renewed for a term that ends on or before September 30, 2023, then this mid-point assessment must address the entire term for which the SMI Program under the demonstration was authorized. In the design, planning and conduct of the mid-point assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of MCOs, SMI providers, and beneficiaries.

The state must require that the assessor provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS no later than 60 days after September 30, 2023. The state must brief CMS on the report.

For milestones and measure targets identified by the independent assessor as at medium- to high-risk of not being achieved, the state must submit to CMS proposed modifications to the SMI Implementation Plan, the SMI Financing Plan, and the SMI Monitoring Protocol, as appropriate, for mitigating these risks. Modifications to the applicable Implementation Plan, Financing Plan, and/or Monitoring Protocol are subject to CMS approval.

Elements of the mid-point assessment must include at least:

a. An examination of progress toward meeting each milestone and timeframe approved in the SMI Implementation Plan, the SMI Financing Plan, and toward meeting the targets for performance measures as approved in the SMI Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;

c. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

d. For milestones or targets identified by the independent assessor as at medium- to high-risk of not being met, recommendations for adjustments in the state's SMI Implementation Plan and/or SMI Financing Plan or to other pertinent factors that the state can influence that will support improvement; and

e. An assessment of whether the state is on track to meet the budget neutrality requirements in these STCs.

90. **Unallowable Expenditures Under the SMI IMD Expenditure Authority.** In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

   a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

   b. Costs for services furnished to beneficiaries who are residents in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.

   c. Costs for services furnished to beneficiaries who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.

   d. Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the "inpatient psychiatric services for individuals under age 21" benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G.

XII. DESIGNATED STATE HEALTH PROGRAMS

91. **Designated State Health Programs**. Funding of DSHPs is to ensure the continuation of vital health care and provider support programs while the state devotes increased state resources during the period of this demonstration for DSRIP initiatives that will positively impact the Medicaid program, and result in savings to the federal government that will exceed the DSHP funding. Expenditures are claimed in accordance with CMS-approved claiming and documentation protocols to be specified in the DSHP Claiming Protocol (Attachment B). In order to ensure achievement of the demonstration's goals, the total annual expenditure authority is subject to the requirements of STC 93. CMS has approved expenditure authority for DSHP with the agreement that this one-time investment of DSHP funding would be phased down over the demonstration period. FFP may be claimed for expenditures made for the DSHPs enumerated in Table 4 beginning January 9, 2017 through December 31, 2022 in accordance with an approved DSHP claiming protocol as described in STC 93.

Table 4: Approved DSHP through December 31, 2022

Agency	Program
HCA	Kidney Disease Program (KDP)
ALTSA	Nursing Homes, Community Residential, and Homecare
ALTSA	State Family Caregiver Support
ALTSA	Senior Citizen's Services Act (SCSA)
ALTSA	Office of the Deaf and Hard of Hearing
DDA	Employment & Day and Other Community Services
DDA	Community Residential & Homecare
BHA	Crisis and other non-Medicaid services
BHA	Program of Assertive Community Treatment (PACT)
BHSIA	Offender Re-entry Community Safety Program
BHA	Spokane Acute Care Diversion
BHA	Psychological Evaluations

BHA	Outpatient and Support Services
BHA	Residential Services
BHA	Parent in Reunification
BHA	Problem Gambling Services
DOC	Mental health transition services
DOC	ORCS (Offender Reentry Community Safety)
DOC	Medications for Releasing Offenders
DOC	Community-supervised violator medical treatment
DOH	Tobacco and Marijuana Prevention and Education
DOH	Family Planning Non-Title X
DOH	HIV/AIDS Prevention
Other	Health Professional Loan Repayments (WA Student Achievement Council)
Other	Street Youth Service (Department of Commerce)
Other	"County Levy" Health Programs (see Attachment B)

92. **Limit of FFP for DSHP.** The amount of FFP that the state may receive for DSHP may not exceed the limits described below. If upon review, the amount of FFP received by the state is found to have exceeded the applicable limit, the excess must be returned to CMS as a negative adjustment to claimed expenditures on the CMS-64.

   a. The state may claim up to $748,431,326 million TC for DSHP expenditures incurred through December 31, 2022.

   b. The state may continue receiving FFP each DY for the difference between the Maximum Allowable DSHP and the Maximum Allowable DSRIP spending (see "Difference DSHP & DSRIP" in Table 5 below). For the differences listed each DY, as long as the state has another allowable (non-DSHP) source of non-federal share, the state may claim FFP for those additional expenditures.

Table 5: DSHP Annual Limits: Total Computable and At-Risk Percentages

	DY1 01/01/17-12/31/2017	**DY2 01/01/18-12/31/18**	**DY3 01/01/19-12/31/19**	**DY4 01/01/20-12/31/20**	**DY5 01/01/21-12/31/21**	**DY6 01/01/22-12/31/22**
Maximum* Allowable DSHP	$193,000,000	$182,000,000	$117,008,060	$76,543,710	$98,879,556	$81,000,000
Maximum * Allowable DSRIP	$242,100,000	$240,600,000	$187,180,434	$151,510,022	$71,250,000	$101,679,588
Difference * DSHP & DSRIP	$49,100,000	$58,600,000	$70,172,374	$74,966,312	($27,629,556)	$20,679,588

*These amounts reflect actual spending in DY1 – DY5.

93. **DSHP Claiming Protocol.** The state will develop a CMS-approved DSHP claiming protocol with which the state will be required to comply in order to draw down DSHP funds for the demonstration and submit the protocol no later than 60 calendar days after the demonstration approval date. State expenditures for the DSHP listed above must be documented in accordance with the protocols. The state is not eligible to receive FFP until an applicable protocol is approved by CMS. Once approved by CMS, the protocol becomes Attachment B of these STCs, and thereafter may be changed or updated with CMS approval. Changes and updates are to be applied prospectively. For each DSHP, the protocol must contain the following information:

    a. The sources of non-federal share revenue, full expenditures and rates.

    b. Procedures to ensure that FFP is not provided for any of the following types of expenditures:

        i. Grant funding to test new models of care

        ii. Construction costs (bricks and mortar)

        iii. Room and board expenditures

        iv. Animal shelters and vaccines

        v. School based programs for children

        vi. Unspecified projects

        vii. Debt relief and restructuring

        viii. Costs to close facilities

        ix. HIT/HIE expenditures

        x. Services provided to undocumented individuals

        xi. Sheltered workshops

        xii. Research expenditures

        xiii. Rent and/or Utility Subsidies that are normally funded by the United States Department of Housing and Urban Development and United States Department of Agriculture (USDA) or other state/local rental assistance programs

        xiv. Prisons, correctional facilities, services for incarcerated individuals and services provided to individuals who are civilly committed and unable to leave

xv. Revolving capital fund

xvi. Expenditures made to meet a maintenance of effort requirement for any federal grant program

xvii. Administrative costs

xviii. Cost of services for which payment was made by Medicaid or CHIP (including from managed care plans)

xix. Cost of services for which payment was made by Medicare or Medicare Advantage

xx. Funds from other federal grants

xxi. Needle-exchange programs

xxii. Abortions that would not be allowable if furnished under Medicaid or CHIP

xxiii. Costs associated with funding federal matching requirements.

To assure DSHP expenditures from responsible entities of "County Levy" Health Programs (Attachment B) do not include coverage of services to undocumented individuals, the state will reduce each reported "County Levy" program costs by 3.6% unless a more detailed accounting of actual costs for these individuals is provided that is acceptable to CMS.

94. DSHP Claiming Process. Documentation of each designated state health program's expenditures, as specified in the DSHP Protocol, must be clearly outlined in the state's supporting work papers and be made available to CMS. In order to assure CMS that Medicaid funds are used for allowable expenditures, the state will be required to supply summary DSHP expenditure information with the CMS-64 by account coding at the same level as information is currently provided to support the CMS-64.

Federal funds must be claimed within two years following the calendar quarter in which the state disburses expenditures for the DSHP. Federal funds are not available for expenditures disbursed before January 1, 2017, or after December 31, 2022.

Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. To the extent that federal funds from any federal programs are received for the DSHP listed above, they shall not be used as a source of non-federal share. The administrative costs associated with the DSHP listed above, and any others subsequently added by amendment to the demonstration, shall not be included in any way as demonstration and/or other Medicaid expenditures. Any changes to the DSHP listed above shall be considered an amendment to the demonstration and processed in accordance with STC 5 in Section III.

95. **Reporting DSHP Payments**. The state will report all expenditures for DSHP payments to the programs listed above on the forms CMS-64.9 Waiver and/or 64.9P Waiver under the waiver name "DSHP" as well as on the appropriate forms.

XIII. GENERAL FINANCIAL REQUIREMENTS

96. **Allowable Expenditures**. This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

97. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

98. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

    a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

    b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

99. **State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

100. **Financial Integrity for Managed Care Delivery Systems**. As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

101. **Requirements for Health Care-Related Taxes and Provider Donations.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

102. **State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 10. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

103. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section XIV:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

104. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

105. Medicaid Expenditure Groups. Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 6: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
Non-Expansion Adults	Main	X		X	Expenditures authorized under the demonstration for Medicaid beneficiaries specified in STC 16 (excluding SUD and SMI IMD expenditures).
DSHP	Main			X	Expenditures authorized under the demonstration for the Designated State Health Programs (DSHP).
DSRIP	Main			X	Expenditures authorized under the demonstration for delivery system transformation.
MAC and TSOA Not Eligible	Main			X	Expenditures authorized under the demonstration for beneficiaries receiving presumptive eligibility for TSOA and MAC services and determined ineligible.
MAC and TSOA	Hypo 1		X	X	Expenditures authorized under the demonstration for beneficiaries receiving MAC and TSOA services. Excludes expenditures for individuals who received MAC and TSOA services during the presumptive eligibility period and determined ineligible.
HepC Rx	Hypo 2		X	X	Expenditures for prescription drugs (“HepC Rx”) related to a diagnosis of Hepatitis C for individuals affected by or eligible under the demonstration.
Foundational Community Supports 1 & 2	Hypo 3		X	X	One-time community transition services to individuals moving from institutional to community settings and those at

Table 6: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
					imminent risk of institutional placement, and HCBS that could be provided to the individual under a 1915(c) waiver or 1915(i) SPA.
SUD IMD: Medicaid Disabled	Hypo 4	X		X	Expenditures for costs of SUD-related medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible individuals during a month in an IMD, for Medicaid disabled individuals.
SUD IMD: Medicaid Non-Disabled	Hypo 4	X		X	Expenditures for costs of SUD-related medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible individuals during a month in an IMD, for Medicaid non-disabled individuals.
SUD IMD: Newly Eligible	Hypo 4	X		X	Expenditures for costs of SUD-related medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible individuals during a month in an IMD, for newly eligible individuals.
SUD IMD: American Indian/Alaskan Native	Hypo 4	X		X	Expenditures for costs of SUD-related medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible individuals during a month in an IMD,

Table 6: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
					for American Indian/Alaskan Native individuals.
SMI IMD: Medicaid Disabled	Hypo 5	X		X	Expenditures for costs of SMI-related medical assistance that could be covered, were it not for the statutory IMD payment exclusion, provided to otherwise eligible individuals during a month in an IMD pursuant to the SMI Program under this demonstration, for Medicaid disabled individuals.
SMI IMD: Medicaid Non-Disabled	Hypo 5	X		X	Expenditures for costs of SMI-related medical assistance that could be covered, were it not for the statutory IMD payment exclusion, provided to otherwise eligible individuals during a month in an IMD pursuant to the SMI Program under this demonstration, for Medicaid non-disabled individuals.
SMI IMD: Newly Eligible	Hypo 5	X		X	Expenditures for costs of SMI-related medical assistance that could be covered, were it not for the statutory IMD payment exclusion, provided to otherwise eligible individuals during a month in an IMD pursuant to the SMI Program under this demonstration, for newly eligible individuals.
SMI IMD: American Indian/Alaskan Native	Hypo 5	X		X	Expenditures for costs of SMI-related medical assistance that could be covered, were it not for the statutory IMD payment exclusion, provided to otherwise eligible individuals during a month in an IMD pursuant to the SMI

Table 6: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
					Program under this demonstration, for American Indian/Alaskan Native individuals.
CE Children Non-Disabled	Hypo 6	X		X	Expenditures for continued benefits for non-disabled children who have been determined eligible for the continuous eligibility period who would otherwise lose coverage during an eligibility determination
CE Children Disabled	Hypo 6	X		X	Expenditures for continued benefits for disabled children who have been determined eligible for the continuous eligibility period who would otherwise lose coverage during an eligibility determination
ADM	N/A				All additional administrative costs that are directly attributable to the demonstration and not described elsewhere and are not subject to budget neutrality.

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

106. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00304/0). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. **Pharmacy Rebates.** Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the state must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The state must have a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in section XIV, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. **Member Months**. As part of the Quarterly and Annual Monitoring Reports described in section IX, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 7: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
Non-Expansion Adults	Report all medical assistance expenditures authorized under the demonstration for Medicaid beneficiaries specified in STC 16 (excluding SUD and SMI IMD expenditures).		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/09/17	06/30/23
DSHP	Report all expenditures authorized under the demonstration for the Designated State Health Programs (DSHP).		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	N	1/09/17	12/31/22
DSRIP	Report all expenditures authorized under the demonstration for delivery system transformation.		Follow standard CMS 64.10 Category of Service Definitions	Date of service/Date of payment	ADM	N	1/09/17	12/31/22
MAC and TSOA Not Eligible	Report all expenditures authorized under the demonstration for beneficiaries receiving presumptive eligibility for TSOA and MAC services and determined ineligible.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	1/09/17	06/30/23
MAC and TSOA	Expenditures authorized under the demonstration for beneficiaries receiving	Excludes expenditures for individuals who received MAC and TSOA services	Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	1/09/17	06/30/23

	MAC and TSOA services.	during the presumptive eligibility period and determined ineligible.						
HepC Rx	Report all expenditures for prescription drugs (“HepC Rx”) related to a diagnosis of Hepatitis C for individuals affected by or eligible under the demonstration.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	1/09/17	06/30/23
Foundational Community Supports 1 & 2	Report all expenditures for one-time community transition services to individuals moving from institutional to community settings and those at imminent risk of institutional placement and expenditures for HCBS that could be provided to the individual under a 1915(c) waiver or 1915(i) SPA.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	1/09/17	06/30/23
SUD IMD: Medicaid Disabled	Report all expenditures for costs of SUD-related medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible individuals during a month in an		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	07/01/18	06/30/23

	IMD, for Medicaid disabled individuals.							
SUD IMD: Medicaid Non-Disabled	Report all expenditures for costs of SUD-related medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible individuals during a month in an IMD, for Medicaid non-disabled individuals.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	07/01/18	06/30/23
SUD IMD: Newly Eligible	Report all expenditures for costs of SUD-related medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible individuals during a month in an IMD, for newly eligible individuals.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	07/01/18	06/30/23
SUD IMD: American Indian/Alaskan Native	Report all expenditures for costs of SUD-related medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible individuals		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	07/01/18	06/30/23

	during a month in an IMD, for American Indian/Alaskan Native individuals.							
SMI IMD: Medicaid Disabled	Report all expenditures for costs of SMI-related medical assistance that could be covered, were it not for the statutory IMD payment exclusion, provided to otherwise eligible individuals during a month in an IMD pursuant to the SMI Program under this demonstration, for Medicaid disabled individuals.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	11/06/20	06/30/23
SMI IMD: Medicaid Non-Disabled	Report all expenditures for costs of SMI-related medical assistance that could be covered, were it not for the statutory IMD payment exclusion, provided to otherwise eligible individuals during a month in an IMD pursuant to the SMI Program under this demonstration, for Medicaid non-disabled individuals.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	11/06/20	06/30/23

SMI IMD: Newly Eligible	Report all expenditures for costs of SMI-related medical assistance that could be covered, were it not for the statutory IMD payment exclusion, provided to otherwise eligible individuals during a month in an IMD pursuant to the SMI Program under this demonstration, for newly eligible individuals.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	11/06/20	06/30/23
SMI IMD: American Indian/Alaskan Native	Report all expenditures for costs of SMI-related medical assistance that could be covered, were it not for the statutory IMD payment exclusion, provided to otherwise eligible individuals during a month in an IMD pursuant to the SMI Program under this demonstration, for American Indian/Alaskan Native individuals.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	11/06/20	06/30/23
CE Children Non-Disabled	Expenditures for continued benefits for non-disabled children who have been determined eligible for the continuous eligibility period who would otherwise lose		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	04/14/2023	06/30/23

	coverage during an eligibility determination							
CE Children Disabled	Expenditures for continued benefits for disabled children who have been determined eligible for the continuous eligibility period who would otherwise lose coverage during an eligibility determination		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	04/14/2023	06/30/23
ADM	Report all additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality		Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	01/09/17	06/30/23

ADM – administration; DY – demonstration year; MAP – medical assistance payments; MEG – Medicaid expenditure group;

107. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the table below.

Table 8: Demonstration Years		
Demonstration Year 1	January 9, 2017 to December 31, 2017	12 months
Demonstration Year 2	January 1, 2018 to December 31, 2018	12 months
Demonstration Year 3	January 1, 2019 to December 31, 2019	12 months
Demonstration Year 4	January 1, 2020 to December 31, 2020	12 months
Demonstration Year 5	January 1, 2021 to December 31, 2021	12 months
Demonstration Year 6	January 1, 2022 to December 31, 2022	12 months
Demonstration Year 7	January 1, 2023 to June 30, 2023	6 months

108. **Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing the demonstration's actual expenditures to the budget neutrality expenditure limits described in section XIV. CMS will provide technical assistance, upon request.

109. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

110. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:

    a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

111. **Budget Neutrality Mid-Course Correction Adjustment Request**. No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 111.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 5. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes**. Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data.

Examples of the types of mid-course adjustments that CMS might approve include the following:

i. Provider rate increases that are anticipated to further strengthen access to care;

ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

vi. High cost innovative medical treatments that states are required to cover; or,

vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

XIV. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

112. Limit on Title XIX Funding. The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Main Budget Neutrality Test and Hypothetical Budget Neutrality Tests, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C

CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

113. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 6, Master MEG Chart and Table 7, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

114. Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

115. Main Budget Neutrality Test. The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

Table 9: Main Budget Neutrality Test										
MEG	PC or Agg*	WOW Only, WW Only, or BOTH	Trend Rate	DY 1	DY 2	DY 3	DY 4	DY 5	DY 6	DY7
Non-Expansion Adults Only	PC	Both	4.0%	$1,012.82	$1,046.24	$694.38	$722.16	$751.05	$751.05	$751.05
DSHP	Agg	WW Only	N/A	$193,000,000	$182,000,000	$117,008,060	$76,543,710	$98,879,556	$81,000,000	$0
DSRIP	Agg	WW Only	N/A	$242,100,000	$240,600,000	$187,180,434	$151,510,022	$71,250,000	$101,679,588	$0^
MAC and TSOA Not Eligible	Agg	WW Only	N/A	The state must have savings to offset these expenditures.						

*PC = Per Capita, Agg = Aggregate
^Incentive payments may be made in DY 7 for prior periods of performance and administrative activities to close out the DSRIP program. Total DSRIP payments for the section 1115 demonstration may not exceed total authorized limits.

116. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and

CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

117. **Hypothetical Budget Neutrality Test 1: MAC and TSOA**. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 10: Hypothetical Budget Neutrality Test 1

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 1	DY 2	DY 3	DY 4	DY 5	DY 6	DY 7
MAC and TSOA	Agg	Both	N/A	$200,000	$3,800,000	$11,300,000	$21,086,370	$49,451,000	$47,453,000	$23,726,500

118. **Hypothetical Budget Neutrality Test 2: HepC Rx .** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 2 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 11: Hypothetical Budget Neutrality Test 2										
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 1**	**DY 2**	**DY 3**	**DY 4**	**DY 5**	**DY 6**	**DY 7**
HepC Rx	Agg	Both	N/A	$131,821,200	$136,171,300	$140,664,952	$145,306,896	$132,792,053	$17,309,970	$8,654,985

119. Hypothetical Budget Neutrality Test 3: Foundational Community Supports 1 & 2. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 3. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 3 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 12: Hypothetical Budget Neutrality Test 3										
MEG	**PC or Agg**	**WOW Only, WW Only, or**	**Trend Rate**	**DY 1**	**DY 2**	**DY 3**	**DY 4**	**DY 5**	**DY 6**	**DY 7**
Foundational Community Supports 1 & 2	Agg	Both	N/A	$14,992,000	$10,264,593	$27,346,190	$39,155,919	$42,494,053	$22,961,407	$11,480,704

120. Hypothetical Budget Neutrality Test 4: SUD Expenditures. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 4. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against

this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 4 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 13: Hypothetical Budget Neutrality Test 4										
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 1**	**DY 2**	**DY 3**	**DY 4**	**DY 5**	**DY 6**	**DY 7**
SUD Medicaid Disabled	PC	Both	3.4%	N/A	$1,084	$1,142	$1,149	$1,189	$1,229	$1,229
SUD Medicaid Non-Disabled	PC	Both	3.6%	N/A	$292	$300	$311	$322	$334	$334
SUD Newly Eligible	PC	Both	4.7%	N/A	$462	$478	$500	$524	$549	$549
SUD American Indian/ Alaskan Native	PC	Both	3.1%	N/A	$3,009	$3,079	$3,174	$3,273	$3,374	$3,374

121. **Hypothetical Budget Neutrality Test 5: SMI Expenditures.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 5. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 5 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 14: Hypothetical Budget Neutrality Test 5											
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 1**	**DY 2**	**DY 3**	**DY 4**	**DY 5**	**DY 6**	**DY 7**
SMI Medicaid Disabled	PC	Both	6.3%	N/A	N/A	N/A	$1,138.75	$1,192.14	$1,267.24	$1,267.24
SMI Medicaid Non-Disabled	PC	Both	6.9%	N/A	N/A	N/A	$262.51	$275.98	$295.02	$295.02
SMI Newly Eligible	PC	Both	6.1%	N/A	N/A	N/A	$470.60	$491.97	$521.98	$521.98
SMI American Indian/ Alaskan Native FFS	PC	Both	6.3%	N/A	N/A	N/A	$14,008.47	$14,665.29	$15,589.20	$15,589.20

122. Hypothetical Budget Neutrality Test 6: Continuous Eligibility Expenditures. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 6. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 5 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 15: Hypothetical Budget Neutrality Test 6										
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 1**	**DY 2**	**DY 3**	**DY 4**	**DY 5**	**DY 6**	**DY 7**
CE Children Non-Disabled	PC	Both	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$320
CE Children Disabled	PC	Both	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$2,697

123. Composite Federal Share. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

124. Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the demonstration period, which extends from 01/09/2017 to 6/30/2023. If at the end of the demonstration approval period the Main Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

125. Corrective Action Plan. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 15: Budget Neutrality Test Corrective Action Plan Calculation

Demonstration Year	Cumulative Target Definition	Percentage
DY 1	Cumulative budget neutrality limit plus:	2.0 percent
DY 1 through DY 2	Cumulative budget neutrality limit plus:	1.5 percent
DY 1 through DY 3	Cumulative budget neutrality limit plus:	1.0 percent
DY 1 through DY 4	Cumulative budget neutrality limit plus:	0.0 percent
DY 1 through DY 5	Cumulative budget neutrality limit plus:	0.0 percent
DY 1 through DY 6	Cumulative budget neutrality limit plus:	0.0 percent

XV. EVALUATION OF THE DEMONSTRATION

126. Submission of a Draft Evaluation Design Update. The state must submit to CMS for approval a draft evaluation design no later than 180 calendar days after CMS's approval date of the demonstration, and a revised draft evaluation design must be submitted within 180 calendar days after approval of the amendment to incorporate the additional policies in evaluation plans. The draft evaluation design must include a discussion of the goals, objectives, and evaluation questions specific to the entire delivery system reform demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population, specific testable hypothesis, including those that focus on target populations for the demonstration and more generally on beneficiaries, providers, plans, market areas and public expenditures. The draft design should be described in sufficient detail to determine that it is scientifically rigorous. The data strategy must be thoroughly documented. It must discuss the data sources, including the use of Medicaid encounter data, and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring within the state (i.e. SIM grant). However, it is understood that the transformation initiatives under the demonstration inherently build upon the State Health Care Innovation Plan and other ongoing transformation efforts in Washington, and the summative evaluation design will reflect this. The state commits to the development of a draft evaluation design that directly reflects the demonstration domains of focus, and will ensure separate evaluations of federally funded efforts. The draft design must describe the state's process to select an outside contractor for the evaluation.

The design should describe how the evaluation and reporting will develop and be maintained to assure its scientific rigor and completion. In summary, the demonstration evaluation will meet all standards of leading academic institutions and academic journal peer review, as appropriate for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings. Among the characteristics of rigor that will be met are the use of best available data; controls for and reporting of the limitations of data and their effects on results; and the generalizability of results. Information from the external quality review organization (EQRO) may be considered for the purposes of evaluation, as appropriate.

The state must require an independent entity to conduct the evaluation. The evaluation design must describe the state's process to contract with an independent evaluator, including a description of the qualifications the entity must possess, how the state will ensure no conflict of interest, and budget for evaluation activities.

127. Demonstration Hypotheses. The state will test the following hypotheses in its evaluation of the demonstration.

a. Whether community-based collaborations that define community health needs can (1) support redesigned care delivery, (2) expand health system capacity, and (3)

improve individual and population health outcomes - resulting in a reduction in the use of avoidable intensive services, a reduction in use of intensive service settings, bringing spending growth below national trends, and accelerating value-based payment reform.

b. Whether providing limited scope LTSS to individuals “at risk” for Medicaid and to Medicaid beneficiaries who are not currently receiving Medicaid-funded LTSS will avoid or delay eligibility for and use of full Medicaid LTSS benefits while preserving quality of life for beneficiaries and reducing costs for the state and federal government.

c. Whether the provision of foundational community supports - supportive housing and supported employment - will improve health outcomes and reduce costs for a targeted subset of the Medicaid population.

d. Whether federal funding of DSHPs enabled the state to leverage Medicaid spending to support delivery system reforms that resulted in higher quality care and in long term federal savings that exceeded the federal DSHP funding.

e. Whether authorizing expenditure authority for services in IMDs will increase Medicaid beneficiary access to inpatient and residential SUD treatment services as part of an effort to provide the full continuum of treatment services, and increase the likelihood that Medicaid beneficiaries receive SUD treatment in the setting most appropriate for their needs.

f. For the continuous eligibility policy, the state must evaluate the impact of the program on all relevant populations tailored for the specific time span of eligibility. For example, the state must evaluate how the continuous eligibility policy affects coverage, enrollment and churn (i.e., temporary loss of coverage in which beneficiaries are disenrolled but then re-enroll within 12 months) as well as population-specific appropriate measures of service utilization and health outcomes.

g. The state must also evaluate how changing the definition of transportation for beneficiaries who receive the MAC and TSOA LTSS benefit packages enables participants to gain access to community services, activities, and resources.

128. Domains of Focus. The Evaluation Design must, at a minimum, address the research questions listed below. For questions that cover broad subject areas, the state may propose a more narrow focus for the evaluation.

a. Was the DSRIP program effective in achieving the goals of better care for individuals (including access to care, quality of care, health outcomes), better health for the population, or lower cost through improvement through the implementation of transformation projects by community-based collaborations? To what degree can improvements be attributed to the activities undertaken under DSRIP?

b. To what extent has the DSRIP enhanced the state's health IT ecosystem to support delivery system and payment reform? Has it specifically enhanced these four key areas through ACHs and provider partners: governance, financing, policy/legal issues and business operations?

c. To what extent has the DSRIP program improved quality, efficiency and effectiveness of care processes through care delivery redesign, including bi-directional integration of behavioral, physical and SUD services, alignment of care coordination, and coordination between providers, including bi-directional integrated delivery of physical, behavioral health services, SUD services, and transitional care services, and alignment of care coordination and to serve the whole person?

d. What are the effects of modifying eligibility criteria and benefit packages for long-term services and supports?

e. What is the effectiveness of the providing foundational community supports, described in Section VII in terms of health, quality of life, and other benefits to the Medicaid program?

129. Evaluation Design Process: Addressing the research questions listed above will require a mix of quantitative and qualitative research methodologies. When developing the DSRIP Planning Protocol, the state should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design. From these, the state must select a preferred research plan for the applicable research question, and provide a rationale for its selection.

To the extent applicable, the following items must be specified for each design option that is proposed:

a. Quantitative or qualitative outcome measures;

b. Baseline and/or control comparisons;

c. Process and improvement outcome measures and specifications;

d. Data sources and collection frequency;

e. Robust sampling designs (e.g., controlled before-and-after studies, interrupted time series design, and comparison group analyses);

f. Cost estimates;

g. Timelines for deliverables.

130. Levels of Analysis: The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include

population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups. In its review of the draft evaluation plan, CMS reserves the right to request additional levels of analysis.

131. Final Evaluation Design and Implementation. CMS shall provide comments on the draft Evaluation Design within 60 calendar days of receipt, and the state shall submit a final Evaluation Design within 60 calendar days after receipt of CMS comments. The state shall implement the Evaluation Design and submit its progress in each of the quarterly and annual reports.

132. Evaluation Reports.

a. **Interim Evaluation Report.** The state must submit a Draft Interim Evaluation Report with any application to extend the demonstration or by no later than 12 months prior to the expiration of the demonstration if an extension is not being requested. The Interim Evaluation Report must capture findings to cover as many demonstration years as possible, after appropriately accommodating time needed for conducting analysis, preparing the report, and data lag and quality considerations. The purpose of the Interim Evaluation Report is to present preliminary evaluation findings, and plans for completing the evaluation design and submitting a Final Evaluation Report according to the schedule outlined in (b). The state shall submit the final Interim Evaluation Report within 60 calendar days after receipt of CMS comments.

b. **Final Evaluation Report.** The state must submit to CMS a draft of the Final Evaluation Report by June 30, 2024. The state shall submit the final evaluation report within 60 calendar days after receipt of CMS comments.

c. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration, the state shall cooperate fully, to the greatest extent possible, with CMS or the independent evaluator selected by CMS. The state must submit the required data to CMS or the contractor. Requests for information and data from CMS or the independent evaluator selected by CMS shall be made in a timely manner and provide the state with an adequate timeframe to provide the information as agreed to by CMS and the state.

XVI. Schedule of State Deliverables for the Demonstration Period

Date	Deliverable	STC
Administrative		
30 calendar days after approval date	State acceptance of demonstration STCs and Expenditure Authorities	Approval letter
Post Approval Protocols		
60 calendar days after approval date	Submit Draft DSRIP Planning Protocol (Attachment C) and DSRIP Program Funding & Mechanics Protocol (Attachment D)	STCs 37, 38
60 calendar days after approval date	Submit Draft DSHP Claiming Protocol (Attachment B)	STC 93
90 calendar days after approval date	Submit Tribal Engagement and Collaboration Protocol (Attachment H)	STC 27
October 1, 2017 and due on October 1 of each year annually thereafter	Submit Value-Based Roadmap (Original) (Attachment F)	STC 43
120 calendar days after approval date.	Submit Intergovernmental (IGT)Transfer Protocol (Attachment E)	STC 99
60 calendar days after approval date	Submit Financial Executor Role (Attachment G)	STC 30
60 calendar days after approval date	Submit Foundational Community Supports Protocol (Attachment I)	STC 65
90 days after SUD program approval date	SUD Implementation Protocol	STC 83(a)
150 days after SUD program approval date	SUD Monitoring Protocol	STC 83(b)
90 days after SMI program approval date	SMI Implementation Plan Protocol	STC 85
150 days after SMI program approval date	SMI Monitoring Protocol	STC 86
Evaluations		
180 calendar days after approval date	Submit Draft Design for Evaluation Report	STC 126
One year prior to the expiration of the demonstration	Submit Draft Interim Evaluation Report	STC 132
60 calendar days after receipt of CMS comments	Submit Revised Interim Evaluation Report	STC 132
June 30, 2024	Submit Draft Final Evaluation Report for DSRIP, LTSS and FCS.	STC 132

60 calendar days after receipt of CMS comments	Submit Revised Final Evaluation Report	STC 132
June 30, 2024	Submit Draft Final Evaluation Report for SUD and SMI	STC 83, 87, 132
60 calendar days after receipt of CMS comments	Submit Revised Final Evaluation Report for SUD and SMI	STC 132
December 31, 2020	Submit SUD Mid-point Assessment	STC 83
September 30, 2023	Submit SMI Mid-point Assessment	STC 89
Quarterly/Annual/Final Reports		
Quarterly Deliverables, except 4th quarter: Quarter 1 report: June 1 of each demonstration year Quarter 2 report: September 1 of each demonstration year Quarter 3 report: December 1 of each demonstration year	Quarterly Progress Reports	STC 77
Quarterly Expenditure Reports (CMS-64) are due 60 calendar days after the end of each quarter.	Quarterly Expenditure Reports (CMS 64)	STC 97
March 31 of each subsequent demonstration year.	Draft Annual Report	STC 79
Quarterly	Quarterly Budget Neutrality Reports	STC 108
Final Report due 120 days after the end of the demonstration	Final Report	STC 80

ATTACHMENT A
Quarterly Report Template

Quarterly Report Template

Pursuant to STC 72 (Quarterly Operational Reports), the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

NARRATIVE REPORT FORMAT:

Title Line One**:** Washington State Medicaid Transformation Project (MTP) Section 1115 Waiver Demonstration

Title Line Two: Section 1115 Quarterly Report

Demonstration/Quarter
Reporting Period: ***[Example: Demonstration Year: 1 (1/1/2016– 12/31/2016)***
Federal Fiscal Quarter:
Footer: Date on the approval letter through end of demonstration period]

Introduction

Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

Accountable Communities of Health (ACH) and Delivery System Reform Information

Discuss the following:

1. Trends and any issues related to access to care, quality of care, care integration and health outcomes, including progress toward statewide fully integrated managed care.

2. Information about each regional ACH, including the number and type of participating providers, and efficiencies realized through ACH development and maturation.

3. Information about the state's Health IT ecosystem, including improvements to governance, financing, policy/legal issues, business operations and bi-directional data sharing with ACHs.

4. Information about progress made toward demonstration objectives: health systems and community capacity, financial sustainability through participation in VBP, bidirectional integration of physical and behavioral health, community-based whole person care and improved health equity and reduced health disparities.

Please complete the following table that outlines number of beneficiaries residing in each region under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0".

Attribution by Residence Counts for Quarter and Year to Date

Note: Enrollment counts should be unique enrollee counts by *each* regional ACH, not member months

Name of ACH	Current Enrollees (year to date)

VI. Operational/Policy/Systems/Fiscal Developments/Issues

A status update that identifies all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, health plan contract changes and financial performance relevant to the demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

IX. Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the state's actions to address these issues.

XI. Consumer Issues

A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

XII. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

XIII. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

XIV. Enclosures/Attachments

Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

XV. State Contact(s)

Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

ATTACHMENT B
DSHP Claiming Protocol and County Levy Programs

I. Review of DSHPs included in STCs

To support the goals of health system transformation, the state may claim Federal Financial Participation (FFP) for actual expenditures related to Designated State Health Programs (DSHP), subject to a maximum 5-year capped amount of $928,481,856 (total computable; see Section X). As described in these STCs, DSHP expenditures may be claimed for the period beginning January 9, 2017 and ending December 31, 2021. The state's programs that will serve as DSHPs are described in Table A below (see also STC 90, Table 3) and the limits and timelines under which the state may claim matching funds for these expenditures are described in Table B (see also STC 91, Table 4). This protocol describes the methodology and guidelines by which the state may claim FFP for DSHP expenditures.

Table A. Designated State Health Programs (DSHP) List

Number	Responsible Entity	Program
A	Health Care Authority (HCA) or successor	Kidney Disease Program (KDP)
B	Aging and Long-Term Support Administration (ALTSA) or successor	Nursing Homes, Community Residential, and Homecare
C	Aging and Long-Term Support Administration (ALTSA) or successor	State Family Caregiver Support
D	Aging and Long-Term Support Administration (ALTSA) or successor	Senior Citizen's Services Act (SCSA)
E	Aging and Long-Term Support Administration (ALTSA) or successor	Office of the Deaf and Hard of Hearing
F	Development Disabilities Administration (DDA) or successor	Employment & Day and Other Community Services
G	Development Disabilities Administration (DDA) or successor	Community Residential & Homecare
H	Behavioral Health Administration (BHA) or successor	Crisis and other non-Medicaid services
I	Behavioral Health Administration (BHA) or successor	Program of Assertive Community Treatment (PACT)
J	Behavioral Health Administration (BHA) or successor	Offender Re-entry Community Safety Program
K	Behavioral Health Administration (BHA) or successor	Spokane Acute Care Diversion

L	Behavioral Health Administration (BHA) or successor	Psychological Evaluations
M	Behavioral Health Administration (BHA) or successor	Outpatient and Support Services
N	Behavioral Health Administration (BHA) or successor	Residential Services
O	Behavioral Health Administration (BHA) or successor	Parent in Reunification
P	Behavioral Health Administration (BHA) or successor	Problem Gambling Services
Q	Department of Corrections (DOC) or successor	Mental health transition services
R	Department of Corrections (DOC) or successor	ORCS (Offender Reentry Community Safety)
S	Department of Corrections (DOC) or successor	Medications for Releasing Offenders
T	Department of Corrections (DOC) or successor	Community-supervised violator medical treatment
U	Department of Health (DOH) or successor	Tobacco and Marijuana Prevention and Education
V	Department of Health (DOH) or successor	Family Planning Non-Title X
W	Department of Health (DOH) or successor	HIV/AIDS Prevention
X	Other or successor	Health Professional Loan Repayments (WA Student Achievement Council)
Y	Other or successor	Street Youth Service (Department of Commerce)
Z	Other or successor	"County Levy" Health Programs (see Attachment B)

Table B. DSHP Limits

Demonstration Year (DY)	DSHP Total
DY1 (1/9/2017-12/31/2017)	$240,000,000
DY2 (1/1/2018 – 12/31/2018)	$216,000,000
DY3 (1/1/2019 – 12/31/2019)	$190,080,000
DY4 (1/1/2020 – 12/31/2020)	$157,766,400
DY5 (1/1/2021 – 12/31/2021)	$124,635,456
Total	**$928,481,856**

II. Documentation of Expenditures for General DSHP

In claiming DSHP expenditures, the state will provide CMS with a summary Excel worksheet by Responsible Entity and program in an orderly format, or other CMS-

approved alternative, so that CMS may review and test underlying supporting documentation as detailed in this claiming protocol.

A. For all DSHPs claimed, the state will make available to CMS for quarterly DSHP expenditures the following information:

- Responsible Entity
- Program
- Total amount paid to date
- Certified Public Expenditure (CPE) Documentation

B. Documentation of expenditures for each DSHP will be clearly outlined in supporting documents and be made available to CMS in accordance with this claiming protocol.

III. Unallowable DSHP Expenditures

In accordance with STC 92(b), DSHP expenditures submitted to CMS will not include:

- Grant funding to test new models of care;
- Construction costs (bricks and mortar);
- Room and board expenditures;
- Animal shelters and vaccines;
- School-based programs for children;
- Unspecified projects;
- Debt relief and restructuring;
- Costs to close facilities;
- HIT/HIE expenditures;
- Services provided to undocumented individuals;
- Sheltered workshops;
- Research expenditures;
- Rent and utility subsidies normally funded by the United States Department of Housing and Urban Development;
- Prisons, correctional facilities, and services provided to individuals who are civilly committed and unable to leave;
- Revolving capital fund;
- Expenditures made to meet a maintenance of effort requirement for any federal grant program;
- Administrative costs;

- Cost of services for which payment was made by Medicaid or CHIP (including from managed care plans);
- Cost of services for which payment was made by Medicare or Medicare Advantage;
- Funds from other federal grants;
- Needle-exchange programs;
- Abortions that would not be allowable if furnished under Medicaid or CHIP; and
- Costs associated with funding federal matching requirements.

IV. Background on Washington's Financing and Accounting Systems

The Financial Services Division (FSD), within the Health Care Authority (HCA), is responsible for accounting and financial management services that include accounts payable, accounts receivable, billing, data management and financial reporting and analysis. The FSD is responsible for the draw-down of federal funds in accordance with the Cash Management Improvement Act (CMIA). Additionally, financial managers of the various DSHPs are responsible for identifying costs eligible and allowable for federal match at the state-specific Federal Medical Assistance Percentages (FMAP) for federal reimbursement, and proper reporting.

A. Agency Financial Reporting System (AFRS)

The Agency Financial Reporting System (AFRS) is the state's official accounting system. This system is used to process accounting transactions (pay bills, record revenue and general ledger). The integrity of all accounting processes is audited as part of the state's Single Audit performed by the Washington State Auditor's Office, in accordance with OMB Circular A-133. This independent audit of internal control systems, financial records, financial statements, and federal award transactions and expenditures over federally funded programs is to ensure compliance with federal regulations.

B. Sources of Non-Federal Share

Federal Financial Participation for DSHP expenditures, as described above, is time-limited and phases down each year of the demonstration, as described in STC 91, Table 4. The state provides assurance that the non-federal share of funds for the demonstration is consistent with STC 86. The state further assures that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law.

For purposes of expenditures claimed under this protocol, the state will use certified public expenditures (CPE) as the funding mechanism to claim federal match for the approved state and local DSHPs as identified in STC 87(c). In addition to certifying that expenditures are eligible for FFP under the DSHP provisions of the demonstration

project, the contributing Responsible Entities must certify that the sources of the non-federal share comply with the terms of this paragraph, excluding the types of program costs that are not eligible for FFP as defined in STC 92(b).

Certified Public Expenditure Process

For each DSHP, the state must perform the following steps to determine the amount of the DSHP expenditures eligible for FFP. The payments and associated claimed expenditures must be commensurate with actual program services delivered and actual allowable program expenditures. DSHPs with claims processed through ProviderOne[1] are based on an approved unit rate.

For each demonstration year, the Responsible Agency with an approved DSHP will complete an annual form to be provided to HCA. The annual form is for HCA's internal budgeting, monitoring and reporting and is not used to inform or support federal claiming. This form will include:

- Name of Responsible Entity
- Name of Program
- Program account coding
- Budget for the demonstration year
- Estimated expenditures by month for the demonstration year
- Certification and attestation by the Responsible Entity CFO or designee

On a monthly basis, HCA will collect from Responsible Entities with an approved DSHP the following information for federal claiming purposes

- Actual monthly costs spent for the approved DSHP
- Cost documentation to support the Responsible Entity DSHP expenditures

Certification and attestation by the Responsible Entity CFO or designee. The Responsible Entity will attest to the following specific attributes:

- information submitted is true, accurate, and complete
- information submitted is prepared in accordance with governing law and HCA instructions
- acknowledge that all information submitted in the CPE application is subject to audit by HCA or its authorized designee
- unallowable expenditures as defined in STC 92(b) are excluded from certified expenditures, only net expenditures are being claimed

[1] ProviderOne is Washington's Medicaid Management Information System (MMIS).

The State will perform the following steps in order to provide reasonable assurance that the CPE expenditures are accurate and allowable:

- Review the CPE form and supporting documentation for accuracy.
- Ensure the Responsible Entity's CFO or designee's attestation is obtained
- Inquire with the Responsible Entity if any discrepancies are discovered on the application or supporting documentation
- If discrepancies exist, ensure that the Responsible Entity submits a revised CPE form

Using the CPE funding mechanism, the state will claim the federal share on its quarterly CMS 64 based on the actual total computable expenditures certified by the Responsible Entity with an approved DSHP.

HCA will maintain all CPE records and other supporting documentation. HCA will prepare and submit the CMS-64 Quarterly Expense Report, identifying the expenditures allowable for federal claiming.

HCA will contract with an independent auditor to annually validate the accuracy of the federal claim. Each of the Responsible Entities with an approved DSHP will be required to provide full cooperation with the independent auditor.

V. DSHP Program Details

General DSHP expenditures will be claimed for the following programs, as listed in Table A. A description of each of these programs and the procedures used to document expenditures for these programs are included below.

A. **Program Title:** Kidney Disease Program (KDP)

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

The Kidney Disease Program (KDP) is a state-funded program that helps low-income residents with their high costs for treatment of end stage renal disease (ESRD), also known as kidney disease or kidney failure. Undocumented individuals are not eligible for KDP services. HCA contracts with kidney centers to provide ESRD services to KDP clients. Services include:

- In-center dialysis
- In-home dialysis
- Medications

- Anti-rejection medication for transplant patients
- Home helper costs
- Equipment and home supplies
- Transportation
- Pre-transplant dental work (with prior authorization)

HCA also reimburses the client's share of the following expenses:

- Insurance premiums
- Medicare premiums
- Co-insurance and co-pays

Eligible Population:

Gross household income must be at or below 220 percent of Federal Poverty Level and must satisfy resource limitations and medical and residential criteria.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in the STCs. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b)(i) through (xxiii). All expenditures on these contracts are related to treating the client's costs for ESRD. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

B. Program Title: Nursing Homes, Community Residential and Homecare

Funding Sources: General Fund State, Medicaid.

These programs receive Medicaid funding; however, only General Fund State expenditures will be claimed.

Brief Description:

Medicaid services for non-Medicaid eligible elderly and disabled populations not meeting functional and/or financial requirements through the traditional Medicaid Long Term Services and Supports (LTSS) system. Services include in-home personal care, residential care, dementia care, behavioral supports, and other in-home services, which may include personal response systems, equipment, and registered nurse delegation. Clients receive services based on their individual assessment, which measures their level of need with activities of daily living (ADL) in addition to other supports/needs.

Eligible Population:

Generally, any individual normally served under Medicaid Community First Choice (CFC), but who has fallen out of eligibility (temporarily). These costs exclude those receiving services under the Alien Emergency Medical program.

Residential Care Discharge Allowance (RCDA): individuals eligible for residential discharge allowance:

- Receive long-term care services from home and community services;
- Are being discharged from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to your own home;
- Do not have other programs, services, or resources to assist with these costs;
- Have needs beyond what is covered under the Community Transition Services (under Community First Choice); and
- DDA clients who are being discharged from Nursing Facilities only.

Washington Roads:

There are three cohorts of individuals eligible for Washington Roads. Clients who are recipients in the N05 Medicaid coverage group in ACES are eligible for WA Roads when cohort-specific criteria are met:

- Cohort 1. Individuals eligible for WA Roads while in an institution are:
  - People age 18 and older with a continuous 30-day or longer stay in a hospital or nursing facility; and
  - Medicaid recipients in the institution for at least one day or Fast Track eligible; and
  - Functionally and financially eligible (or Fast Tracked) for waiver/state plan home and community based services (HCBS), which currently include Community First Choice (CFC), Medicaid Personal Care (MPC), Alternative Benefit Plan – Medicaid Personal Care (ABP-MPC), Community Options Program Entry System (COPES), Residential Support Waiver (RSW) and New Freedom.
- Cohort 2. Individuals eligible for WA Roads while living in the community are functionally and financially eligible for waiver/state plan HCBS AND have any one of these characteristics:
  - Unstable residential or in-home settings

- Frequent institutional contacts (ER visits, SNF stays, hospital admits, etc.)
- Frequent turnover of caregivers
- Multiple systems involvement (DOC, psychiatric institutions, etc.)
- Is interested in obtaining employment through the Steps to Employment (S2E) project and the project is available in the individual's geographical area.

- Cohort 3. Individuals living in subsidized housing that have been coordinated through ALTSA (including NED, Bridge, 811, etc.), regardless of whether they are currently eligible for, or receiving, waiver/state plan HCBS.

  Individuals who are not eligible for WA Roads are:

  - Clients residing in Intermediate Care Facilities for the Intellectually Disabled (ICF/IIDs) or Residential Habilitation Centers (RHCs).
  - Clients enrolled in managed long-term care programs such as PACE.
  - Clients enrolled in programs for non-citizens (Alien LTC)

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in the Special Terms & Conditions of the demonstration. Any unallowable expenditures identified for the items listed in STC 92(b)(i) through (xxiii) will be excluded from claiming. Controls exist within ProviderOne and IPOne[2] to identify those expenditures that should be excluded. Expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

C. **Program Title:** State Family Caregiver Support

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Supportive services for the unpaid caregivers of non-Medicaid enrolled elderly and disabled adults to delay or divert the care recipient from entering or spending down to the more expensive traditional Medicaid long-term care system. Services include respite,

[2] The Individual Provider One (IPOne) is the online, electronic payment system that allows individual providers to submit timesheets, receive pay for hours worked for in home clients, and allows providers to manage claims.

consultation and options counseling, training, equipment, and evidence based interventions. The current state program will continue in its current form; however, initiative two of the waiver proposes a significant program expansion to serve additional caregivers.

Eligible Population:

Any income level. Individuals with higher income levels will be asked to participate towards the cost of care for respite based on a sliding fee basis. Eligible individuals must be adults 18 or older caring for adults 18 or older.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in the Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organization to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that such services are not provided to undocumented individuals.

D. Program Title: Senior Citizen's Services Act (SCSA)

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Supportive services for the elderly population who are not receiving Medicaid LTSS paid services or who need services not payable through Medicaid funds to delay entry into the Medicaid long-term care system. Services are administered and/or delivered by the Area Agencies on Aging (AAA) and are provided to restore or maintain each client's ability to maintain living in the community. Services vary by AAA and include information and referrals, foot care, bath assistance, adult day health/day care, transportation, meals, Family Caregiver Support, Long-Term Care Ombudsman, and health promotion. AAAs also use SCSA funding to support their planning, coordination, and administrative functions but these expenditures will not be claimed as DSHP.

Eligible Population:

Clients must be either (a) 65 or older or (b) 60 and older and unemployed or working less than 20 hours per week. Clients must be at risk of not being able to remain in their home with an income at or below 40 percent of state median income and resources of less than

$10,000 single or $15,000 household of two. People with higher incomes may participate using a sliding fee basis.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these STCs. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

E. **Program Title:** Office of the Deaf and Hard of Hearing

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

The Office of the Deaf and Hard of Hearing provides Medicaid-eligible services to Medicaid and non-Medicaid eligible individuals who are deaf, hard of hearing, and deaf-blind. Services include information, referral, advocacy, sign language interpreter services, telecom equipment distribution, relay services, and assistive community technology.

Eligible Population:

Any state resident who is deaf, hard of hearing, deaf-blind, or speech-disabled and hearing are eligible. Hearing parents with deaf babies or children are also eligible.

There are no income limits for Social and Human Services and Communication Access Services.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in the Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

F. **Program Title:** Employment & Day and Other Community Services

Funding Sources: General Fund State, Medicaid

These programs receive Medicaid funding; however, only General Fund State expenditures will be claimed.

Brief Description:

Services provided to non-Medicaid eligible adults and children who have a developmental disability diagnosis, to allow them to thrive in their communities and have the typical day-to-day life of their peers. Individuals age 21 and older may receive employment services. Contractors, including counties and non-profits, provide services in the traditional state Developmental Disabilities Administration service system, including individualized and group supported employment; community access; individualized technical assistance; respite individual providers; enhanced respite; medical and psychological evaluation/consultation; and crisis intervention.

Eligible Population:

Individuals who:

- Are age 21 and over, meet the other requirements contained in Chapter 388-823, and have evidence of the following:
  - A developmental disability (RCW 71A.10.020(3) attributable to intellectual disability, cerebral palsy, epilepsy, autism, or another neurological or other condition found by DDA to be closely related to intellectual disability or requiring treatment similar to that required for individuals with intellectual disability;
  - Originate prior to age eighteen;
  - Be expected to continue indefinitely; and
  - Result in substantial limitations to the individual's adaptive functioning.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these STCs of the demonstration. Any unallowable expenditures identified for the items listed in STC 92(b) i through xxiii will be excluded from claiming. Controls exist within ProviderOne and IPOne to identify those expenditures that should be excluded. Expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program,

including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

G. Program Title: Community Residential & Homecare

Funding Sources: General Fund State, Medicaid

These programs receive Medicaid funding; however, only General Fund State expenditures will be claimed.

Brief Description:

Medicaid and Non-Medicaid adults and children who have a developmental disability diagnosis receive services provided through contracts with for-profit and non-for-profit organizations. This allows them to remain in the community in the least restrictive setting that supports full engagement in their communities. Services include: group homes; child foster group care; alternate living; companion home; companion home respite; client evaluation; supported living; residential transportation; staff add-ons; nurse delegation; HCBS care Individual Providers (IP); HCBS care parent provider; personal care IP child non-waiver; personal care IP adult non-waiver; personal care agency child non-waiver; personal care adult family homes; personal care transportation non-waiver; personal care IP training wages non-waiver; personal care residential arc; Children's Administration shared funding for personal care; caregiver training; residential provider training; client allowance; and, attendant care. Only services paid with state only funding will be claimed as DSHP expenditures.

Eligible Population:

Clients must be enrolled and eligible clients of the Developmental Disabilities Administration, and have been assessed as needing community residential and homecare services to meet their health and welfare needs.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in the STCs of the demonstration. Any unallowable expenditures identified for the items listed in STC 92(b) i through xxiii will be excluded from claiming. Controls exist within ProviderOne and IPOne to identify those expenditures that should be excluded. Expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

H. Program Title: Crisis and other non-Medicaid services

Funding Sources: General Fund State, Medicaid

These programs receive Medicaid funding; however, only General Fund State expenditures will be claimed.

Brief Description:

Short-term crisis services stabilize non-Medicaid and Medicaid -eligible individuals. These are provided in the community and at home by traditional designated mental health professionals. Services may be provided in partnership with the court system to ensure that referrals are medically appropriate and effectively managed.

Eligible Population:

Services are provided based on resources and access standards defined by each Behavioral Health Organization.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these STCs of the demonstration. Any unallowable expenditures identified for the items listed in STC 92(b) i through xxiii will be excluded from claiming. Controls exist within ProviderOne and IPOne to identify those expenditures that should be excluded. Expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

I. Program Title: Program of Assertive Community Treatment (PACT)

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

An evidence-based program for people with the most severe and persistent mental illness who experience significant difficulties with activities of daily living, with active symptoms and impairments, and who have not benefited from traditional outpatient programs. The program is a person-centered, recovery-oriented mental health service delivery model that has received substantial empirical support for reducing psychiatric hospitalizations, facilitating community living, and enhancing recovery. Services are

designed to avoid the frequent access of inpatient services and jails and are provided by traditional Mental Health Professionals using a wraparound approach.

Eligible Population:

Services are provided based on resources and access standards set by each Behavioral Health Organization.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these STCs of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. In addition, any expenditures associated with services provided in an IMD setting will be excluded. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

J. **Program Title:** Offender Re-entry Community Safety Program

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Public safety enhancement through additional mental health treatment, including short-term counseling and discharge planning for dangerously mentally ill and/or intellectually disabled individuals to avoid intensive hospitalization upon release from prison. Clients participating in the program receive services such as pre-engagement, intensive case management, needs assessment, mental health services and treatment, sex offender treatment, chemical dependency treatment, medical and other non-medical treatment supports. Once designated into the program and released into the community, the offender is eligible for up to 60 months of support including Enhanced Mental Health Treatment; Chemical Dependency Treatment, Care Management, and Educational/Vocational Services.

Eligible Population:

Population is determined by Department of Corrections/Department of Social and Health Services screening committee. Participants must have been incarcerated in DOC facility.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. In addition, any expenditures associated with services provided pre-release will be excluded. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

K. Program Title: Spokane Acute Care Diversion

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Evaluation and treatment services that divert clients with complex mental health issues from long-term stays at hospitals that are IMDs. This expenditure is for a non-IMD inpatient facility serving non-Medicaid clients.

Eligible Population:

Services are provided based on resources and access standards set by each Behavioral Health Organization.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

M. Program Title: Outpatient and Support Services

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Substance use disorder (SUD) outpatient and support services provided in the community

to non-Medicaid, low income eligible individuals, often in partnership with drug courts and juvenile justice systems to ensure referrals to SUD treatment are medically appropriate and effectively managed. Services are provided by traditional chemical dependency providers who also provide State Plan Medicaid services and include assessments, opiate substitution treatment, detox, case management and outreach for adults, youth, and pregnant and parenting women.

Eligible Population:

Services are provided based on resources and access standards set by each BHO. Clients must be ten years of age or older.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

N. **Program Title:** Residential Services

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Residential (non-IMD) treatment services for low income adults, youth and women who are pregnant or postpartum and women with dependent children.

Eligible Population:

Services are provided based on resources and access standards set by each Behavioral Health Organization.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the

program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

P. Program Title: Problem Gambling Services

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

This program funds problem and pathological gambling prevention efforts. Activities include elder awareness, literature distribution, and problem gambling prevention activities targeting young adults. Training specific to problem and pathological gambling is provided for chemical dependency professionals, licensed mental health counselors, psychologists, and agency affiliated counselors. A 24-hour helpline for problem and pathological gambling assists people with referrals to treatment providers and crisis stabilization.

Eligible Population:

Clients must be eighteen years of age or older and Medicaid eligible and/or Low Income (not able to afford treatment).

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

Q. Program Title: Mental Health Transition Services

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Two Psych Associates located at two separate Community Justice Centers in the community to provide mental health transitional services. These staff work one on one with offenders with identified mental health needs in the community after release from prison to help coordinate transition of care to community providers and assure those

individuals are linked to the appropriate entities to address their needs and assist in a successful transition back into the community.

Eligible Population:

Any releasing offender with identified mental health transition assistance needs.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

R. Program Title: Offender Reentry Community Safety(ORCS)

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

As part of the reentry process, a multisystem care planning team (MSCPT) works with the offender to identify, release and transition needs, which include housing, treatment for mental health and/or chemical dependency, community supports, transportation, and other specialized treatment services. Members of the MSCPT may include the Department of Corrections staff (ORCS transition mental health counselor, classification counselor, community corrections officers, and primary therapist), community mental health professional, chemical dependency professional and community support people, including family members. The MSCPT and offender complete a 48-hour transition plan that identifies appointments and activities to be completed during the first 48-hours of release. One of the main components of the program is to connect the offender with a community mental health provider prior to releasing to create a more successful link to services in the community.

Eligible Population:

Seriously mentally ill offenders transitioning back into the community.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

S. **Program Title:** Medications for Releasing Offenders

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Offenders who are on medications at the time of release are provided a 30-day supply of their medications to maintain health care stability while they get accustomed to life in the community. It is more beneficial for the offender to leave with the prescription in hand and provides better assistance to transition back into the community from prison by allowing the offender time to get established with a community provider without needing to worry to get a prescription filled immediately after release.

Eligible Population:

All releasing offenders who have a current prescription as of the date of release.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

T. **Program Title:** Community-supervised Violator Medical Treatment

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Payment for medical costs for supervised offenders residing in the community. Supervision includes a regular designated check-in time with the assigned Community Corrections Officers, along with any number of court-ordered stipulations (e.g., no drug use, maintaining employment, no travel out of state).

Eligible Population:

All violators under Department of Corrections jurisdiction on the date of service.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

U. **Program Title:** Tobacco and Marijuana Prevention and Education

Funding Sources: Dedicated Marijuana Account (State), Tobacco Control Program (Federal)

These programs receive federal funding; however, only State expenditures will be claimed.

Brief Description:

The Tobacco and Vapor Product Prevention and Control Program works with diverse partners statewide to implement policies, systems and environmental changes to prevent underage use of tobacco, promote our Tobacco Quitline, reduce second-hand smoke, and reduce disparities in our priority populations (Latino/Hispanic, LGBTQ, American Indian/Alaska Native, Asian/Pacific Islander and Black/African American). The Marijuana Prevention and Education Program works with diverse partners statewide to implement policies, systems and environmental changes to prevent underage use of marijuana, reduce second-hand smoke, and reduce disparities in our priority populations (Latino/Hispanic, LGBTQ, American Indian/Alaska Native, Asian/Pacific Islander and Black/African American).

Eligible Population:

The Washington State Tobacco Quitline (1-800-QUIT-NOW) serves all of Washington and triages callers to their health plan. About 40 percent of the calls are transferred to Medicaid or a private insurance plan. DOH covers people who are uninsured and the

underinsured (callers with a health plan with no telephone counseling or nicotine replacement benefit). The Quitline does not collect income information.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

V. **Program Title:** Family Planning Non-Title X

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Access to family planning services, supplies, and information to all who want and need them. Family planning services are a critical part of basic healthcare that allows men and women to plan the size and spacing of their families, prepare for the birth of healthy children, and prevent unplanned pregnancies. Priority is given to people from low-income families. We do not ask about citizenship status when providing these services.

Eligible Population:

Individuals of reproductive age, with reproductive capacity, who want family planning services and are uninsured, under-insured, at or below 250 percent FPL, OR require confidential services.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above, are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

W. Program Title: HIV/AIDS Prevention

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Supplies antiretroviral medications (Pre-Exposure Prophylaxis; PrEP) in an effort to accelerate reductions in new HIV infections for high-risk individuals by covering the full cost of Truvada® for those who are uninsured (on case by case basis) and providing co-pay assistance for Truvada® for those who are insured. The program purchases insurance for a limited amount of enrollees through the Health Benefit Exchange.

Eligible Population:

HIV-negative, insured, state residents at high risk of becoming infected with HIV. There is no income requirement.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these STCs. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

X. Program Title: Health Professional Loan Repayments (WA Student Achievement Council)

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Financial assistance - loan repayments and conditional scholarships - to encourage licensed primary care health professionals to provide primary health care in rural or underserved urban areas with designated shortages.

Eligible Population:

Health professionals serving rural or underserved urban areas.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above, are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

Y. Program Title: Street Youth Service (Department of Commerce)

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

State-funded outreach program for unaccompanied homeless youth to connect them to health and housing services.

Eligible Population:

Unaccompanied homeless youth under the age of 18.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

Z. Program Title: "County Levy" Health Programs (see Attachment B)

Funding Sources: General Fund Private/Local

Brief Description:

Sales and use tax distributed for chemical dependency or mental health treatment services or therapeutic courts to support communities in implementing cost containment measures dealing with eliminating chronic jail recidivism, assuring substance abuse and mental health treatment for vulnerable populations, and gaining appropriate use of community

safety and emergency services. Twenty-two (of 39) counties and 1 city (Tacoma) levied the tax in FY14. Nine counties and one city are included in this DSHP.

Eligible Population:

Eligibility and target populations vary from county to county; however, specific programs identified largely apply to financially needy populations who are otherwise ineligible for Medicaid, or provide needed services not covered by Medicaid to Medicaid beneficiaries.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above, are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

ATTACHMENT C
DSRIP Planning Protocol

I. Preface

On January 9, 2017, the Centers for Medicare & Medicaid Services (CMS) approved Washington State's request for a section 1115(a) Medicaid demonstration entitled *Medicaid Transformation Project* demonstration (hereinafter MTP or "demonstration"). Part of this demonstration is a Delivery System Reform Incentive Payment (DSRIP) program, through which the state will make performance-based funding available to regionally-based Accountable Communities of Health (ACH) and their partnering providers. The demonstration is currently approved through December 31, 2021.

The Special Terms and Conditions (STC) of the demonstration set forth in detail the nature, character, and extent of federal involvement in the demonstration, the state's implementation of the expenditure authorities, and the state's obligations to CMS during the demonstration period. The DSRIP requirements specified in the STCs are supplemented by two attachments to the STCs. The DSRIP Planning Protocol (this document, Attachment C) describes the ACH Project Plans, the set of outcome measures that must be reported, transformation projects eligible for DSRIP funds, and timelines for meeting associated metrics.

This protocol is supplemented by a Project Toolkit and Project Measure and Performance Table. The toolkit provides additional details and requirements related to the ACH projects and will assist ACHs in developing their Project Plans.

In accordance with STC 34, the state may submit modifications to this protocol for CMS review and approval. Any changes approved by CMS will apply prospectively unless otherwise specified by CMS.

II. ACH Project Plan Requirements

a. Introduction

ACH Project Plans will provide an outline of the work that an ACH, through its partnering providers, will undertake. The plans must be developed in collaboration with community stakeholders and be responsive to community needs. The plans will provide details on how the selected projects respond to community-specific needs and further the objectives of the demonstration. The

plans also will describe the ACH's capacities, composition and governance structure. In order to be eligible to receive DSRIP incentive payments, an ACH must have an approved Project Plan.

There are three steps for ACH Project Plan approval:

1. ACHs must satisfy a two-phase certification process that will confirm the ACHs are prepared to submit Project Plan applications. Completion of each phase will qualify the ACHs for Project Design funding. Certification criteria will be set forth by the state, and ACHs will submit both phases of certification information to the state within the required time frames. The state will review and approve each certification phase prior to distribution of Project Design funds for that phase.

    a. Phase 1 certification requirements must be submitted to the state by May 15, 2017.
    b. Phase 2 certification requirements must be submitted to the state by August 14, 2017.

    Certification criteria are described further below.
2. ACHs must develop and submit a Project Plan application for approval. The components of the Project Plan are described in STC 36 and further detailed in this protocol. Completed Project Plan applications are due to the state by November 16, 2017.
3. The state and its contracted Independent Assessor will evaluate and (if appropriate) approve ACH Project Plans. ACHs with approved Project Plans are eligible to receive performance-based incentive payments. The state and the Independent Assessor will approve Project Plans as early as November 20, 2017, and no later than December 22, 2017.

The state will develop and post a draft Project Plan Template for public feedback prior to releasing a final version. Design funds attached to each certification phase will support ACHs as they address specific requirements and submit their Project Plans. As ACHs develop Project Plans, they must solicit and incorporate community and consumer input to ensure that Project Plans reflect the specific needs of the region. After the Project Plans are submitted to the state, they will be reviewed by an Independent Assessor contracted by the state. The Independent Assessor will review and make recommendations to the state for approval of Project Plans. The state must approve of Project Plans in order to authorize DSRIP incentive funding. Project Plans may be subject to additional review by CMS.

b. ACH Certification Criteria

The certification process is intended to ensure that each ACH is prepared to serve as the lead entity and single point of accountability to the state for the transformation projects in its region. The certification application solicits information to ensure that: (a) the ACH is qualified to fulfill the role of overseeing and coordinating regional transformation activities; (b) the ACH meets the composition standards outlined in STC 23; and (c) the ACH is eligible to receive project design funds. There are two phases to the certification process. According to a timeline developed by the state, each ACH must complete both phases and receive approval from the state before submitting a Project Plan application.

Phase 1 Certification: Each ACH must demonstrate compliance and/or document how it will comply with state expectations in the following areas, at a minimum:

1. Governance and Organizational Structure, including compliance with principles outlined in STC 22 and decision-making expectations outlined by the state.
2. Initiation or continuation of work with regional Tribes, including adoption of the Tribal Engagement and Collaboration Policy or alternate policy as required by STC 24.
3. Community and Stakeholder Engagement to demonstrate how the ACH is accountable and responsive to the community.
4. Budget and funds flow, including how design funds will support project plan development.
5. Clinical capacity and engagement to demonstrate engagement and input from clinical providers.
6. Other requirements as the state may establish.

Phase 2 Certification: Each ACH must demonstrate that it is in compliance with state expectations in the following areas, at a minimum:

1. Governance and Organizational Structure, including compliance with principles outlined in STC 22 and decision-making expectations outlined by the state. ACHs will describe whether any developments or adjustments have occurred since Phase 1 Certification.
2. Tribal Engagement and Collaboration describing specific activities and events that further the relationship between the ACH and Tribes.
3. Community and Stakeholder Engagement to describe concrete actions that have occurred since Phase 1 Certification. Provide details for how

the ACH will satisfy public engagement requirements for Project Plan development outlined in STC 23.
4. Budget and funds flow to summarize strategic use of funding and decision making processes regarding incentive funding distribution.
5. Data-informed decision making strategies, including processes for applying available data to project selection and implementation planning.
6. Transformation project planning to describe progress on project selection processes.
7. Other requirements as the state may establish.

c. ACH Project Plan Requirements

As part of this demonstration, each ACH and its regional participating providers will be responsible for implementing a set of projects selected from the Project Toolkit. The Project Plan:

- Provides a blueprint of the work that each region, coordinated by the ACH, will undertake through the implementation of these projects.
- Explains how the regional work responds to community-specific needs, relates to the mission of the ACH, and furthers the objectives of the demonstration.
- Provides details on the ACH's composition and governance structure, specifically any adjustments to refine the model based on initial lessons learned.
- Demonstrates ACH compliance with the terms and conditions of participation in the demonstration.
- Incorporates the voice and perspective of the community and consumers through outreach and engagement.

Each ACH will submit a Project Plan to the state for review. The Project Plans will be used by the state to assess ACH preparedness in planning and implementing its local demonstration program and the regional alignment with the demonstration's overall objectives and requirements. The state's contracted Independent Assessor will review and evaluate Project Plans and make recommendations to the state for approval/remediation of each Plan. In addition, commitments made by an ACH in its Project Plan must be consistent with the terms of a contract between the state and the ACH, outlining the requirements and obligations of the ACH as the lead and other partnering providers in the ACH in order to be eligible to receive DSRIP incentive funding.

The Project Plan Template will provide a structured format and outline the information required to be submitted by each ACH as part of its Project Plan. The template will be divided into two main sections and will include scoring criteria. Section I will focus on how the ACH, through its partnering providers, is being directly responsive to the needs and characteristics of the community it serves. It will include details regarding the ACH's overall programmatic vision, composition, and decision-making processes. Section II will ask ACHs to provide detailed project-specific plans. The state may add additional requirements to the Project Plan application in addition to what is outlined below.

The categories for Section I of the Project Plan template will include:

1. *ACH Theory of Action and Alignment Strategy*: Rationale explaining how the ACH plans to improve the quality, efficiency, and effectiveness of care processes in its community.

2. *Governance*: Description of how the ACH complies with the state's governance and decision-making expectations.

3. *Regional Health Needs Inventory:* Description of how the ACH used available data to identify target populations and ensure that project selection responds to community-specific needs, aims to reduce health disparities, and furthers the objectives of the demonstration.

4. *Community and Consumer Engagement and Input*: Evidence of public input into the project plans, including consumer engagement. ACHs must demonstrate that they solicited and incorporated input from community members and consumers. The plan must also describe the processes the ACHs will follow to engage the public and how such engagement will continue throughout the demonstration period.

5. *Tribal Engagement and Collaboration*: Demonstration that the ACH has complied with the Tribal Engagement and Collaboration requirements.

6. *Budget and Funds Allocation*: Description of how decisions about the distribution of funds will be made, the roles and responsibilities of each partner in funds distribution and a detailed budget for the remaining years of the demonstration.

7. *Value-based Payment Strategies:* Description of the regional strategies to support attainment and readiness of statewide VBP targets.

For each selected project, Section II requires, that ACHs provide details regarding:

1. *Partnering Organizations*: Description of the partnering providers, both traditional and non-traditional, that have committed to participate in projects. Partnering providers must serve and commit to continuing to serve the Medicaid population. ACHs must ensure that together, these partnering providers serve a significant portion of Medicaid covered lives in the region and represent a broad spectrum of care and related social services that are critical to improving how care is delivered and paid for. Additional details on recommended implementation partners will be provided in Project Toolkit guidance documents.

2. *Relationships with Other Initiatives:* The ACH will attest to securing descriptions of any initiatives that its partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place and ensuring these projects are not duplicative of DSRIP projects. In DY 2, partnering providers will be required to provide descriptions and attest that DSRIP projects are not duplicative of other funded projects and do not duplicate the deliverables required by the former project(s). If projects are built on one of these other projects, or represent an enhancement of such a project, that may be permissible but the ACH will be required to explain how the DSRIP project is not duplicative of activities already supported with other federal funds.

3. *Monitoring and Continuous Improvement*: Description of the ACH's plan for monitoring project implementation progress and continuous improvement or adjustments in alignment with Section V (Process for ACH Project Plan Modification).

4. *Expected Outcomes*: Description of the outcomes the ACH expects to achieve in each of the project stages, in alignment with the metrics and parameters provided by the state.

5. *Sustainability:* Description of how the projects support sustainable delivery system transformation for the target population.

6. *Regional Assets, Anticipated Challenges and Proposed Solutions*: Description of the assets that the ACH and partnering providers bring to the delivery system transformation efforts, and the challenges or barriers they expect to confront in improving outcomes and lowering costs for the target populations. For identified challenges, the ACH must describe how

it expects to mitigate the impact of these challenges and what new capabilities will be required to be successful.

7. *Implementation Approach and Timing*: Explanation of the planned approach to accomplishing each set of required project milestones for each of the selected projects.

III. Project Toolkit

a. Overview of Project Categories

Each ACH, through its partnering providers, is required to implement at least four transformation projects and participate in statewide capacity building efforts to address the needs of Medicaid beneficiaries. These projects will be spread across the following three domains:

1. Health Systems and Community Capacity Building
2. Care Delivery Redesign (at least two projects)
3. Prevention and Health Promotion (at least two projects)

The Domains, and the strategies defined within each Domain, are interdependent. Domain 1 is focused on systemwide planning and capacity-building to reinforce transformation projects. Domain 1 strategies are to be tailored to support efforts in Domain 2 and Domain 3; projects in Domain 2 and Domain 3 integrate and apply Domain 1 strategies to the specified topics and approaches.

ACHs will develop detailed implementation plans. As described in Section IV, project progress will be measured based on state-defined milestones and metrics that track project planning, implementation, and sustainability.

b. Description of project domains

i. Health Systems and Community Capacity Building

This domain addresses the core health system capacities to be developed or enhanced to transition the delivery system according to Washington's Medicaid Transformation demonstration. Domain 1 does not outline individual projects, but rather three required focus areas to be implemented and expanded across the delivery system, inclusive of all provider types, to benefit the entire Medicaid population. The three areas of focus are: financial sustainability through value-based payment, workforce, and systems for population health management. Each of these areas will need to be addressed progressively throughout the five-year

timeline to directly support Domain 2 and Domain 3 transformation project success.

ii. **Care Delivery Redesign**
Transformation projects within this domain focus on innovative models of care that will improve the quality, efficiency, and effectiveness of care processes. Person-centered approaches and integrated models are emphasized. Domain 2 includes one required project and three optional projects. ACHs will be required to select at least one of the optional projects for a minimum of two Domain 2 projects in total.

iii. **Prevention and Health Promotion**
Transformation projects within this domain focus on prevention and health promotion to eliminate disparities and achieve health equity across regions and populations. Domain 3 includes one required project and three optional projects. ACHs will be required to select at least one of the optional projects for a minimum of two Domain 3 projects in total.

Table 1. Menu of Transformation Projects

#	Project	Description
Health Systems and Community Capacity Building		Foundational activities that address the core health system capacities to be developed or enhanced to transition the delivery system in accordance with the demonstration's goals and transformation objectives.
Financial sustainability through value-based payment		Paying for value across the continuum of care is necessary to ensure thesustainability of the transformation projects undertaken through this demonstration. A transition away from paying for volume may be challenging to some providers, both financially and administratively. Asnot all provider organizations are equipped at present to successfully operate in these payment models, providers may need assistance to develop additional capabilities and infrastructure.
Workforce		The health services workforce will need to evolve to meet the demands ofthe redesigned system of care. Workforce transformation will be supported through the provision of training and education services, hiringand deployment processes, and integration of new positions and titles to support transition to team-based, patient-centered care and ensure the equity of care delivery across populations.

Systems for population healthmanagement		The expansion, evolution, and integration of health information systemsand technology will need to be supported to improve the speed, quality, safety, and cost of care. This includes linkages to community-based care models. Health data and analytics capacity will need to be improved to
		support system transformation efforts, including combining clinical and claims data to advance VBP models and to achieve the triple aim.
Care Delivery Redesign		Strategies that focus on innovative models of care to improve the quality, efficiency, and effectiveness of care processes. Person-centeredapproaches and integrated models are emphasized.
2A	**Bi-directional integration of physicaland behavioral health through care transformation**	The Medicaid system aims to support person-centered care that delivers the right services in the right place at the right time. Primary care servicesare a key gateway to the behavioral health system, and primary care providers need additional support and resources to screen and treat individuals for behavioral health care needs, provide or link with appropriate services, and manage care. Similarly, for persons not engagedin primary care services, behavioral health settings can be equipped to provide essential primary care services. Integrating mental health, substance use disorder, and primary care services has been demonstrated to deliver positive outcomes and is an effective approach to caring for people with multiple health care needs. Through a whole-person approachto care, physical and behavioral health needs will be addressed in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need. This project will advance Healthier Washington's initiative to bring together the financing and delivery of physical and behavioral health services, through managed care organizations, for people enrolled in Medicaid.

2B	**Care coordination**	Care coordination is essential for ensuring that children and adults withcomplex health service needs are connected to the evidence-based interventions and services that will improve their outcomes. Appropriately coordinated care is especially important for high-risk populations, such as those living with chronic conditions, those impacted by the social determinants of health such as unstable housing and/or food insecurity, the aging community, and those dependent on institutionalizedsettings. Communities are challenged to leverage and coordinate existing services, as well as establish new services to fill gaps. Without a centralized approach to "coordinating the coordinators," a single person might be assigned multiple care coordinators who are unaware of one another, potentially provide redundant services, and risk creating confusion for the individual.
2C	**Transitional care**	Points of transition out of intensive services/settings, such as individualsdischarged from acute care, inpatient care or from jail or prison into the community are critical intervention points in the care continuum. Transitional care services provide opportunities to reduce or eliminate avoidable admissions, readmissions and jail use. Individuals discharged from intensive settings may not have a stable environment to return to or may lack access to reliable care. Transitions can be especially difficult on beneficiaries and caregivers when there are substantial changes in medications or routines or an increase in care tasks. This project includes multiple care management and transitional care approaches.
2D	**Diversion interventions**	Diversion strategies provide opportunities to re-direct individuals away from high-cost medical and legal avenues and into community-based health care and social services that can offer comprehensive assessment,care/case planning and management to lead to more positive outcomes. This strategy promotes more appropriate use of emergency care servicesand also supports person-centered care through increased access to primary care and social services, especially for medically underserved populations.
Prevention and Health Promotion		Projects focus on prevention and health promotion to eliminate disparities and achieve health equity across regions and populations.

3A	**Addressing opioid usepublic health crisis**	The opioid epidemic affects communities, families, and overwhelms law enforcement, health care and social service providers. Opioid use disorderis a devastating and life-threatening chronic medical condition and accessto treatments that support recovery and access to lifesaving medications to reverse overdose needs to be improved. This project will support strategies focused on addressing prevention, treatment, overdose prevention and recovery supports aimed at supporting whole-person health
3B	**Reproductive and maternal/child health**	Focusing on the health of women and children is a primary focus for theMedicaid program as Medicaid funds more than half of the births in the state and provides coverage to more than half of Washington's children.This project focuses on ensuring access to ongoing women's health careto improve utilization of effective family planning strategies. It further focuses on providing mothers and their children with home visits that have been demonstrated to improve maternal and child health. Home visitors work with the expectant or new mother in supporting a healthy pregnancy, by recognizing and reducing risk factors, promoting prenatalhealth care through healthy diet, exercise, stress management, ongoing well-woman care, and by supporting positive parenting practices that facilitate the infant and young child's safe and healthy development. Child health promotion is a state priority to keep children as healthy andsafe as possible, which includes parents accessing timely and routine preventative care for children, especially well-child screenings and assessments.
3C	**Access to oral healthservices**	Oral health impacts overall health and quality life, and most oral disease is preventable. Oral disease has been associated with increased risk for serious adverse health outcomes. Increasing access to oral health servicesfor adults provides an opportunity to prevent or control the progression oforal disease, and to reduce reliance on emergency departments for oral pain and related conditions. This project focuses on providing oral health screening and assessment, intervention, and referral in the primary care setting, or through the deployment of mobile clinics and/or portable

		equipment. The project seeks to leverage the primary care workforce, andto strengthen relationships between primary care and dental providers, through stronger referral networks, improved communications, and shared incentives.
3D	**Chronic disease prevention and control**	Chronic health conditions are prevalent among Washington's Medicaid beneficiaries, and the number of individuals with or at risk for chronic disease is increasing. Disease prevention and effective management is critical to quality of life and longevity. Many individuals face cultural, linguistic and structural barriers to accessing quality care, navigating the health care system, and understanding how to take steps to improve their health. Improving health care services and health behaviors is only part ofthe solution. Washington State recognizes the impact that factors outside the health care system have on health and is committed to a "health in all policies" approach to effective health promotion and improved treatment of disease. The Chronic Disease Prevention and Control Project focuses on integrating health system and community approaches to improve chronic disease management and control.

IV. Project Stages, Milestones, and Metrics

a. Overview

In accordance with STC 35, over the duration of the demonstration, the state will shift accountability from a focus on rewarding achievement of progress milestones in the early years of the demonstration to rewarding improvement on performance metrics in the later years of the demonstration. During Years 2, 3 and 4, ACHs will be required to report against several progress milestones for each project, as described further below and as detailed in the Project and Metrics Specification guide. These progress milestones are, by definition, 'pay-for-reporting' or 'P4R,' since ACHs will be rewarded based on reported progress. Project progress milestones are defined in the Project Toolkit, specific to each project focus, and organized into three core categories: project planning milestones, project implementation progress milestones, and scale and sustain milestones.

To monitor performance, ACHs will be accountable for achieving targeted levels of improvement for project-specific outcome measures. These measures are primarily "pay-for-performance," or "P4P," since ACHs are only rewarded if

defined outcome metric targets are achieved. However, a subset of these measures will be rewarded on a P4R basis for reasons that include: to allow ACHs time for project implementation activities; to allow time to establish necessary reporting infrastructure; and to allow for the testing of new, innovative outcome measures for project areas where there is a lack of nationally-vetted, widely used outcomemeasures. Performance metrics are consistent with the objectives of the demonstration as outlined in STC 30.

Table 2 below summarizes the different categories of measures. Each category isdescribed in further detail below.

Table 2. Demonstration Milestone/Metric Categories

Milestone/Metric Type	DY1 (2017)	DY2 (2018)	DY3 (2019)	DY4 (2020)	DY5 (2021)	DY6 (2022)
Project Progress Milestones	NA	P4R	P4R	P4R	NA	NA
Performance Metrics	NA	NA	P4R/P4P	P4R/P4P	P4R/P4P	P4R/P4P
Value-based Payment Metrics	P4R/P4P	P4R/P4P	P4R/P4P	P4R/P4P	P4P	N/A[1]

b. *Progress Milestones (Capacity Building Elements, Progress/Planning Milestones,and Metrics)*

During demonstration Year 1, each ACH will be responsible for the development,submission and approval of a Project Plan application. As part of the Project Planapplication, the ACH will provide a timeline for implementation and completion of each project, in alignment with progress milestones specified in the Project Toolkit and accompanying documents. General categories of progress milestones required to be completed for each project include:

- Identify target population and assess partnering providers' capacity tofulfill project requirements. Collectively, partnering providers should serve a significant portion of

[1]As described in the DSRIP Funding and Mechanics Protocol, it is important to note that this change only relates to MCO and ACH VBP incentives under DSRIP P4R and P4P. The VBP adoption targets remain for statewide accountability and are reinforced through the Apple Health Appendix and the state's managed care withhold program.

Medicaid covered lives in the region andrepresent a broad spectrum of care and related social services that are critical to improving how care is delivered and paid for.

- Engage and obtain formal commitment from partnering providersresponsible for carrying out project activities.
- Develop a detailed implementation plan, including timing of activities,financial sustainability, workforce strategies, and population health management.
- Ongoing reporting of standardized process measures, including number ofindividuals served, number of staff recruited and trained, and impact measures as defined in the evaluation plan.

c. *Performance Metrics* (Statewide and Project-level Outcome Metrics)

See Appendix II for the project metrics that will be used to measure progress against meeting project goals and targeted levels of improvement against outcome-based performance indicators. Section III of the Funding and MechanicsProtocol provides further detail on how identified measures will be used to evaluate ACH performance.

d. Value-based Payment Milestones

Pursuant to STC 40, the state will update its Value-based Roadmap annually, which will address how the state will achieve its goal of converting 90 percent ofMedicaid provider payments to reward outcomes by 2022. This Roadmap is a document that describes the payment reforms required for a high-quality and financially sustainable Medicaid delivery system and establishes VBP targets and incentives for the Managed Care Organizations (MCOs) and ACHs. This document also serves to revise and clarify the details surrounding Washington State’s VBP incentives and framework.

Achievement of VBP targets will be assessed at both a regional and MCO- specific level. As indicated in Table 3, ACHs and MCOs will be rewarded basedon reported progress in the early years of the demonstration. This will shift to rewarding for performance on the VBP targets.

Table 3. Value-based Payment Milestone Categories

Through this demonstration, the DSRIP program and initiatives such as

the HealthCare Payment Learning Action Network will yield new best practices. Therefore,this Roadmap will be updated annually throughout the demonstration to ensure long-term sustainability of the improvements made possible by the DSRIP investment and that best practices and lessons learned can be incorporated into thestate's overall vision of delivery system reform.

Washington will submit quarterly progress updates to CMS, which will includethe progress made both in terms of total dollars included in VBP arrangements and quantitative and qualitative lessons learned.

V. Process for Project Plan Modification

No more than twice a year, ACHs may submit proposed modifications to an approvedProject Plan for state review and approval/denial. In certain limited cases it may become evident that the methodology used to identify a performance goal and/or improvement target is no longer appropriate, or that unique circumstances/developments outside of an ACH's control require the ACH to modifyits original plan. Examples of these circumstances could include a significant regulatory change that requires an ACH to cease a planned project intervention or initiate substantial changes to the way a standard performance metric is measured, requiring an ACH to modify its planned approach.

In order to request a Project Plan modification, an ACH must submit a formal request,with supporting documentation, for review by the state. The state will have 60 calendar days to review and respond to the request. Allowable Project Plan modifications are not anticipated to change the overall ACH project incentive valuation. However, modifications to decrease scope of a project may result in a decrease in the valuation of potential earnable funds. Unearned funds as a result of a decrease in the scope of a project will be directed to the Reinvestment pool and earned in accordance with the DSRIP Funding and Mechanics Protocol (Attachment D). The state will not permit modifications that lower expectations for performance because of greater than expected difficulty in meeting a milestone. Removal of a planned project intervention may result in a forfeiture of funding for that project as determined by the state,

VI. Health Information Technology

Health Information Technology. (The state will discuss how it plans to meet the Health IT goals/milestones outlined in the STCs.)

In accordance with STC 39, the state will use Health Information Technology ("Health IT") and Health information exchange services to link core providers acrossthe continuum of care to the greatest extent possible. To detail how the state will achieve its stated Health IT goals, the state will provide a Health IT strategy by April1, 2017. That document provides detailed tactics and initiatives, technical gaps addressed, critical actions, policy levers and key metrics in place or planned for the following key business processes:

1. Addressing data needs and gaps
2. Acquiring Clinical Data
3. Leveraging Data Resources
4. Supporting clinical decisions with integrated patient information
5. Ensuring data integrity
6. Making large sets of clinical data available for program and business decisions

Medicaid Transformation Project (MTP) Toolkit

May 2022

Centers for Medicare and Medicaid Services (CMS) approved Washington's MTP Toolkit in June 2017 as part of the Delivery System Incentive Payment (DSRIP) planning protocol. The CMS-approved Project Toolkit contains the final projects, evidence-based approaches/strategies, and metrics for the Medicaid Transformation Project. (MTP) A timeline and summary of modifications made to this document (since CMS approval) are below.

- June 2017: approved by CMS as part of the DSRIP planning protocol.
- October 2017: revised to reflect the removal of five project pay-for-performance (P4P) metrics. The list of metrics and associated rationale and other resources are available on the MTP metrics page.
- July 2018: revised to streamline and clarify reporting requirements associated with achievement values (AVs), updated to reflect change in pay-for-reporting (P4R) metrics, minor change to one P4P metric (inpatient hospital utilization replaced by acute hospital utilization, per Healthcare Effectiveness Data and Information Set (HEDIS) 2018 recommendation).
- August 2019: the state adopted adjustments to the set of DSRIP accountability metrics associated with the Project Toolkit. More information is available on the MTP metrics page. The following P4P metric updates were incorporated into the Project Toolkit:
    - Metric: dental sealants for children at elevated risk: deactivate for ACH P4P accountability for demonstration year (DY)4. Assess activation for DY5 when revised specifications available. Applies to Project 3C.
    - Metric: medication management for people with asthma (National Quality Forum (NQF) 1799)): No change to DY3. In DY4, remove medication management for people with asthma and replace with asthma medication ratio (NQF 1800). Applies to Project 2A and 3D.
- September 2019: typos corrected in Appendix A: P4R and P4P AV association.
- June 2021: updated P4P metrics consisting with HEDIS changes for DY4 and DY5. The following measures were updated based on the changes:
    - Metric: Children's and Adolescent's Access to Primary Care Practitioners (CAP) was retired.
    - Metric: Child and Adolescent Well-Care Visits 3-21 Years of Age replaces CAP.
    - Metric: Well-Child Visits in the 3-6 Years of Age was retired.
    - Metric: Child and Adolescent Well-Care Visits 3-11 Years of Age replaces Well-Child Visits 3-6 Years of Age.
    - Metric: Well-Child Visits in the First 15 Months of Life was retired.
    - Metric: Well-Child Visits in the First 30 Months of life replaces Well-Child Visits in the First 15 Months of Life.
    - Metric: Comprehensive Diabetes Care: Medical Attention for Nephropathy retired.
    - Metric: Kidney Health Evaluation with Patients with Diabetes replaces CDC: Nephropathy.
- May 2022: DY6 adjustments, including project achievement values added to each project section for P4R and P4P.

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Using the Project Toolkit: definitions

Project objective: aim the project is intended to achieve.

Target population: population the project is intended to address. For each project selected, the Accountable Community of Health (ACH) must define the target population, informed by regional needs, and based on the target population defined in the toolkit. ACHs may choose one or more target populations.

Evidence-based approach: menu of interventions available for the project. One or more evidence-based approaches are identified to serve as a menu of interventions for each project. ACHs may pursue one of the following approaches:

- Selecting one evidence-based approach for the entire project.
- Combining evidence-based approaches for the entire project.
- Applying different evidence-based approaches for different target populations/geographies for the project.

ACHs are required to implement one of the evidence-based approaches identified under the selected project or identify another, similar evidence-based approach. If selecting an alternative evidence-based approach, the ACH must demonstrate convincingly its equivalency to those in the toolkit, including the ability to achieve required project metrics.

Project stages and milestones: each project progresses from project planning, implementation, and sustainability. Each project is divided into three stages, which has defined milestones. ACHs must provide proof of completion of each milestone within a specified timeline to earn receive full project incentive funds from DY2 to DY4. To the extent possible, milestones, timeline, and proof of completion are standardized across projects. ACHs are awarded AVs for successful completion of project milestones according to the toolkit timeline.

P4R recurrent deliverables and P4P project metrics: in addition to milestones listed in the project stage, each ACH will be responsible for additional, recurrent P4R deliverables from DY2 to DY6. Each ACH will be held accountable and awarded incentive funds based on a P4P basis from DY3 through DY6 for the metrics listed in the toolkit. All P4P measurement and calculations will be produced by the state on an annual basis. Specifics on project performance measurement are further detailed in the DSRIP Measurement Guide.

Project incentive funds are earned on AVs for each specified item in the toolkit (project milestones, recurrent P4R deliverables, P4R metrics, and P4P metrics). See Appendix A: AV snapshot by project for a full schedule of AVs.

Project implementation guidelines: additional details on the project's core components, including health systems and community capacity building strategies and evidence-based approaches that are intended to guide ACHs' development of project implementation plans and quality improvement plans (QIPs).

Appendix A: P4R and P4P AV association: tables provide a quick reference for AVs for P4R and P4P funds by project by year.

Appendix B: Project Toolkit P4P metrics: ACHs are accountable for achieving targeted levels of improvement for project-specific outcome metrics. The tables provide a quick reference of the final project performance metrics used to measure ACH progress toward meeting project goals and targeted levels of improvement against outcome-based performance indicators.

Domain 1: health systems and community capacity building

This domain addresses the core health system capacities to be developed or enhanced to transition the delivery system under MTP. Domain 1 outlines three required focus areas: financial sustainability through value-based payment, workforce, and systems for population health management. Each of these areas will need to be addressed progressively throughout the five-year timeline to directly support Domain 2 and Domain 3 transformation project success.

Financial sustainability through value-based purchasing (VBP)

Overarching goal

Achieve the target of driving 90 percent of state-financed health care to value-based payment by the end of 2021.

The success and sustainability of the state's DSRIP program is largely dependent on moving along the value-based payment continuum as a state and at the regional level. ACHs may earn VBP incentives by reporting progress on VBP milestones (P4R), and improvement and attainment of VBP targets (P4P) in their region. ACHs will be primarily rewarded on progress in the early years, shifting to performance in later years.

VBP categories as defined by the Health Care Payment Learning Action Network (HCP-LAN) Framework will be used for calculating the annual targets below. Targets will be calculated by dividing the total Medicaid dollars spent in HCP-LAN categories 2C and higher by total Medicaid managed care organization (MCO) payments to providers.

Annual targets

Percentage of provider payments in HCP-LAN categories 2C or above required to earn VBP incentives.

Table 1: VBP targets

	DY1	DY2	DY3	DY4	DY5	DY6
HCP-LAN category 2C-4B	30%	50%	75%	85%	90%	90%[1]
Subset of goal above: HCP-LAN category 3A-4B	-	10%	20%	30%	50%	N/A
Payment in Advanced alternative payment methods (APMs)	-	-	TBD	TBD	TBD	N/A

Further information on regional, MCO, and statewide VBP targets, and how incentives are earned are available in the Apple Health Appendix and the DSRIP Measurement Guide.

Governance

HCA will create and facilitate a statewide Medicaid Value-based Payment (MVP) Action Team. The MVP Action Team will serve as a learning collaborative to support ACHs and MCOs in attainment of Medicaid VBP targets. It will serve as a forum to help prepare providers for value-based contract arrangements and to provide guidance on HCA's VBP definition (based on the HCP-LAN Framework). Representatives may include state, regional and local leaders, and stakeholders.

[1] As described in the Funding and Mechanics Protocol, statewide accountability for VBP remains in DY6 but state will no longer provide regional ACH incentives and statewide MCO incentives. This change was made due to the limited total funding available in DY6 and the significant VBP advancement DY1-DY5. As such, the subset goal and APM requirement are not applicable to DY6.

Project stages

Table 2: stage 1 – financial sustainability through VBP planning

Responsibility (regional/ statewide)	Activity	Timeline (complete no later than)
Statewide	The MVP Action Team will assist HCA in performing an assessment to capture or validate a baseline of the current VBP levels. To the extent assessments have already been conducted, the MVP Action Team will build from those assessments. Building from existing work when applicable, the MVP Action Team will: • Assist HCA in deploying survey/attestation assessments to facilitate the reporting of VBP levels to understand the current types of VBP arrangements across the provider spectrum. • Perform and/or review assessments of VBP readiness across regional provider systems. • Develop recommendations to improve VBP readiness across regional provider systems.	DY2, Q4

Regional	To support regional attainment of VBP targets, ACHs will achieve the following milestones:
	• Inform providers of VBP readiness tools to assist their move toward value-based care. Some viable tools may include:
	  o NACHC Payment Reform Readiness Toolkit
	  o AMA Steps Forward – preparing your practice for value-based care
	  o Rural Health Value Team's comprehensive Value-Based Care Strategic Planning Tool
	  o Assessments deployed by the Healthier Washington Collaboration Portal (WA Portal), formerly known as the Practice Transformation Support Hub, and the Transforming Clinical Practice Initiative (TCPI).
	  o Adoption of diagnostic coding in dental for bi-directional medical/dental data sharing and population health.
	• Connect providers to training and/or technical assistance offered through HCA, WA Portal, MCOs, and/or the ACH.
	• Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the annual Paying for Value provider survey.
	• Support providers in developing strategies to move toward value-based care.
		DY2, Q4

Table 3: stage 2 – financial sustainability through VBP implementation

Responsibility (regional/ statewide)		Timeline (complete no later than)
Statewide	Perform ongoing monitoring of regional, MCO, and statewide VBP attainment as described in the Apple Health Appendix.	DY5, Q4
Regional	To support regional attainment of VBP targets, ACHs will achieve the following milestones: • Identify providers who are struggling to implement practice transformation and move toward value-based care.	DY3, Q4

	• Support providers to implement strategies to move toward value-based care. • Continue to support regional VBP attainment assessments by encouraging and/or incentivizing completion of the annual Paying for Value provider survey.	
	To support regional attainment of VBP targets, ACHs will achieve the following milestones: • Continue to support regional VBP attainment assessments by encouraging and/or incentivizing completion of the annual Paying for Value provider survey. • Continued identification and support of providers struggling to implement practice transformation and move toward value-based care.	DY4, Q4

Table 4: stage 2.1 – Continued sustainability through VBP implementation

Responsibility (regional/ statewide)		Timeline (complete no later than)
Statewide	Perform ongoing monitoring of regional, MCO, and statewide VBP attainment as described in the Apple Health Appendix. MCO VBP incentives will be phased out in DY6 due to the limited total funding available in DY6 and the significant VBP advancement DY1-DY5.	DY6, Q4
Regional	VBP achievement values will be phased out in DY6 due to the limited total funding available in DY6 and the significant VBP advancement DY1-DY5.	DY6, Q4

Workforce

Overarching goal

Promote a health workforce that supports comprehensive, coordinated, and timely access to care.

Governance

Throughout the design and implementation of transformation efforts, ACHs and partnering providers must consider workforce needs pertaining to selected projects and the broader objectives of MTP. There are several statewide taskforces and groups with expertise in identifying emerging health workforce needs and providing actionable information to inform the evolving workforce demands of a redesigned system of care. ACHs should leverage existing resources available to inform workforce strategies for the projects their region is implementing.

Project stages

Table 4: stage 1 – workforce planning

Responsibility (regional/ statewide)	Activity	Timeline (to complete no later than)
Statewide	• Based on identified regional workforce gaps and needs, provide recommendations and guidance to support and evolve the health care workforce consistent with MTP goals and objectives.	DY2, Q4

	• Identify existing educational and other resources available to educate, train, and re-train individuals to promote a workforce that supports and promotes evolving care models.	

Regional	• Consider workforce implications as part of project implementation plans and identify strategies to prepare and support the state's health workforce for emerging models of care under MTP.
	• Develop workforce strategies to address gaps and training needs, and to make overall progress toward the future state of MTP:
	  ○ Identify regulatory barriers to effective team-based care and practice transformation.
	  ○ Incorporate strategies and approaches to cultural competency and health literacy trainings.
	  ○ Incorporate strategies to mitigate impact of health care redesign on workforce delivering services for which there is a decrease in demand.
		DY2, Q4

Table 5: stage 2 – workforce implementation

Responsibility (regional/statewide)		Timeline (complete no later than)
Statewide and regional	• Implement practice transformation and workforce strategies. • Administer necessary resources to support all efforts.	DY4, Q4

Systems for population health management

Overarching goal

Leverage and expand health information technology (HIT) and health information exchange (HIE) infrastructure and tools to capture, analyze, and share relevant data.

For the purposes of MTP, population health management is defined as:

- Data aggregation
- Data analysis
- Data-informed care delivery
- Data-enabled financial models

Governance

Governance is envisioned as a multi-tiered approach. Data and measurement activity in service of MTP will be facilitated by the Washington State Health Care Authority (HCA), in coordination with departments of Social and Health Services (DSHS) and Health (DOH).

- The Office of the National Coordinator develops policy and system standards for interoperability, which govern Certified Electronic Health Record Technology (CEHRT) and sets the national standards for how health information systems can collect, share, and use information. The use of interoperable HIT and HIE is expected to support care coordination and integration, quality improvement, and value-based payment.

- HCA will coordinate efforts among multiple state government agencies to link Medicaid claims, social services data, population health information, and social determinants of health data, as well as direct efforts to increase accessibility of data in line with current legislation.
- HCA will work with ACHs to ensure that:
    - Data products are developed that meet ACH project need.
    - Data are combined in ways that meet local needs.
    - Access to data accommodates different levels of IT sophistication, local use, and support improved care.

Project stages

Table 6: stage 1 – systems for population health management planning and implementation

Responsibility (regional/ statewide)	Activity	Timeline (complete no later than)

Statewide	• HCA will provide guidance to ACHs in assessing current population health management capacity in service of Domain 2 and Domain 3 projects.
	• HCA will Identify tools available for population health management, which may include:
	  ○ Agency for Healthcare Research and Quality's (AHRQ) Practice-Based Population Health.
	  ○ Office of the National Coordinator for Health IT's 2016 Interoperability Standards Advisory.
	  ○ SAMHSA-HRSA's Center for Integrated Health Solutions Population Health Management webinars.
	• The HCA will promote on-demand access to standard care summaries and medical records within the Clinical Data Repository (CDR) through the HIE and claims through the development of an integrated health information system.
	• To support the work, HCA will coordinate with the state-designated entity for HIE, OneHealthPort, which is responsible for building and implementing the infrastructure used for HIE and developing tools and services that support broader access and utilization of both HIE and clinical data. In addition, OneHealthPort works for and with the provider community to help develop community best practices for data exchange and use.
		DY4 Q2

Regional	To support transformation projects, ACHs will convene key providers and health system alliances to share information with the state on: • Provider needs to effectively access and use population health data. • Local health system stakeholder needs for population health, social service, and social determinants of health data. ACHs must address systems for population health management within their project implementation plans. This must include: • Identified work steps and deliverables to implement information exchange for community-based, integrated care. Implementation plans should be tailored based on regional providers' current state of readiness and the implementation strategies selected within Domains 2 and 3.	DY4 Q2

	• Actionable steps taken to develop or enhance information exchange between providers at points of care, which will allow for the ability to track and follow up on patients with target conditions. • Identified opportunities to leverage transformation incentives, resources, and activities to respond to needs and gaps identified in the current infrastructure and support statewide information exchange systems.	

Domain 2: care delivery redesign

Transformation projects within this domain focus on innovative models of care that will improve the quality, efficiency, and effectiveness of care processes.

Project 2A: bi-directional integration of physical and behavioral health through care transformation

Project objective

This project uses a whole-person approach to care by addressing physical and behavioral health needs in one system through an integrated network of providers. This approach offers better coordinated care for patients and more seamless access to the services they need. This project will support and advance MTP and bring together the financing and delivery of physical and behavioral health services through MCOs for people enrolled in Medicaid.

Target population

All Medicaid beneficiaries (children and adults), particularly those with or at-risk for behavioral health conditions, including mental illness and/or substance use disorder (SUD).

Guidelines

ACHs must implement a project that includes at least one approach from integrating:

- Behavioral health into primary care settings.
- Primary care into the behavioral health setting.

Evidence-based approaches for integrating behavioral health into a primary care setting:

- Bree Collaborative's Behavioral Health Integration Report and Recommendations
- Collaborative Care Model
    - The Collaborative Care Model is a team-based model that adds a behavioral health care manager and a psychiatric consultant to support the primary care provider's management of individual patients' behavioral health needs.
    - The model can be either practice-based or telehealth-based, so it can be used in both rural and urban areas.
    - The model can be used to treat a wide range of behavioral health conditions, including depression, SUD, bipolar disorder, post-traumatic stress disorder (PTSD), and other conditions.

Approaches based on emerging evidence for integrating primary care into behavioral health settings:

These approaches are described in the report "Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness."

For any approach, apply core principles of the Collaborative Care Model (see above) to integration into the behavioral health setting.

- Off-site, enhanced collaboration
- Co-located, enhanced collaboration
- Co-located, integrated

Project stages

Table 7: stage 1 – bi-directional integration planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess current state capacity of integrated care model adoption: describe the level of integrated care model adoption among the target providers/organizations serving Medicaid beneficiaries. Explain which integrated models or practices are currently in place and describe where each target provider/organization currently falls in the levels of collaboration as outlined in the Standard Framework for Integrated Care.**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for health systems/community capacity building • **Identify how strategies for health systems/community capacity building focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2
Definition of evidence-based approaches or promising practices and target populations • **Define target population(s) and evidence-based approach(es)/promising practices informed by regional health needs.**	Report milestone completion in semi-annual report	DY2, Q2
Completion of initial partnering provider list • **Identify and engage initial partnering providers, including behavioral and physical health providers, organizations, and relevant committees or councils.** • **Execute Master Services Agreement for partnering providers receiving funds through the FE portal.**	Report milestone completion in semi-annual report	DY2, Q2
Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.** • **For 2020 adopters of integrated managed care: ensure planning reflects timeline and process to transition to integration of physical and behavioral health, including engaging and convening county commissioners, Tribal Governments, MCOs, behavioral health and primary care providers, and other critical partners.**	Timely submission of implementation plan	DY2, Q3

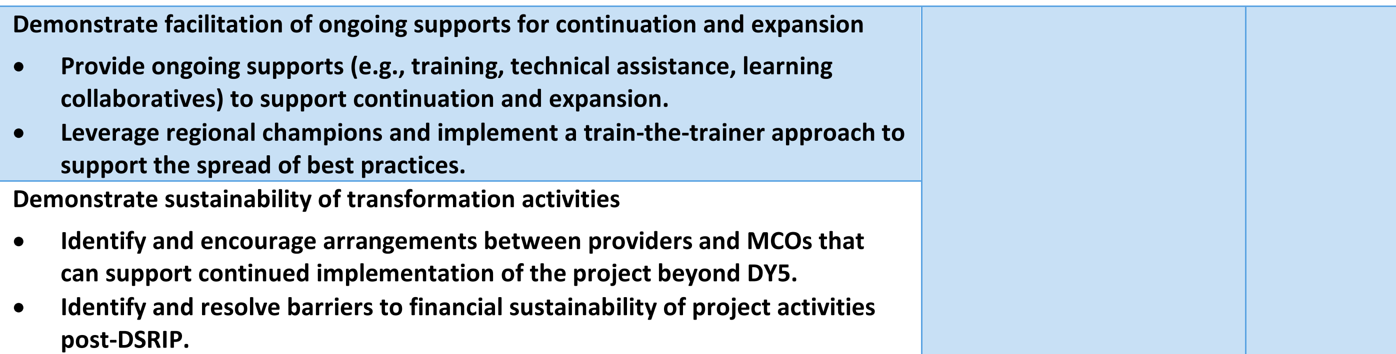
Support regional transition to integrated managed care (2020 regions only) • **Note: This milestone only applies to those ACH regions that were not early or mid-adopters for integrated managed care.** • **Engage and convene county commissioners, Tribal Governments, MCOs, behavioral health and primary care providers, and other critical partners to develop a plan and description of a process to transition to integrated managed care.**	Report milestone completion in semi-annual report	DY2, Q4

Table 8: stage 2 – bi-directional integration implementation

Project milestone	Proof of completion required	Due
Description of partnering provider progress in adoption of policies, procedures, and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches.**	Timely submission of QIP	DY3, Q2
Description of training and implementation activities • **Ensure each partnering provider and/or organization is provided with, or has secured, the training and technical assistance resources and HIT/HIE tools necessary to perform their role in the integrated care activities.** • **Obtain technology tools needed to create, transmit, and download shared care plans and other HIE technology tools to support integrated care activities.** • **Provide participating providers and organizations with financial resources to offset the costs of infrastructure necessary to support integrated care activities.**	Demonstrate progress in semi-annual report	DY3, Q4
Attestation of successfully integrating managed care • **Implementation of integrated managed care (applicable to mid-adopter regions).**	Report milestone completion in semi-annual report	

Table 9: stage 3 – bi-directional integration scale and sustain

Project milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Increase use of technology tools to support integrated care activities by additional providers/organizations.** • **Identify new, additional target providers/organizations.**	Demonstrate progress in semi-annual report	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Employ continuous quality improvement methods to refine the model, updating model and adopting guidelines, policies, and procedures as required.**		



Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.** • **Leverage regional champions and implement a train-the-trainer approach to support the spread of best practices.**		
Demonstrate sustainability of transformation activities • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of project activities post-DSRIP.**		

Table 10: stage 3.1 – bi-directional integration continued sustainability and transitioning

Project milestone	Proof of completion required	Due
Completion of all P4R reporting • **Completion of required P4R metrics. This includes any MeHAF and WA-ICA transition[2] support to advance bidirectional clinical integration.** • **Support providers through coaching, training, technical assistance, learning cohorts.** • **Provider engagement and continuation along the integration care continuum.**	Demonstrate progress in DY6 P4R report	DY6, Q4

Table 11: P4R recurrent deliverables and P4P project metrics

Year	Type	Recurrent deliverable or metric	Due
DY2 (2018)	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of independent external evaluator (IEE) activities	DY2, Q4
DY3 (2019)	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (Maine Health Access Foundation (MeHAF) Site Self-Assessment Survey))	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (MeHAF Site Self-Assessment Survey)	DY3, Q4

[2] The WA-ICA is a new integration assessment tool that will replace the MeHAF beginning in DY6. This is a direct replacement for the existing P4R requirements. This tool was selected based on provider feedback and significant collaboration among ACHs, MCOs and HCA.

	P4P: state-produced	• All-Cause Emergency Department (ED) Visits per 1000 Member Months • Antidepressant Medication Management • Children's and Adolescents' Access to Primary Care Practitioners • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Comprehensive Diabetes Care: Medical Attention for Nephropathy • Medication Management for People with Asthma (5 – 64 Years) • Mental Health Treatment Penetration (Broad Version) • Plan All-Cause Readmission Rate (30 Days) • SUD Treatment Penetration	Annual
DY4 (2020)	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (MeHAF Site Self-Assessment Survey)	DY4, Q2
		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (MeHAF Site Self-Assessment Survey)	DY4, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Antidepressant Medication Management • Asthma Medication Ratio • Child and Adolescent Well-Care Visits (3-21 Years of Age) • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Kidney Health Evaluation with Patients with Diabetes • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Mental Health Treatment Penetration (Broad Version) • Plan All-Cause Readmission Rate (30 Days) • SUD Treatment Penetration	Annual
DY5 (2021)	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (MeHAF Site Self-Assessment Survey)	DY5, Q2
		• Completion of semi-annual report (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (MeHAF Site Self-Assessment Survey)	DY5, Q4

	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Antidepressant Medication Management • Asthma Medication Ratio • Child and Adolescent Well-Care Visits (3-21 Years of Age) • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Kidney Health Evaluation with Patients with Diabetes • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Mental Health Treatment Penetration (Broad Version) • Plan All-Cause Readmission Rate (30 Days) • SUD Treatment Penetration	Annual
DY6 (2022)	P4R: ACH-reported	• Completion of DY6 P4R report 1 (template available January 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Completion of required P4R metrics.	DY6, Q1
		• Completion of P4R report 2 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Completion of required P4R metrics.	DY6, Q3
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Antidepressant Medication Management • Asthma Medication Ratio • Child and Adolescent Well-Care Visits (3-21 Years of Age) • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Kidney Health Evaluation with Patients with Diabetes • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Mental Health Treatment Penetration (Broad Version) • Plan All-Cause Readmission Rate (30 Days) • SUD Treatment Penetration	Annual

Project implementation guidelines

This section provides additional details on the project's core components and should guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems community and capacity building strategies

- **Population health management/HIT:** current level of adoption of electronic health records (EHRs) and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes,

information to enable population health management and quality improvement processes, and provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.

- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:
  - Shortage of mental health providers, SUD providers, social workers, nurse practitioners, primary care providers, care coordinators and care managers.
  - Opportunities for use of telehealth and integration into work streams.
  - Workflow changes to support integration of new screening and care processes, care integration, and communication.
  - Cultural and linguistic competency and health literacy deficiencies.
- **Financial sustainability:** alignment between current payment structures and guidelines for physical and behavioral care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support integrated care efforts into the regional VBP transition plan. Assess timeline or status for adoption of fully integrated managed care contracts. Development of model benefit(s) to cover integrated care models.

Guidance for evidence-based approaches

Integrating behavioral health into primary care setting

Standards adopted by the Bree Collaborative in the Behavioral Health Integration Report and Recommendations (As part of this option, regions will implement the core components that are consistent with the standards adopted by the Bree Collaborative).

Summary of core elements and minimum standards for integrated care element specifications under consideration by the Bree Collaborative:

- Integrated Care Team: each member of the integrated care team has clearly defined roles for both physical and behavioral health services. Team members, including clinicians and non-licensed staff, may participate in team activities, either in person or virtually.
- Routine access to integrated services: access to behavioral health and primary care services are available routinely as part of the care team's daily workflow and on the same day as patient needs are identified, as feasible. Patients can be engaged and receive treatment in person or by phone or videoconferencing, as convenient for the patient.
- Accessibility and sharing of patient information: the integrated care team has access to actionable medical and behavioral health information via a shared care plan at the point of care. All clinicians work together to jointly support their roles in the patient's shared care plan.
- Access to psychiatry services: access to psychiatry consultation services is available in a systematic manner to assist the care team in developing a treatment plan and to advise the team on adjusting treatments for patients who are not improving as expected.
- Operational systems and workflows support population-based care: a structured method is in place for proactive identification and stratification of patients for behavioral health conditions. The care team

tracks patients to make sure each patient is engaged and treated-to-target (i.e., to remission or other appropriate individual improvement goals).

- Evidence-based treatments: age-appropriate, measurement-based interventions for physical and behavioral health interventions are adapted to the specific needs of the practice setting. Integrated practice teams use behavioral health symptom rating scales in a systematic and quantifiable way to determine whether their patients are improving.
- Patient involvement in care: the patient's goals are incorporated into the care plan. The team communicates effectively with the patient about their treatment options and asks for patient input and feedback into care planning.

Collaborative Care Model

As part of this option, regions can choose to focus initially on depression screening and treatment program (such as tested in the IMPACT model). Many successful Collaborative Care pilot programs begin with an initial focus on depression and later expand to treat other behavioral health conditions, including SUD.

Implement the core components and tasks for effective integrated behavioral health care, as defined by the Advancing Integrated Mental Health Solutions (AIMS) Center of the University of Washington and shown here:

- Patient identification and diagnosis:
    - Screen for behavioral health problems using valid instruments.
    - Diagnose behavioral health problems and related conditions.
    - Use valid measurement tools to assess and document baseline symptom severity.
- Engagement in integrated care program:
    - Introduce collaborative care team and engage patient in integrated care program.
    - Initiate patient tracking in population-based registry.
- Evidence-based treatment:
    - Develop and regularly update a biopsychosocial treatment plan.
    - Provide patient and family education about symptoms, treatments, and self-management skills.
    - Provide evidence-based counseling (e.g., motivational interviewing, behavioral activation).
    - Provide evidence-based psychotherapy (e.g., problem-solving treatment, cognitive behavioral therapy, interpersonal therapy).
    - Prescribe and manage psychotropic medications as clinically indicated.
    - Change or adjust treatments if patients do not meet treatment targets.
- Systematic follow-up, treatment adjustment, and relapse prevention:
    - Use population-based registry to systematically follow all patients.
    - Proactively reach out to patients who do not follow-up.
    - Monitor treatment response at each contact with valid outcome metrics.
    - Monitor treatment side effects and complications.
    - Identify patients who are not improving to target them for psychiatric consultation and treatment adjustment.
    - Create and support relapse prevention plan when patients are substantially improved.

- Communication and care coordination:
    - Coordinate and facilitate effective communication among all providers on the treatment team, regardless of clinic affiliation or location.
    - Engage and support family and significant others as clinically appropriate.
    - Facilitate and track referrals to specialty care, social services, and community-based resources.
- Systematic psychiatric case review and consultation (in-person or via telemedicine):
    - Conduct regular (e.g., weekly) psychiatric caseload review on patients who are not improving.
    - Provide specific recommendations for additional diagnostic work-up, treatment changes, or referrals.
    - Provide psychiatric assessments for challenging patients, either in-person or via telemedicine.
- Program oversight and quality improvement:
    - Provide administrative support and supervision for program.
    - Provide clinical support and supervision for program.
    - Routinely examine provider- and program-level outcomes (e.g., clinical outcomes, quality of care, patient satisfaction) and use this information for quality improvement.

Integrating primary care into behavioral health setting

Offsite enhanced collaboration

Primary care and behavioral health providers located at a distance from one another will move beyond basic collaboration (in which providers make referrals, do not share any communication systems, but may or may not have periodic non-face-to-face communication, including sending reports), to enhanced collaboration that includes tracking physical health outcomes, with the following core components:

- Providers have regular contact and view each other as an interdisciplinary team, working together in a client-centered model of care.
- A process for bi-directional information sharing, including shared treatment planning, is in place and is used consistently.
- Providers may maintain separate care plans and information systems, but regular communication and systematic information sharing results in alignment of treatment plans, and effective medication adjustments and reconciliation to effectively treat beneficiaries to achieve improved outcomes.
- Care managers and/or coordinators are in place to facilitate effective and efficient collaboration across settings ensuring that beneficiaries do not experience poorly coordinated services or fall through the cracks between providers.
- Care managers and/or coordinators track and monitor physical health outcomes over time using registry tools, facilitate communication across settings, and follow up with patients and care team members across sites.

Co-located, enhanced collaboration or co-located, integrated

Apply and implement the core principles of the Collaborative Care Model to the integration of primary care; implement the core components and tasks for effective integration of physical health care into the behavioral health setting.

- Patient identification and diagnosis:
    - Screen for and document chronic diseases and conditions, such as obesity, diabetes, heart disease and others.
    - Diagnose chronic diseases and conditions.
    - Assess chronic disease management practices and control status.
- Engagement in integrated care program:
    - Introduce collaborative care team and engage patient in integrated care program.
    - Initiate patient tracking in population-based registry.
- Evidence-based treatment:
    - Develop and regularly update a biopsychosocial treatment plan.
    - Provide patient and family education about symptoms, treatments, and self-management skills.
    - Provide evidence-based self-management education.
    - Provide routine immunizations according to Advisory Committee on Immunization Practices (ACIP) recommendations as needed.
    - Provide the U.S. Preventive Services Task Force screenings graded A and B as needed.
    - Prescribe and manage medications as clinically indicated.
    - Change or adjust treatments if patients do not meet treatment targets, refer to specialists as needed.
- Systematic follow-up, treatment adjustment:
    - Use population-based registry to systematically follow identified patients.
    - Proactively reach out to patients who have difficulty following up.
    - Monitor treatment response at each contact with valid outcome metrics.
    - Monitor treatment side effects and complications.
    - Identify patients who are not improving and identify them for specialist evaluation or connection to increased primary care access/utilization.
- Communication and care coordination:
    - Coordinate and facilitate effective communication among all providers on the treatment team, regardless of clinic affiliation or location.
    - Engage and support family and significant others as clinically appropriate.
    - Facilitate and track referrals to specialty care, social services, and community-based resources.
- Systematic case review and consultation (in person or via telemedicine):
    - Conduct regular (e.g., weekly) chronic disease and condition caseload review on patients who are not improving.
    - Provide specific recommendations for additional diagnostic work-up, treatment changes, or referrals.
- Program oversight and quality improvement:

- Provide administrative support and supervision to support an integrated team.
- Provide clinical support and supervision for care team members who are co-located.
- Routinely examine provider-level and program-level outcomes (e.g., clinical outcomes, quality of care, patient satisfaction) and use to inform quality improvement processes and activities.

Project 2B: community-based care coordination

Project objective

Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.

Target population

Medicaid beneficiaries (adults and children) with one or more chronic disease or condition (such as arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity, and stroke), or mental illness/depressive disorders, or moderate to severe SUD and at least one risk factor (e.g., unstable housing, food insecurity, high emergency management services (EMS) utilization).

Evidence-based approach

Pathways Community HUB

Project stages

Table 12: stage 1 – community-based care coordination planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess current state capacity to effectively focus on the need for regional community-based care coordination.**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for health systems/community capacity • **Identify how strategies for health systems community and capacity building focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2
Definition of evidence-based approaches or promising practices and target populations • **Define target population(s) and evidence-based approach(es)/promising practices informed by regional health needs.**	Report milestone completion in semi-annual report	DY2, Q2

Completion of initial partnering provider list
• **Identify and engage project implementation partnering provider organizations, including:**
  ○ **Review national HUB standards and provide training on the HUB model to stakeholders.**
  ○ **Identify, recruit, and secure formal commitments for participation from all implementation partners, including patient-centered medical homes, health homes, care coordination service providers, and other community-based service organizations, with a written agreement specific to the role each will perform in the HUB.**
  ○ **Determine how to fill gaps in resources, including augmenting resources within existing organizations and/or hiring at the HUB lead entity.**
  ○ **Execute Master Services Agreement for partnering providers receiving funds through the financial executor (FE) portal.**
	Report milestone completion in semi-annual report	DY2, Q2

Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.**	Timely submission of implementation plan	DY2, Q3
Identified HUB lead entity and description of qualifications • **Identify project lead entity, including:** ○ **Establishing HUB planning group, including payers.**	Report milestone completion in semi-annual report	DY2, Q4

Table 13: stage 2 – community-based care coordination implementation

Project milestone	Proof of completion required	Due
Description of partnering provider progress in adoption of policies, procedures and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches/pathways.**	Timely submission of QIP	DY3, Q2
Description of training and implementation activities **Implement project, which includes the Phase 2 (creating tools and resources) and 3 (launching the HUB) elements specified by AHRQ:** • **Create and implement checklists and related documents for care coordinators.** • **Implement selected pathways from the Pathways Community HUB Certification Program or implement care coordination evidence-based protocols adopted as standard under a similar approach.** • **Develop systems to track and evaluate performance.** • **Hire and train staff.** • **Implement technology-enabled care coordination tools and enable the appropriate integration of information captured by care coordinators with clinical information captured through statewide HIE.**	Demonstrate progress in semi-annual report	DY3, Q4
Description of each pathway scheduled for initial implementation and expansion/partnering provider roles and responsibilities to support Pathways implementation.	Demonstrate progress in semi-annual report	DY3, Q4

Table 14: stage 3 – community-based care coordination scale and sustain

Project milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Expand the use of care coordination technology tools to additional providers and/or patient populations.**	Demonstrate progress in semi-annual report	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Employ continuous quality improvement methods to refine the model, updating model, and adopting guidelines, policies, and procedures as required.**		
Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.**		
Demonstrate sustainability of transformation activities • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of project activities post-DSRIP.**		

Table 15: community-based care coordination P4R recurrent deliverables and P4P project metrics

Year	Type	Recurrent deliverable or metric	Due
DY2 – 2018	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY2, Q4
DY3 – 2019	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Mental Health Treatment Penetration (Broad Version) • Percent Homeless (Narrow definition) • Plan All-Cause Readmission Rate (30 Days) • SUD Treatment Penetration	Annual
DY4 – 2020	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q2

		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Mental Health Treatment Penetration (Broad Version) • Percent Homeless (Narrow definition) • Plan All-Cause Readmission Rate (30 Days) • SUD Treatment Penetration	Annual
DY5 – 2021	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q2
		• Completion of semi-annual report 8 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Mental Health Treatment Penetration (Broad Version) • Percent Homeless (Narrow definition) • Plan All-Cause Readmission Rate (30 Days) • SUD Treatment Penetration	Annual
DY6 – 2022	P4R: ACH-reported	• Completion of DY6 P4R report 1 (template available January 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q1
		• Completion of P4R report 2 (template available July 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q3
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Mental Health Treatment Penetration (Broad Version) • Percent Homeless (Narrow definition) • Plan All-Cause Readmission Rate (30 Days) • SUD Treatment Penetration	Annual

Project implementation guidelines

This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems/community capacity strategies

- **Population health management/HIT:** current level of adoption of electronic health records (EHRs) and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, information to enable population health management and quality improvement processes, and provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.
- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:
    - Shortage of mental health providers, SUD providers, social workers, nurse practitioners, primary care providers, care coordinators and care managers.
    - Opportunities for use of telehealth and integration into work streams.
    - Workflow changes to support integration of new screening and care processes, care integration, and communication.
    - Cultural and linguistic competency and health literacy deficiencies.
- **Financial sustainability:** alignment between current payment structures and guidelines for physical and behavioral care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support integrated care efforts into the regional VBP transition plan. Assess timeline or status for adoption of fully integrated managed care contracts. Development of model benefit(s) to cover integrated care models.

Project 2C: transitional care

Project objective

Improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.

Target population

Medicaid beneficiaries in transition from intensive settings of care or institutional settings, including beneficiaries discharged from acute care to home or to supportive housing, and beneficiaries with serious mental illness (SMI) discharged from inpatient care, or client returning to the community from prison or jail.

Evidence-based approaches for care management and transitional care:

1) Interventions to Reduce Acute Care Transfers, INTERACT™4.0: a quality improvement program that focuses on the management of acute change in resident condition.
2) Transitional Care Model: a nurse-led model of transitional care for high-risk older adults that provides comprehensive in-hospital planning and home follow-up.

3) The Care Transitions Intervention® (CTI): a multi-disciplinary approach toward system redesign incorporating physical, behavioral, and social health needs and perspectives. Note: the CTI is also known as the Skill Transfer Model™, the Coleman Transitions Intervention Model®, and the Coleman Model®.
4) Care Transitions Interventions in Mental Health provides a set of components of effective transitional care that can be adapted for managing transitions among persons with SMI.

Evidence-informed approaches to transitional care for people with health and behavioral health needs leaving incarceration

Despite the relative dearth of specific, outcomes-focused research on effective integrated health and behavioral health programs for people leaving incarceration, considerable evidence on effective integrated care models, prison/jail reentry, and transitional programming has paved the way for increased understanding of critical components of an integrated transitional care approach. See the following:

- American Association of Community Psychiatrists' Principles for Managing Transitions in Behavioral Health Services

Project stages

Table 16: transitional care planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess current state capacity to effectively deliver care transition services.**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for Health systems/community capacity • **Identify how strategies for health systems community and capacity building focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2
Definition of evidence-based approaches or promising practices and target populations • **Define target population(s) and evidence-based approach(es)/promising practices informed by regional health needs.**	Report milestone completion in semi-annual report	DY2, Q2
Completion of initial partnering provider list • **Identify, recruit, and secure formal commitments for participation from implementation partners via a written agreement specific to the role each organization and/or provider will perform in the selected approach.** • **For projects targeting people transitioning from incarceration: identify and secure formal partnerships with relevant criminal justice agencies (including but not limited to correctional health, local releasing, and community supervision authorities), health care and behavioral health care service providers, and reentry-involved community-based organizations, including state and local reentry councils.** • **Execute Master Services Agreement for partnering providers receiving funds through the FE portal.**	Report milestone completion in semi-annual report	DY2, Q2

Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.**	Timely submission of implementation plan	DY2, Q3

Table 17: transitional care implementation

Project milestone	Proof of completion required	Due
Description of partnering provider progress in adoption of policies, procedures and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches/pathways.**	Timely submission of QIP	DY3, Q2
Description of training and implementation activities • **Implement project, including the following core components across each approach selected:** • **Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner.** • **Implement bi-directional communication strategies/interoperable HIE tools to support project priorities (e.g., ensure care team members, including client and family/caregivers, have access to the electronic shared care plan).** • **Establish mechanisms for coordinating care management and transitional care plans with related community-based services and supports, such as those provided through supported housing programs.** • **Incorporate activities that increase the availability of POLST forms across communities/agencies, where appropriate.** • **Develop systems to monitor and track performance.**	Demonstrate progress in semi-annual report	DY3, Q4

Table 18: transitional care scale and sustain

Project milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities.**	Demonstrate progress in semi-annual report	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Employ continuous quality improvement methods to refine the model, updating model, and adopting guidelines, policies, and procedures as required.**		

Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.**		
Demonstrate sustainability of transformation activities • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of project activities post-DSRIP.**		

Table 19: P4R recurrent deliverables and P4P project metrics

Year	Type	Recurrent deliverable or metric	Due
DY2 – 2018	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY2, Q4
DY3 – 2019	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Percent Homeless (Narrow definition) • Plan All-Cause Readmission Rate (30 Days)	Annual
DY4 – 2020	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Submission of QIP • Metric reporting	DY4, Q2
		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Percent Homeless (Narrow Definition) • Plan All-Cause Readmission Rate (30 Days)	Annual

DY5 – 2021	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q2
		• Completion of semi-annual report 8 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Percent Homeless (Narrow Definition) • Plan All-Cause Readmission Rate (30 Days)	Annual
DY6 – 2022	P4R: ACH-reported	• Completion of DY6 P4R report 1 (template available January 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q1
		• Completion of P4R report 2 (template available July 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q3
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Percent Homeless (Narrow Definition) • Plan All-Cause Readmission Rate (30 Days)	Annual

Project implementation guidelines

This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems/community capacity strategies

- **Population health management/HIT:** current level of adoption of electronic health records (EHRs) and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, information to enable population health management and quality improvement processes, and provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.
- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:

  - Shortage of mental health providers, SUD providers, social workers, nurse practitioners, primary care providers, care coordinators and care managers.
  - Opportunities for use of telehealth and integration into work streams.
  - Workflow changes to support integration of new screening and care processes, care integration, and communication.
  - Cultural and linguistic competency and health literacy deficiencies.
- **Financial sustainability:** alignment between current payment structures and guidelines for physical and behavioral care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support integrated care efforts into the regional VBP transition plan. Assess timeline or status for adoption of fully integrated managed care contracts. Development of model benefit(s) to cover integrated care models.

Guidance for evidence-based approaches

Evidence-based approaches for care management and transitional care

INTERACT™4.0

The skilled nursing facility (SNF) and the project implementation team will utilize INTERACT™4.0 toolkit and resources and implement the following core components:

- Educate leadership in the INTERACT™ principles.
- Identify a facility champion who can engage other staff and serve as a coach.
- Develop care pathways and other clinical tools for monitoring patients that lead to early identification of potential instability and allow intervention to avoid hospital transfer.
- Provide all staff with education and training to fill their role in the INTERACT™ model.
- Educate patients and families and provide support that facilitates their active participation in care planning.
- Establish enhanced communication with acute care hospitals, relying on technology where appropriate.
- Establish quality improvement process, including root cause analysis of transfers and identification and testing of interventions.
- Demonstrate cultural competence and client engagement in the design and implementation of the project.

Transitional Care Model

Implement the essential elements of this model:

- Use of advanced knowledge and skills by a transitional care nurse (TCN) to deliver and coordinate care of high-risk older adults within and across all health care settings. The TCN is primary coordinator of care throughout potential or actual episodes of acute illness.
- Comprehensive, holistic assessment of each older adult's priority needs, goals, and preferences.
- Collaboration with older adults, family caregivers, and team members in implementation of a streamlined, evidenced-based plan of care designed to promote positive health and cost outcomes.
- Regular home visits by the TCN with available, ongoing telephone support (seven days per week) through an average of two months.

- Continuity of health care between hospital, post-acute, and primary care clinicians facilitated by the TCN by accompanying patients to visits to prevent or follow-up on an acute illness care management.
- Active engagement of patients and family caregivers with a focus on meeting their goals.
- Emphasis on patients' early identification and response to health care risks and symptoms to achieve longer-term positive outcomes and avoid adverse and untoward events that lead to acute care service use (e.g., ED visits, re-hospitalizations).
- Multidisciplinary approach that includes the patient, family caregivers, and health care providers as members of a team.
- Strong collaboration and communication between older adults, family caregivers, and health care team members across episodes of acute care and in planning for future transitions (e.g., palliative care).
- Ongoing investment in optimizing transitional care via performance monitoring and improvement.

Care Transitions Intervention®

Implementation guidance:

- A meeting with a Transitions coach in the hospital (where possible, as this is desirable but not essential) to discuss concerns and to engage patients and their family caregivers.
- Set up the Transitions coach in home follow-up visit and accompanying phone calls designed to increase self-management skills, personal goal attainment, and provide continuity across the transition.

Care transitions interventions in mental health

Set of components of effective transitional care that can be adapted for managing transitions among persons with serious mental illness:

- Adapt components of care transitions interventions to focus on points of transition for the SMI population, including discharge from intensive behavioral health care, and discharge from emergency room (ER) for mental health, alcohol, or other drug dependence.
- Prospective modeling: employ prospective modeling to identify who is at greatest risk. Consider different patterns of morbid conditions within and among mental illnesses, SUDs, and general medical/surgical conditions that might require modifications.
- Patient and family engagement: create culturally competent engagement strategies to drive authentic inclusion of patient and/or family in treatment/transitional care plan. Adapt engagement strategies for individuals with SMI.
- Transition planning: establish an appropriate client-specific plan for transition to the next point of care. Consider how to utilize step-down mental health services, such as day treatment and intensive outpatient care. Consider trade-offs between length of stay for stabilization and risk of rehospitalization. Include assessment of need of primary care planning as well as substance abuse and dual disorders. An assessment and specific plan for housing and other social services should be included.
- Information transfer/personal health record: ensure all information is communicated, understood, and managed, and links patients, caregivers, and providers. Establish protocols to ensure privacy and other regulations are followed. Establish pathways for information flow among providers and clinics.

- Transition coaches/agents: define transition coach role, tasks, competencies, training, and supervision requirements. Consider the need for mental health providers, such as social workers, to serve as transition agents or to train other personnel in mental health tools and techniques. Consider use of health information technology to augment/assist coaches.
- Provider engagement: providers at each level of care should have clear responsibility and plan for implementing all transition procedures/interventions. Communication and hand-off arrangements should be pre-specified in a formal way.
- Quality metrics and feedback: gather metrics on follow-up post-hospitalization, rehospitalization and other feedback on process and outcomes and consumer/family perspective. Utilize metrics in quality improvement and accountability.
- Shared accountability: all providers share in expectations for quality as well as rewards/penalties. Accountability mechanisms may include financial mechanisms and public reporting about quality and value. Consumers/families share in accountability as well.

Evidence-informed approaches to transitional care for people with health and behavioral health needs leaving incarceration

For projects targeting people transitioning from incarceration, include in the implementation plan at a minimum:

- Strategy to increase Medicaid enrollment, including:
    - Process for identifying (1) individuals who are covered under Medicaid and whose benefits will not be terminated because of incarceration, (2) individuals whose Medicaid eligibility will terminate because of incarceration, and (3) individuals who will likely be Medicaid-eligible at release, regardless of current or prior beneficiary status.
    - Process for completing and submitting Medicaid applications for individuals (2) and (3) above, timed appropriately such that their status moves from suspended to active at release.
    - Agreements in place with relevant criminal justice agencies to ensure individuals (1) above receive community-based, Medicaid-reimbursable care in a timely matter when clinically appropriate (with a focus on populations "at risk," such as the elderly, LGBTQ, chronically ill, those with serious mental illness and/or SUD, and more).
- Strategy for beginning care planning and transition planning prior to release, including:
    - A process for conducting in-reach to prison/jails and correctional facilities, which leverages and contemplates resources, strengths, and relationships of all partners.
    - A strategy for engaging individuals in transitional care planning as a one component to a larger reentry transition plan.
    - A strategy for ensuring care planning is conducted in a culturally competent manner and contemplates social determinants of health, barriers to accessing services or staying healthy, as well as barriers to meeting conditions of release or staying crime-free.

Project 2D: diversion interventions

Project objective

Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, especially for medically underserved populations.

Target population

Medicaid beneficiaries presenting at the ED for non-acute conditions, Medicaid beneficiaries who access the EMS system for a non-emergent condition, and Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement.

Evidence-supported diversion strategies

- ED diversion: a systematic approach to re-directing and managing persons who present at the ED for non-emergency conditions, which may be oral health, general physical health, and/or behavioral health conditions.
  - ER is for emergencies
  - Non–ED Interventions to Reduce ED Utilization: A Systematic Review
- Community Paramedicine Model: an evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations. Additional resources include:
  - communityparamedic.org
  - Community paramedicine evaluation tool
  - RHI Hub
- Law Enforcement Assisted Diversion (LEAD®): a community-based diversion approach with the goals of improving public safety and public order and reducing the criminal behavior of people who participate in the program.

Project stages

Table 20: stage 1 – diversion interventions planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess current state capacity to effectively deliver diversion services.**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for health systems/community capacity • **Identify how strategies for Domain I focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2

Definition of evidence-based approaches or promising practices and target populations • **Select target population and evidence-supported approach informed by regional health needs.** • **If applicable: determine which non-emergent condition(s) should be the focus of ED diversion and/or community paramedicine (oral health, general physical health, and/or behavioral health conditions).**	Report milestone completion in semi-annual report	DY2, Q2
Completion of initial partnering provider list • **Identify, recruit, and secure formal commitments for participation from implementation partners via a written agreement specific to the role each organization and/or provider will perform in the selected approach.** • **For lead: establish a community advisory group that includes representation from community members, health care and social services, law enforcement and community public safety leaders.** • **Execute Master Services Agreement for partnering providers receiving funds through the FE portal.**	Report milestone completion in semi-annual report	DY2, Q2
Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.**	Timely submission of implementation plan	DY2, Q3

Table 21: stage 2 – diversion interventions implementation

Project milestone	Proof of completion required	Due
Description of partnering provider progress in adoption of policies, procedures, and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches/pathways.**	Timely submission of QIP	DY3, Q2

Description of training and implementation activities
• **Implement project, including the following core components across each approach selected:**
  ○ **Ensure participating partners are provided with, or have access to, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner.**
  ○ **Implement bi-directional communication strategies/interoperable HIE tools to support project priorities (e.g., ensure team members, including client, have access to the information appropriate to their role in the team).**
  ○ **Establish mechanisms for coordinating care management plans with related community-based services and supports, such as those provided through supported housing programs.**
	Demonstrate progress in semi-annual report	DY3, Q4

Table 22: stage 3 – diversion interventions scale and sustain

Project milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Expand the model to additional communities and/or partner organizations.**	Demonstrate progress in semi-annual report.	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Employ continuous quality improvement methods to refine the model, updating model, and adopting guidelines, policies, and procedures as required.**	Demonstrate progress in semi-annual report.	DY4, Q4
Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.**	Demonstrate progress in semi-annual report.	DY4, Q4
Demonstrate sustainability of transformation activities • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of project activities post-DSRIP.**	Demonstrate progress in semi-annual report.	DY4, Q4

Table 23: P4R recurrent deliverables and P4P project metrics

Year	Type	Recurrent deliverable or metric	Due
DY2 – 2018	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY2, Q4
DY3 – 2019	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Percent Homeless (Narrow Definition)	Annual
DY4 – 2020	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q2
		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q4

	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Percent Arrested • Percent Homeless (Narrow Definition)	Annual
DY5 – 2021	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q2
		• Completion of semi-annual report 8 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Percent Arrested • Percent Homeless (Narrow Definition)	Annual
DY6 – 2022	P4R: ACH-reported	• Completion of DY6 P4R report 1 (template available January 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q1
		• Completion of P4R report 2 (template available July 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q3
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Percent Arrested • Percent Homeless (Narrow Definition)	Annual

Project implementation guidance

This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems/community capacity strategies

- **Population health management/HIT:** current level of adoption of electronic health records (EHRs) and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, information to enable population health management and quality improvement processes, and provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.
- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:
    - Shortage of mental health providers, SUD providers, social workers, nurse practitioners, primary care providers, care coordinators and care managers.
    - Opportunities for use of telehealth and integration into work streams.
    - Workflow changes to support integration of new screening and care processes, care integration, and communication.
    - Cultural and linguistic competency and health literacy deficiencies.

- **Financial sustainability:** alignment between current payment structures and guidelines for physical and behavioral care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support integrated care efforts into the regional VBP transition plan. Assess timeline or status for adoption of fully integrated managed care contracts. Development of model benefit(s) to cover integrated care models.

Guidance for evidence-based approaches

ED diversion

While there is no single model for effective ED diversion, a variety of examples can be found that share common elements. The following elements must be reflected in the implementation, unless noted otherwise:

- ED will establish linkages to community primary care provider(s) to connect beneficiaries without a primary care provider to one, or for the purpose of notifying the current primary care provider of the ED presentation and coordinating a care plan. Where available, care coordinators can facilitate this process.
- ED will establish policies and procedures for identifying beneficiaries with minor illnesses who do not have a primary care provider. After completing appropriate screenings validating a non-emergency need, will assist the patient in receiving a timely appointment with a primary care provider.

Community Paramedicine Model

This is an evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations

Approved medical program directors (MPDs), working with first responders, ED practitioners, and primary care providers to develop protocols, which may include transporting beneficiaries with non-emergency needs to alternate (non-ED) care sites, such as urgent care centers and/or patient-centered medical homes. Providers may collaborate to develop community paramedicine programs. Core issues to be addressed in the design of a community paramedicine program should include:

- A detailed explanation about how the community paramedics would be trained and would maintain their skills.
- A description of how appropriate medical supervision would be ensured.
- A description of how data to evaluate quality assurance and quality improvement activities would be obtained and monitored.
- An evaluation plan for assessing the impacts on quality and cost of care, and how the local EMS agency will ensure that all patients are treated equally regardless of insurance status and health condition, among other factors.
- A plan for integrating the community paramedicine program with other community-based health care and social service programs and for analyzing the potential impacts of the community paramedicine program on these providers, including safety-net providers.
- How to leverage the potential of EHRs and HIE to facilitate communication between community paramedics and other health care providers.

Law Enforcement Assisted Diversion, LEAD®

LEAD is a community-based diversion approach with the goals of improving public safety and public order and reducing the criminal behavior of people who participate in the program.

Review resources and assistance available from the LEAD® National Support Bureau. Many components of LEAD® can be adapted to fit local needs and circumstances, however, the following core principles must be built into the implementation:

- Establish the LEAD® program as a voluntary agreement among independent decision-makers.
- Engage law enforcement and generate buy-in, including obtaining commander-level support.
- Identify a dedicated project manager.
- Tailor the LEAD® intervention to the community.
- Provide intensive case management – to link diverted individuals to housing, vocational and educational opportunities, treatment, and community services. Participants may need access to medication-assisted therapy and other drug treatment options; they may also need access to food, housing, legal advocacy, job training, and other services.
    - Apply a harm reduction/housing first approach – develop individual plans that address the problematic behavior as well as the factors driving that behavior.
    - Consider the use of peer supports.
- Provide training in the areas of trauma-informed care and cultural competencies.
- Prepare an evaluation plan.

Domain 3: prevention and health promotion

Transformation projects within this domain focus on prevention and health promotion to eliminate disparities and achieve health equity across regions and populations. Domain 3 includes one required project and three optional projects.

Project 3A: addressing the opioid use public health crisis (required)

Project objective

Support the achievement of the state's goals to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.

Target population

Medicaid beneficiaries, including youth, who use, misuse, or abuse prescription opioids and/or heroin.

Recommended resources for identifying promising practices/evidence-supported strategies

Clinical guidelines

- AMDG's Interagency Guideline on Prescribing Opioids for Pain
- CDC Guideline for Prescribing Opioids for Chronic Pain (United States, 2016)
- Substance Use during Pregnancy: Guidelines for Screening and Management

Statewide plans

- 2016 Washington State Interagency Opioid Working Plan
- Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan

Implementation plans must demonstrate a multi-pronged approach that includes strategies targeting the following essential components:

- Prevention: prevent opioid use and misuse
- Treatment: link individuals with OUD with treatment services
- Overdose prevention: intervene in opioid overdoses to prevent death
- Recovery: promote long-term stabilization and whole-person care

Project stages

Table 24: stage 1 – prevention and health promotion planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess the current regional capacity to effectively impact the opioid crisis and include strategies to leverage current capacity and address identified gaps.**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for health systems/community capacity • **Identify how strategies for health systems/community capacity focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2
Definition of evidence-based approaches or promising practices and target populations • **Select target population and evidence-based approach informed by regional health needs. (Consider areas with limited access to treatment for opioid disorder, and rates of opioid use, misuse, and abuse.)**	Report milestone completion in semi-annual report	DY2, Q2
Completion of initial partnering provider list • **Identify and engage project implementation partnering provider organizations.** • **Identify established local partnerships that are addressing the opioid crisis in their communities and establish new partnerships where none exist.** • **Identify, recruit, and secure formal commitments for participation in project implementation including professional associations, physical, mental health and SUD providers and teaching institutions.** • **Execute Master Services Agreement for partnering providers receiving funds through the FE portal.**	Report milestone completion in semi-annual report	DY2, Q2
Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.**	Timely submission of implementation plan	DY2, Q3

Table 25: stage 2 – prevention and health promotion implementation

Project milestone	Proof of completion required	Due
Description of partnering provider progress in adoption of policies, procedures and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches.**	Timely submission of QIP	DY3, Q2

Description of training and implementation activities
• **Implement selected strategies/approaches across the core components:**
  ○ **Prevention**
  ○ **Treatment**
  ○ **Overdose prevention**
  ○ **Recovery supports**
• **Monitor state-level modifications to the 2016 Washington State Interagency Opioid Working Plan and/or related clinical guidelines and incorporate any changes into project implementation plan.**
• **Convene or leverage existing local partnerships to implement project; one or more such partnerships may be convened:**
  ○ **Each partnership should include health care services, including mental health and SUD providers, community-based service providers, executive and clinical leadership, consumer representatives, law enforcement, criminal justice, emergency medical services, and elected officials; identify partnership leaders and champions. Consider identifying a clinical champion and one or more community champions.**
  ○ **Establish a structure that allows for efficient implementation of the project and provides mechanisms for any workgroups or subgroups to share across teams, including implementation successes, challenges, and overall progress.**
  ○ **Continue to convene the partnership(s) and any necessary workgroups on a regular basis throughout implementation phase.**
	Demonstrate progress in semi-annual report	DY3, Q2

Address gaps in access and availability of providers offering recovery support services • **Develop a plan to address gaps in the number or locations of providers offering recovery support services, (this may include the use of peer support workers).**	Demonstrate progress in semi-annual report	DY3, Q4

Table 26: stage 3 - prevention and health promotion scale and sustain

Project milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Increase scale of activities by adding partners and/or reaching new communities under the current initiative (e.g., to cover additional high-needs geographic areas), as well as defining a path forward to deploy the partnership's expertise, structures, and capabilities to address other yet-to-emerge public health challenges.**	Demonstrate progress in semi-annual report	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Review and apply data to inform decisions regarding specific strategies and action to be spread to additional settings or geographical areas.**		

Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide or support ongoing training, technical assistance, and community partnerships to support spread and continuation of the selected strategies/approaches.** • **Convene and support platforms to facilitate shared learning and exchange of best practices and results to date (e.g., the use of interoperable HIE by additional providers providing treatment of persons with OUD).**		
Demonstrate sustainability of transformation activities • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of project activities post-DSRIP.**		

Table 27: P4R recurrent deliverables and P4P project metrics

Year	Type	Recurrent deliverable or metric	Due
DY2 – 2018	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY2, Q4
DY3 – 2019	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • P4R metrics (Project 3A P4R metrics)	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (Project 3A P4R metrics)	DY3, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Patients prescribed chronic concurrent opioids and sedatives prescriptions • Patients prescribed high-dose chronic opioid therapy	Annual
DY4 – 2020	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (Project 3A P4R metrics)	DY4, Q2
		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (Project 3A P4R metrics)	DY4, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months	Annual

		• Patients prescribed chronic concurrent opioids and sedatives prescriptions • Patients prescribed high-dose chronic opioid therapy • SUD Treatment Penetration (Opioid)	
DY5 – 2021	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (Project 3A P4R metrics)	DY5, Q2
		• Completion of semi-annual report 8 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (Project 3A P4R metrics)	DY5, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Patients prescribed chronic concurrent opioids and sedatives prescriptions • Patients prescribed high-dose chronic opioid therapy • SUD Treatment Penetration (Opioid)	Annual
DY6 – 2022	P4R: ACH-reported	• Completion of DY6 P4R report 1 (template available January 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Completion of required P4R metrics	DY6, Q1
		• Completion of P4R report 2 (template available July 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q3
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Patients prescribed chronic concurrent opioids and sedatives prescriptions • Patients prescribed high-dose chronic opioid therapy • SUD Treatment Penetration (Opioid)	Annual

Project implementation guidance

This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems/community capacity strategies

- **Population health management systems/HIT:** adoption of technology with the capability to support identification of persons at high-risk for opioid overdose, notifications to health care providers of opioid overdose events, monitoring of prescribing practices, and implementation of quality improvement processes; a plan to build enhancements in EHRs and other systems to support clinical decisions in accordance with guidelines; an assessment of the current level of use of the PDMP and ED Information Exchange; and strategies to increase use of PDMP and interoperability with EHRs. Overall, in line with Goal 4 of the State Interagency Opioid Working Plan; develop a plan to use data and information to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions.

- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:
    - Efforts to enhance medical, nursing, and physician assistant school curricula on pain management, the PDMP, and recognition and treatment of opioid use disorder (OUD).
    - Partnering with professional associations and teaching institutions to educate dentists, osteopaths, nurses, and podiatrists on current opioid prescribing guidelines.
    - Encouraging licensing boards of authorized prescribers to mandate continuing education credits (CEUs) on opiate prescribing and pain management guidelines.
    - Encouraging family medicine, internal medicine, obstetrics/gynecology (OB/GYN) residency programs to train residents on care standards/medications for OUD.
    - Identifying critical workforce gaps in the substance use treatment system and develop initiatives to attract and retain skilled professionals in the field.
- **Financial sustainability:** alignment between current payment structures and guidelines for care about opioid prescribing; and evidence-supported treatments and recovery supports for OUDs that incorporate current state and anticipated future state of VBP arrangements to support opioid abuse prevention and control efforts into the regional VBP transition plan.

Guidance for evidence-based approaches

Implementation plan

Each region will develop a plan that provides a detailed description of how the ACH will implement selected strategies and activities that together create a comprehensive strategy addressing prevention, treatment, overdose prevention, and recovery supports aimed at supporting whole-person health.

Prevention: prevent opioid misuse and abuse

- Promote use of best practices among health care providers for prescribing opioids for acute and chronic pain:
    - Promote the use of the prescription drug monitoring plan (PDMP) and its linkage into EHR systems to increase the number of providers regularly using the PDMP and the timely input of prescription medication data into the PDMP.
    - Train, coach, and offer consultation with providers on opioid prescribing and pain management.
    - Promote the integration of telehealth and telephonic approaches.
    - Support innovative telehealth in rural and underserved areas to increase capacity of communities to support OUD prevention and treatment.
- Together, with the Center for Opioid Safety Education and other partners like statewide associations, raise awareness and knowledge of the possible adverse effects of opioid use, including overdose, among opioid users:
    - Promote accurate and consistent messaging about opioid safety and to address the stigma of addiction by public health, health care providers, law enforcement, community coalitions, and others specific to the region and local communities.
- Prevent opioid initiation and misuse in communities, particularly among youth:

    - Build awareness and identify gaps as they relate to ongoing prevention efforts (e.g., school-based programs); connect with local health jurisdictions and DOH and HCA's Department of Behavioral Health and Recovery (DBHR) to understand the efforts currently underway in the region.
- Promote safe home storage and appropriate disposal of prescription pain medication to prevent misuse:
    - Identify and map drug take back programs to highlight where additional programs could be implemented or expanded to meet community need.
    - Promote the use of home lock boxes to prevent unintended access to medication.

Treatment: link individuals with OUD to treatment services

- Build capacity of health care providers to recognize signs of possible opioid misuse, effectively identify OUD, and link patients to appropriate treatment resources:
    - Effective treatment of OUD includes medication and psychosocial supports. Conduct inventory of existing treatment resources in the community (e.g., formal treatment programs and practices/providers providing medications for opioid use disorder (MOUD)(methadone, buprenorphine, naltrexone)).
    - Educate providers across all health professions on how to recognize signs of opioid misuse and OUD among patients and how to use appropriate tools to identify OUD.
    - Offer patients brief interventions and referrals to MOUD and psychosocial support services, if needed.
    - Build skills of health care providers to have supportive patient conversations about problematic opioid use and treatment options.
    - Give pharmacists tools on where to refer patients who may be misusing prescription pain medication.
- Expand access to, and utilization of, clinically appropriate evidence-based practices for OUD treatment in communities, particularly MOUD:
    - Increase the number of providers certified to prescribe OUD medications in the region; promote the application and receipt of physician, Advanced Registered Nurse Practitioner (ARNP), and physician assistant waivers for providers in a variety of settings, such as hospitals, primary care clinics, correctional facilities, mental health and SUD treatment agencies, methadone clinics, and other community-based sites.
    - Together with HCA identify policy gaps and barriers that limit availability and utilization of buprenorphine, methadone, and naltrexone and contribute to the development of policy solutions to expand capacity.
    - Build structural supports (e.g., case management capacity, nurse care managers, integration with SUD providers) to support medical providers and staff to implement and sustain MOUD, such as methadone and buprenorphine. Examples of evidence-based models include the hub and spoke and nurse care manager models.

- Promote and support pilot projects that offer low barrier access to buprenorphine in efforts to reach persons at high risk of overdose. For example, in EDs, correctional facilities, syringe exchange programs, and SUD and mental health programs.
    - Build linkages/communication pathways between those providers providing medication and those providing psychosocial therapies.
- Expand access to and utilization of OUD medications in the criminal justice system:
    - Train and provide technical assistance to criminal justice professionals to endorse and promote agonist therapies for people under criminal sanctions.
    - Optimize access to chemical dependency treatment services for offenders who have been released from correctional facilities into the community and for offenders living in the community under correctional supervision, through effective care coordination and engagement in transitional services.
    - Ensure continuity of treatment for persons with an identified OUD need upon exiting correctional facilities by providing direct linkage to community providers for ongoing care.
- Increase capacity of syringe exchange programs to effectively provide overdose prevention and engage beneficiaries in support services, including housing.
    - Provide technical assistance to local health jurisdictions and community-based service organizations to organize or expand syringe exchange and drug user health services.
    - Develop/support linkages between syringe exchange programs and physical health providers to treat any medical needs that require referral.
- Identify and treat OUD among pregnant and parenting women (PPW) and Neonatal Abstinence Syndrome (NAS) among newborns:
    - Disseminate the guideline Substance Abuse during Pregnancy: Guidelines for Screening and Management.
    - Disseminate the Washington State Hospital Association Safe Deliveries Roadmap standards to health care providers.
    - Educate pediatric and family medicine providers to recognize and appropriately manage newborns with NAS.
    - Increase the number of obstetric and maternal health care providers permitted to dispense and prescribe MOUD through the application and receipt of Drug Enforcement Administration (DEA)-approved waivers.
    - Establish or enhance community pathways to support PPW with connecting to care services that address whole-person health, including physical, mental, and SUD treatment needs during, through and after pregnancy.

Overdose prevention: intervene in opioid overdoses to prevent death

- Educate individuals who use heroin and/or prescription opioids, and those who may witness an overdose, on how to recognize and appropriately respond to an overdose.
    - Provide technical assistance to first responders, chemical dependency counselors, and law enforcement on opioid overdose response training and naloxone programs.

    - Assist EDs to develop and implement protocols on providing overdose education and take-home naloxone to individuals seen for opioid overdose.
- Make system-level improvements to increase availability and use of naloxone.
    - Establish standing orders in all counties and all opioid treatment programs to authorize community-based naloxone distribution and lay administration.
    - Promote co-prescribing of naloxone for pain patients as best practice, per Agency Medical Director's Group (AMDG) guidelines.
- Together with the Center for Opioid Safety Education, promote awareness and understanding of Washington State's Good Samaritan Law.
    - Educate law enforcement, prosecutors, and the public about the Good Samaritan Response Law.

Recovery: promote long-term stabilization and whole-person care

- Enhance/develop or support the provision of peer and other recovery support services designed to improve treatment access and retention and support long-term recovery.
- Establish or enhance community-based recovery support systems, networks, and organizations to develop capacity at the local level to design and implement peer and other recovery support services as vital components of recovery-oriented continuum of care.
- Support whole person health in recovery:

Connect SUD providers with primary care, behavioral health, social service, and peer recovery support providers to address access, referral, and follow up for services.

Project 3B: reproductive and maternal/child health

Project objective

Ensure that people have access to high-quality reproductive health care throughout their lives and promote the health safety of Washington's children.

Target population

Medicaid beneficiaries who are people of reproductive age, pregnant persons, parents of children ages 0-3, and children ages 0-17.

Evidence-based approach

- Strategies to improve adult health to ensure families have intended and healthy pregnancies that lead to healthy children. The Centers for Disease Control and Prevention (CDC) has provided 10 recommendations that aim to improve a person's health before conception, whether before a first or a subsequent pregnancy.
- Evidence-based home visiting model for pregnant high-risk persons, including high-risk, first-time parents. Potential approaches can include Nurse Family Partnership (NFP) or other federally recognized evidence-based home visiting model currently operating in Washington State.

Evidence-based model or promising practice to improve regional well-child visit rates and childhood immunization rates. Project stages

Table 28: stage 1 – reproductive and maternal/child health planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess current state capacity to effectively focus on the need for high-quality reproductive and maternal and child health care.**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for health systems/community capacity • **Identify how strategies for Domain I focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2
Definition of evidence-based approaches or promising practices and target populations • **Select evidence-based approach(es) and specific target population(s) informed by regional health needs.**	Report milestone completion in semi-annual report	DY2, Q2
Completion of initial partnering provider list • **Identify, recruit, and secure formal commitments for participation from implementation partners via a written agreement specific to the role each organization and/or provider will perform in the selected approach.** • **Execute Master Services Agreement for partnering providers receiving funds through the FE portal.**	Report milestone completion in semi-annual report	DY2, Q2

Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.**	Timely submission of implementation plan	DY2, Q3

Table 29: stage 2 – reproductive and maternal/child health implementation

Project milestone	Proof of completion required	Due
Description of partnering provider progress in adoption of policies, procedures, and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches.**	Timely submission of QIP	DY3, Q2
Description of training and implementation activities • **Implement project, including the following core components across each approach selected:** ○ **Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner.** ○ **Implement bi-directional communication strategies/interoperable HIE tools to support project priorities (e.g., ensure care team members, including client and family/caregivers, have access to the care plan).** ○ **Establish mechanisms, including technology enabled, interoperable care coordination tools, for coordinating care management and transitional care plans with related community-based services and supports, such as those provided through supported housing programs.** ○ **Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes, and tracking outcomes.**	Demonstrate progress in semi-annual report	DY3, Q4

Table 30: stage 3 – reproductive and maternal/child health scale and sustain

Project milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities.**	Demonstrate progress in semi-annual report	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Employ continuous quality improvement methods to refine the model, updating model and adopting guidelines, policies, and procedures as required.**		

Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.**		
Demonstrate sustainability of transformation activities • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of transformation activities post-DSRIP.**		

Table 31: project metrics and recurrent deliverables associated with AVs

Year	Type	Metric/deliverable	Due
DY2 – 2018	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY2, Q4
DY3 – 2019	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Chlamydia Screening in Women • Mental Health Treatment Penetration (Broad Version) • SUD Treatment Penetration • Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Age	Annual
DY4 – 2020	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q2
		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Childhood Immunization Status (Combo 10) • Chlamydia Screening in Women • Contraceptive Care – Access Measures (NQF# 2903, 2902) • Performance assessed by annual improvement on at least one of the Contraceptive Care Access measures. • Mental Health Treatment Penetration (Broad Version) • Timeliness of Prenatal Care • SUD Treatment Penetration	Annual

		• Well-Care Visits (3-11 Years of Age) • Well-Child Visits in the First 30 Months of Life	
DY5 – 2021	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q2
		• Completion of semi-annual report 8 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Childhood Immunization Status (Combo 10) • Chlamydia Screening in Women • Contraceptive Care – Access Measures (NQF# 2903, 2902) • Performance assessed by annual improvement on at least one of the Contraceptive Care Access measures. • Mental Health Treatment Penetration (Broad Version) • Timeliness of Prenatal Care • SUD Treatment Penetration • Well-Care Visits (3-11 Years of Age) • Well-Child Visits in the First 30 Months of Life	Annual
DY6 – 2022	P4R: ACH-reported	• Completion of DY6 P4R report 1 (template available January 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q1
		• Completion of P4R report 2 (template available July 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q3
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Childhood Immunization Status (Combo 10) • Chlamydia Screening in Women • Contraceptive Care – Access Measures (NQF# 2903, 2902) • Performance assessed by annual improvement on at least one of the Contraceptive Care Access measures. • Mental Health Treatment Penetration (Broad Version) • Timeliness of Prenatal Care • SUD Treatment Penetration • Well-Care Visits (3-11 Years of Age) • Well-Child Visits in the First 30 Months of Life	Annual

Project implementation guidelines

This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems/community capacity strategies

- **Population health management/HIT:** current level of adoption of EHRs and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, and information to enable population health management and quality improvement processes; provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.
- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:
  - Shortage of mental health providers, SUD providers, social workers, nurse practitioners, primary care providers, care coordinators and care managers.
  - Opportunities for use of telehealth and integration into work streams.
  - Workflow changes to support integration of new screening and care processes, care integration, communication.
  - Cultural and linguistic competency, health literacy deficiencies.
- **Financial sustainability:** alignment between current payment structures and guidelines for reproductive, maternal and child health care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support improvement of reproductive, maternal and child health efforts into the regional VBP transition plan. Development of model benefit(s) to cover reproductive, maternal and child health services.

Guidance for evidence-based approaches

Approaches to improve reproductive, maternal, and children's health

Implementation of evidence-based and emerging strategies to improve reproductive health

The CDC provided 10 recommendations that aim to improve a person's health before conception, whether before a first or a subsequent pregnancy. The recommendations fall into 10 areas: 1) individual responsibility across the lifespan, 2) consumer awareness, 3) preventive visits, 4) interventions for identified risks, 5) interconception care, 6) pre-pregnancy checkup, 7) health insurance coverage for people with low incomes, 8) public health programs and strategies, 9) research, and 10) monitoring improvements.

Strategies to improve adult health to ensure families have intended and healthy pregnancies that lead to healthy children. Specifically, ACHs should consider evidence-based models to improve utilization of effective reproductive health strategies, including pregnancy intention counseling, healthy behaviors and risk reduction, effective contraceptive use, safe and quality perinatal care, interconception care, and general preventive care.

- Washington State acted on these recommendations by providing a program for uninsured people to obtain basic family planning services (Take Charge and working with providers to improve obstetric outcomes) and grants (Personal Responsibility and Education Plan), and through other actions.

- This project builds on current efforts and provides a mechanism for communities to further the implementation of the recommendations.

Implementation for a home-visiting model should follow evidence-based practice standards.

- Evidence-based home visiting model for pregnant, high-risk people, including high-risk, first-time people. Potential approaches can include NFP or other federally recognized evidence-based home visiting model currently operating in Washington State. If chosen, implementing agencies must meet all fidelity, essential requirements, and/or program standard requirements as defined by the model developer. The project must demonstrate a valid need for home-visiting service expansion and that services will be coordinated. The following models are currently operating in Washington State:
    - NFP provides first-time, low-income persons and their children with nurse-led, home-based support and care.
    - Early Head Start Home-Based Model (EHS) works with parents to improve child health, prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness.
    - Parents as Teachers (PAT) promotes optimal early development, learning and health of children by supporting and engaging their parents and caregivers.
    - Family Spirit offers culturally tailored home-visiting to promote the optimal health and wellbeing of American Indian parents and their children.

Implementation of an evidence-based model or promising practice to improve regional well-child visit rates (for ages 3-6) and childhood immunization rates.

If chosen, implementing agencies must meet all fidelity, essential requirements and/or program standard requirements as defined by the model developer. Possible approaches include:

- Bright Futures
- Stony Brook Children's Hospital Enriched Medical Home Intervention (EMHI)

Project 3C: access to oral health services

Project objective

Increase access oral health services to prevent or control the progression of oral disease and ensure that oral health is recognized as a fundamental component of whole-person care.

Target population

All Medicaid beneficiaries, especially adults.

Evidence-based approach

- Oral Health in Primary Care: integrating oral health screening, assessment, intervention, and referral into the primary care setting.
- Mobile/Portable Dental Care: national maternal and child health resource center providers a manual to guide planning and implementation of mobile dental units and portable dental care equipment for school-age children, which could be adapted for adults.

Project stages

Table 32: stage 1- access to oral health services planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess current state capacity to effectively impact access to oral health services**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for health systems/community capacity • **Identify how strategies for health systems/community capacity focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2
Definition of evidence-based approaches or promising practices and target populations • **Select target population and evidence-based approach informed by regional health needs.** ○ **Identify communities or sub-regions with demonstrated shortages of dental providers or otherwise limited access to oral health services.**	Report milestone completion in semi-annual report	DY2, Q2
Completion of initial partnering provider list • **Identify, recruit, and secure formal commitments for participation from implementation partners, to include, at minimum, primary care providers and dentists, via a written agreement.** ○ **Must demonstrate sufficient initial engagement to implement the approach in a timely manner. (Include dentists/dental practices and periodontists who will serve as referral sources.)**	Report milestone completion in semi-annual report	DY2, Q2
Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building**	Timely submission of implementation plan	DY2, Q3

(HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.		

Table 33: stage 2- access to oral health services implementation

Project milestone	Proof of completion required	Due
Description of partnering provider progress in adoption of policies, procedures and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches.**	Timely submission of QIP	DY3, Q2
Description of training and implementation activities • **Implement project, including the following core components across each approach selected:** ○ **Implement bi-directional communications strategies/interoperable HIE tools to support the care model.** ○ **Establish mechanisms for coordinating care with related community-based services and supports.** ○ **Develop workflows to operationalize the protocol, specifying which member of the care performs each function, inclusive of when referral to dentist or periodontist is needed.** ○ **Establish referral relationships with dentists and other specialists, such as ear, nose, and throat specialists (ENTs) and periodontists.** ○ **Ensure each member of the care team receives the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner.** ○ **Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes and tracking outcomes.** ○ **Engage with payers in discussion of payment approaches to support access to oral health services.**	Demonstrate progress in semi-annual report	DY3, Q4

Table 34: stage 3- access to oral health services scale and sustain

Project Milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Increase scope and scale, expand to serve additional high-risk populations, and add partners or service sites to spread approach to additional communities.** **Description of continuous quality improvement methods to refine/revise transformation activities** • **Employ continuous quality improvement methods to refine the model, updating model, and adopting guidelines, policies, and procedures as required.** **Demonstrate facilitation of ongoing supports for continuation and expansion** • **Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.** **Demonstrate sustainability of transformation activities** • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of project activities post-DSRIP.**	Demonstrate progress in semi-annual report	DY4, Q4

Table 35: P4R recurrent deliverables and P4P project metrics

Year	Type	Recurrent deliverable or metric	Due
DY2 – 2018	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY2, Q4
DY3 – 2019	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Primary Caries Prevention Intervention as Offered by Medical Provider: Topical Fluoride Application Delivered by Non-Dental Health Professional • Utilization of Dental Services	Annual
DY4 – 2020	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q2

		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Periodontal Evaluation in Adults with Chronic Periodontitis • Primary Caries Prevention Intervention as Offered by Medical Provider: Topical Fluoride Application Delivered by Non-Dental Health Professional • Utilization of Dental Services	Annual
DY5 – 2021	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q2
		• Completion of semi-annual report 8 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Dental Sealants for Children at Elevated Caries Risk • Periodontal Evaluation in Adults with Chronic Periodontitis • Primary Caries Prevention Intervention as Offered by Medical Provider: Topical Fluoride Applications Delivered by Non-Dental Health Professional • Utilization of Dental Services	Annual
DY6 – 2022	P4R: ACH-reported	• Completion of DY6 P4R report 1 (template available January 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q1
		• Completion of P4R report 2 (template available July 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q3
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Dental Sealants for Children at Elevated Caries Risk • Periodontal Evaluation in Adults with Chronic Periodontitis • Primary Caries Prevention Intervention as Offered by Medical Provider: Topical Fluoride Applications Delivered by Non-Dental Health Professional • Utilization of Dental Services	Annual

Project implementation guidelines

This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems/community capacity strategies

- **Population health management/HIT:** current level of adoption of EHRs and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, and information to enable

population health management and quality improvement processes; provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.

- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:
    - Shortage of dentist, hygienist, and other dental care providers, and primary care providers.
    - Access to periodontal services.
    - Training and technical assistance to ensure cultural and linguistic competency, health literacy needs.
- **Financial sustainability:** alignment between current payment structures and integration of oral health services; incorporate current state and anticipated future state of value-based payment arrangements to support access to oral health efforts into the regional VBP transition plan; promote VBP readiness tools and resources, such as the adoption of diagnostic coding in dental for bi-directional medical/dental data sharing and population health.

Guidance for evidence-based approaches

Oral health in primary care

Planning:

For oral health in primary care, consider a phased approach to implementation, such as:

- Begin with screening patients for signs and symptoms of early disease and develop a structured referral process for dentistry.
- Offer fluoride varnish for pediatric patients per the USPSTF61 and AAP guidelines; consider indications for fluoride varnish for high-risk adults.
- Focus on patient/caregiver risk assessment and risk reduction through patient education, dietary counseling, and oral hygiene training.
- Identify a particular high-risk patient population (e.g., adult patients with diabetes, pregnant persons) and begin with a pilot before expanding population/practice wide.
- Articulate the activities in each phase, and the associated timeline.

Implementation:

- Establish and implement clinical guideline or protocol that incorporates the following five elements of the Oral Health Delivery Framework:
    - Ask about symptoms that suggest oral disease and factors that place patients at increased risk for oral disease. Two or three simple questions can be asked to elicit symptoms of oral dryness, pain or bleeding in the mouth, oral hygiene and dietary habits, and length of time since the patient last saw a dentist. These questions can be asked verbally or included in a written health risk assessment.
    - Look for signs that indicate oral health risk or active oral disease. Assess the adequacy of salivary flow; look for signs of poor oral hygiene, white spots or cavities, gum recession, or periodontal inflammation; and conduct examination for signs of disease. During a well-visit

or complete physical exam, this activity could be included as a component of the standard Head, Ears, Eyes, Neck, and Throat Exam (HEENT exam) resulting in a comprehensive assessment that includes the oral cavity—a "HEENOT" exam.
    - Decide on the most appropriate response. Review information gathered and share results with patients and families. Determine a course of action using standardized criteria based on the answers to the screening and risk assessment questions; findings of the oral exam; and the values, preferences, and goals of the patient and family.
    - Act by delivering preventive interventions and/or placing an order for a referral to a dentist or medical specialist. Preventive interventions delivered in the primary care setting may include: 1) changes in the medication list to protect the saliva, teeth, and gums, 2) fluoride therapy, 3) dietary counseling to protect the teeth and gums, and to promote glycemic control for patients with diabetes, 4) oral hygiene training 5) therapy for tobacco, alcohol, or SUD and 6) referrals to dental.
    - Document the findings as structured data to organize information for decision support, measure care processes, and monitor clinical outcomes so that quality of care can be managed.
- Establish and implement workflows to operationalize the protocol, specifying which member of the care performs each function, inclusive of when referral to dentist or periodontist is needed.
- Ensure each member of the care team receives the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner.
- Establish referral relationships with dentists and other specialists, such as ENTs and periodontists.
- Engage with payers in discussion of payment approaches to support the model.

Mobile/portable dental care:

The national maternal and child health resource center provides a manual to guide planning and implementation of mobile dental units and portable dental care equipment for school-age children, which could be adapted for adults.

Planning:

- Specify where the mobile units and/or portable equipment will be deployed. Consider locations where Medicaid beneficiaries access housing, transportation, or other community-based supports, as well as rural communities, migrant worker locations, and American Indian reservations.
- Secure commitments from potential sites and develop a list of potential future sites.
- Specify the scope of services to be provided, hours of operation, and staffing plan.
- Include steps to show how ACH will research, and comply with, laws, regulations, and codes that may impact the design or implementation of the mobile unit and/or portable equipment.
- Include the timeline for educating providers, beneficiaries, and communities about the new service.

Implementation will include the following core components:

- Establish guidelines, policies, protocols, and/or procedures as necessary to support the full scope of services being provided.
- Secure necessary permits and licenses required by the state or locality.
- Establish referral relationships with primary care providers, dental providers, and other specialists, e.g., ENTs and periodontists, as needed.
- Acquire mobile unit and/or portable equipment and other supplies.
- Recruit, hire, and train staff.
- Implement the provider, client, and community education campaign to raise awareness of the new service.

Project 3D: chronic disease prevention and control

Project objective

Integrate health system and community approaches to improve chronic disease management and control.

Target population

Medicaid beneficiaries (adults and children) with or at risk for arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity, and stroke, with a focus on those populations experiencing the greatest burden of chronic disease(s) in the region.

Evidence-based approach:

Chronic Care Model

Project stages

Table 36: stage 1 – chronic disease prevention and control planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess current state capacity to effectively impact chronic disease.**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for health systems/community capacity • **Identify how strategies for health systems/community capacity focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2
Definition of evidence-based approaches or promising practices and target populations • **Select specific target population(s), guided by disease burden and overall community needs, ACHs will identify the population demographic and disease area(s) of focus, ensuring focus on population(s) experiencing the highest level of disease burden.** • **Select evidence-based guidelines and best practices for chronic disease care and management using the Chronic Care Model approach to improve asthma, diabetes, and/or heart disease control, and address obesity in their region.**	Report milestone completion in semi-annual report	DY2, Q2

• Region may pursue multiple target chronic conditions and/or population-specific strategies in their overall approach.		
Completion of initial partnering provider list • Identify, recruit, and secure formal commitments for participation from all implementation partners, including health care providers (must include primary care providers) and relevant community-based service organizations. • Form partnerships with community organizations to support and develop interventions that fill gaps in needed services. • Execute Master Services Agreement for partnering providers receiving funds through the FE portal.	Report milestone completion in semi-annual report	DY2, Q2
Completed implementation plan • Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.	Timely submission of implementation plan	DY2, Q3

Table 37: stage 2 – chronic disease prevention and control implementation

Project milestone	Proof of completion	Due
Description of partnering provider progress in adoption of policies, procedures, and/or protocols • Develop guidelines, policies, procedures, and protocols.	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • Develop continuous quality improvement strategies, measures, and targets to support the selected approaches.	Timely submission of QIP	DY3, Q2
Description of training and implementation activities • Implement disease/population-specific Chronic Care Implementation Plan for identified populations within identified geographic areas, inclusive of identified change strategies to develop and/or improve: ○ Self-management support ○ Delivery system design ○ Decision support ○ Clinical information systems (including interoperable systems) ○ Community-based resources and policy ○ Health care organization • Implementation should ensure integration of clinical and community-based strategies through communication, referral, and data-sharing strategies.	Demonstrate progress in semi-annual report	DY3, Q4

Table 38: stage 3 – chronic disease prevention and control scale and sustain

Project milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Increase scale of approach, expand to serve additional high-risk populations, include additional providers and/or cover additional high-needs geographic areas, to disseminate and increase adoption of change strategies that result in improved care processes and health outcomes.**	Demonstrate progress in semi-annual report	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Employ continuous quality improvement methods to refine the model, updating model, and adopting guidelines, policies, and procedures as required.**		
Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide or support ongoing training, technical assistance, learning collaborative platforms, to support shared learning, spread and continuation, and expansion of successful change strategies (e.g., the use of interoperable clinical information systems by additional providers, additional populations, or types of information exchanged).**		
Demonstrate sustainability of transformation activities • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of project activities post-DSRIP.**		

Table 39: P4R recurrent deliverables and P4P project metrics

Year	Type	Recurrent deliverable or metric	Due
DY2 – 2018	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY2, Q4
DY3 – 2019	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Children's and Adolescents' Access to Primary Care Practitioners • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Comprehensive Diabetes Care: Medical Attention for Nephropathy • Medication Management for People with Asthma (5 – 64 Years)	Annual

DY4 – 2020	P4R: ACH-reported	• Completion of [semi-annual report 5] (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q2
		• Completion of [semi-annual report 6] (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Asthma Medication Ratio • Child and Adolescent Well-Care Visits (3-21 Years of Age) • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Kidney Health Evaluation with Patients with Diabetes • Statin Therapy for Patients with Cardiovascular Disease (Prescribed) • Well Child Visit in the first 30 months of Life	Annual
DY5 – 2021	P4R: ACH-reported	• Completion of [semi-annual report 7] (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q2
		• Completion of semi-annual report 8 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Asthma Medication Ratio • Child and Adolescent Well-Care Visits (3-21 Years of Age) • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Kidney Health Evaluation with Patients with Diabetes • Statin Therapy for Patients with Cardiovascular Disease (Prescribed) • Well Child Visits in the first 30 months of Life	Annual
DY6 – 2022	P4R: ACH-reported	• Completion of DY6 P4R report 1 (template available January 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q1
		• Completion of P4R report 2 (template available July 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q3
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Asthma Medication Ratio • Child and Adolescent Well-Care Visits (3-21 Years of Age) • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Kidney Health Evaluation with Patients with Diabetes	Annual

		• Statin Therapy for Patients with Cardiovascular Disease (Prescribed) • Well Child Visits in the first 30 months of Life	

Project implementation guidelines

This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems/community capacity strategies

- **Population health management/HIT:** current level of adoption of EHRs and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, and information to enable chronic disease population health management and quality improvement processes; provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.
- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:
    - Shortage of community health workers, certified asthma educators, certified diabetes educators, home health care providers.
    - Access to specialty care, opportunities for telehealth integration.
    - Workflow changes to support registered nurses and other clinical staff to be working to the top of professional licensure. Training and technical assistance to ensure a prepared, proactive practice team and prepared, proactive community partners.
    - Cultural and linguistic competency, health literacy needs.
- **Financial sustainability:** alignment between current payment structures and guidelines are, inclusive of community-based services (such as home-based asthma visits, diabetes self-management education, and home-based blood pressure monitoring); incorporate current state and anticipated future state of VBP arrangements to support chronic disease control efforts into the regional VBP transition plan. Consider inclusion of the following within reimbursement models: bundled services, group visits, once-daily medication regimens, community-based self-management support services.

Guidance for evidence-based approaches

Chronic Care Model

Regions are encouraged to focus on more than one chronic condition under the Chronic Care Model approach.

Examples of specific strategies to consider within Chronic Care Model approach:

- The Community Guide
- Million Hearts Campaign
- CDC-recognized National Diabetes Prevention Programs (NDPP)
- Community Paramedicine model: locally designed, community-based, collaborative model of care that leverages the skills of paramedics and EMS systems to address care gaps identified through a community specific health care needs assessment.

Specific change strategies to be implemented across elements of the Chronic Care Model: self-management support, delivery system design, decision support, clinical information systems, community-based resources and policy, and health care organization.

- **Self-management support strategies and resources** to empower and prepare patients to manage their health and health care, such as: incorporate the 5As (assess, advise, agree, assist, arrange) into regular care, such as:
    - Completing and update asthma action plans
    - Providing access to asthma self-management education, diabetes self-management education, and Stanford Chronic Disease Management Program
    - Supporting home-based blood pressure monitoring
    - Providing motivational interviewing
    - Ensuring cultural and linguistic appropriateness
- **Delivery system design strategies** to support effective, efficient care, such as implementing and supporting team-based care strategies; increasing the presence and clinical role of non-physician members of the care team; increasing frequency and improving processes of planned care visits and follow-up; referral processes to care management and specialty care.
- **Decision support strategies** to support clinical care that is consistent with scientific evidence and patient preference, such as development and/or provision of decision support tools (guideline summaries, flow sheets, etc.); embed evidence-based guidelines and prompts into EHRs; provide education as needed on evidence-based guidelines via case-based learning, academic detailing, or modeling by expert providers; establish collaborative management practices and communication with specialty providers; incorporate patient education and engagement strategies.
- **Clinical information systems strategies** to organize patient and population data to facilitate efficient and effective care, such as utilization of patient registries; automated appointment reminder systems; bi-directional data sharing and encounter alert systems; provider performance reporting.
- **Community-based resources and policy strategies** to activate the community, increase community-based supports for disease management and prevention, and development of local collaborations to address structural barriers to care such as community paramedicine; tobacco-free policy expansion; tobacco cessation assistance; nutritional food access policies; National Diabetes Prevention Program; home-based and school-based asthma services; worksite nutritional and physical activity programs; and behavioral screen time interventions.
- **Health care organization strategies** that ensure high-quality care, such as engagement of executive and clinical leadership; support for quality improvement processes; shared learning structures; intersection with care coordination efforts; and financial strategies to align payment with performance.

Appendix A: P4R and P4P AV association

By project and reporting period

AV snapshot: Project 2A - bi-directional integration of physical and behavioral health through care transformation

Table 39: P4R AV earning potential (Project 2A)

P4R milestones and recurrent deliverables	Schedule of AVs									
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)		DY6 (2022)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0									
Completed strategy development for Domain I (health and community systems capacity building)	1.0									
Definition of evidence-based approaches or promising practices and target populations	1.0									
Completion of initial partnering provider list	1.0									
Completed implementation plan		1.0								
Support regional transition to integrated managed care (2020 regions only)		1.0								
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0							
Completion and approval of QIP			1.0							
Description of training and implementation activities				1.0						
Attestation of successfully integrating managed care			1.0		1.0					
Description of scale and sustain transformation activities						1.0				
Description of continuous quality improvement methods to refine/revise transformation activities						1.0				
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0				
Demonstrate sustainability of transformation activities						1.0				
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0		
Collection and reporting of provider-level P4R metrics			1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Total earnable P4R AVs per reporting period	5.0	5.0	8.0	6.0	6.0	9.0	5.0	5.0	4.0	4.0

Table 40: P4P AV earning potential (Project 2A)

P4P project metric	Schedule of AVs			
	DY3 (2019) Q1-Q4	DY4 (2020) Q1-Q4	DY5 (2021) Q1-Q4	DY6 (2022) Q1-Q4
Acute Hospital Utilization	Inactive	1.0	1.0	1.0
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0	1.0
Antidepressant Medication Management	1.0	1.0	1.0	1.0
Asthma Medication Ratio	Inactive	1.0	1.0	1.0
Children's and Adolescents' Access to Primary Care Practitioners	1.0	Inactive	Inactive	Inactive
Child and Adolescent Well-Care Visits (3-21 Years of Age)	Inactive	1.0	1.0	1.0
Comprehensive Diabetes Care: Eye Exam (retinal) performed	Inactive	1.0	1.0	1.0
Comprehensive Diabetes Care: Hemoglobin A1c Testing	1.0	1.0	1.0	1.0
Comprehensive Diabetes Care: Medical Attention for Nephropathy	1.0	Inactive	Inactive	Inactive
Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence	Inactive	1.0	1.0	1.0
Follow-up After ED Visit for Mental Illness	Inactive	1.0	1.0	1.0
Follow-up After Hospitalization for Mental Illness	Inactive	1.0	1.0	1.0
Kidney health Evaluation for Patients with Diabetes	Inactive	1.0	1.0	1.0
Medication Management for People with Asthma: Medication Compliance 75%	1.0	Inactive	Inactive	Inactive
Mental Health Treatment Penetration (Broad Version)	1.0	1.0	1.0	1.0
Plan All-Cause Readmission Rate (30 Days)	1.0	1.0	1.0	1.0
SUD Treatment Penetration	1.0	1.0	1.0	1.0
Total earnable P4P AV per performance period	9.0	14.0	14.0	14.0

AV snapshot: Project 2B - community-based care coordination

Table 41: P4R AV earning potential (Project 2B)

P4R milestones and recurrent deliverables	Schedule of AVs									
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)		DY6 (2022)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0									
Completed strategy development for Domain I (health and community systems capacity building)	1.0									
Definition of evidence-based approaches or promising practices and target populations	1.0									
Completion of initial partnering provider list	1.0									
Completed implementation plan		1.0								
Project 2B: Identified HUB lead entity and description of qualifications		1.0								
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0							
Completion and approval of QIP			1.0							
Description of training and implementation activities				1.0						
Project 2B: Description of each pathway scheduled for initial implementation and expansion / partnering provider role & responsibilities to support Pathways implementation				1.0						
Description of scale and sustain transformation activities						1.0				
Description of continuous quality improvement methods to refine/revise transformation activities						1.0				
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0				
Demonstrate sustainability of transformation activities						1.0				
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0		
Total earnable P4R AVs per reporting period	5.0	5.0	6.0	6.0	4.0	8.0	4.0	4.0	3.0	3.0

Table 42: P4P AV earning potential (Project 2B)

P4P project metric	Schedule of AVs			
	DY3 (2019) Q1-Q4	DY4 (2020) Q1-Q4	DY5 (2021) Q1-Q4	DY6 (2022) Q1-Q4
Acute Hospital Utilization	Inactive	1.0	1.0	1.0
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0	1.0
Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence	Inactive	1.0	1.0	1.0
Follow-up After ED Visit for Mental Illness	Inactive	1.0	1.0	1.0
Follow-up After Hospitalization for Mental Illness	Inactive	1.0	1.0	1.0
Mental Health Treatment Penetration (Broad Version)	1.0	1.0	1.0	1.0
Percent Homeless (Narrow Definition)	1.0	1.0	1.0	1.0
Plan All-Cause Readmission Rate (30 Days)	1.0	1.0	1.0	1.0
SUD Treatment Penetration	1.0	1.0	1.0	1.0
Total earnable P4P AV per performance period	5.0	9.0	9.0	9.0

AV snapshot: Project 2C -transitional care

Table 43: P4R AV earning potential (Project 2C)

P4R milestones and recurrent deliverables	Schedule of AVs									
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)		DY6 (2022)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0									
Completed strategy development for Domain I (health and community systems capacity building)	1.0									
Definition of evidence-based approaches or promising practices and target populations	1.0									
Completion of initial partnering provider list	1.0									
Completed implementation plan		1.0								
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0							
Completion and approval of QIP			1.0							
Description of training and implementation activities				1.0						
Description of scale and sustain transformation activities						1.0				
Description of continuous quality improvement methods to refine/revise transformation activities						1.0				
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0				
Demonstrate sustainability of transformation activities						1.0				
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0		
Total earnable P4R AVs per reporting period	5.0	4.0	6.0	5.0	4.0	8.0	4.0	4.0	3.0	3.0

Table 44: P4P AV earning potential (Project 2C)

P4P project metric	Schedule of AVs, by year			
	DY3 (2019) Q1- Q4	DY4 (2020) Q1- Q4	DY5 (2021) Q1-Q4	DY6 (2022) Q1-Q4
Acute Hospital Utilization	Inactive	1.0	1.0	1.0
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0	1.0
Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence	Inactive	1.0	1.0	1.0
Follow-up After ED Visit for Mental Illness	Inactive	1.0	1.0	1.0
Follow-up After Hospitalization for Mental Illness	Inactive	1.0	1.0	1.0
Percent Homeless (Narrow Definition)	1.0	1.0	1.0	1.0
Plan All-Cause Readmission Rate (30 Days)	1.0	1.0	1.0	1.0
Total earnable P4P AV per performance period	3.0	7.0	7.0	7.0

AV snapshot: Project 2D - diversion interventions

Table 45: P4R AV earning potential (Project 2D)

P4R milestones and recurrent deliverables	Schedule of AVs									
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)		DY6 (2022)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0									
Completed strategy development for Domain I (health and community systems capacity building)	1.0									
Definition of evidence-based approaches or promising practices and target populations	1.0									
Completion of initial partnering provider list	1.0									
Completed implementation plan		1.0								
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0							
Completion and approval of QIP			1.0							
Description of training and implementation activities				1.0						
Description of scale and sustain transformation activities						1.0				
Description of continuous quality improvement methods to refine/revise transformation activities						1.0				
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0				
Demonstrate sustainability of transformation activities						1.0				
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0		
Total earnable P4R AVs per reporting period	5.0	4.0	6.0	5.0	4.0	8.0	4.0	4.0	3.0	3.0

Table 46: P4P AV earning potential (Project 2D)

P4P project metric	Schedule of AVs, by year			
	DY3 (2019)	DY4 (2020)	DY5 (2021)	DY6 (2022)
	Q1- Q4	Q1- Q4	Q1-Q4	Q1-Q4
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0	1.0
Percent Arrested	Inactive	1.0	1.0	1.0
Percent Homeless (Narrow Definition)	1.0	1.0	1.0	1.0
Total earnable P4P AV per performance period	2.0	3.0	3.0	3.0

AV snapshot: Project 3A - addressing the opioid use public health crisis

Table 47: P4R AV earning potential (Project 3A)

P4R milestones and recurrent deliverables	Schedule of AVs									
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)		DY6 (2022)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0									
Completed strategy development for Domain I (health and community systems capacity building)	1.0									
Definition of evidence-based approaches or promising practices and target populations	1.0									
Completion of initial partnering provider list	1.0									
Completed implementation plan		1.0								
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0							
Completion and approval of QIP			1.0							
Description of training and implementation activities				1.0						
Address gaps in access & availability of providers offering recovery support services				1.0						
Description of scale and sustain transformation activities						1.0				
Description of continuous quality improvement methods to refine/revise transformation activities						1.0				
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0				
Demonstrate sustainability of transformation activities						1.0				
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0		
Collection and reporting of provider-level P4R metrics			1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Total earnable P4R AVs per reporting period	5.0	4.0	7.0	7.0	5.0	9.0	5.0	5.0	4.0	4.0

Table 48: P4P AV earning potential (Project 3A)

P4P project metric	Schedule of AVs, by year			
	DY3 (2019) Q1- Q4	DY4 (2020) Q1- Q4	DY5 (2021) Q1-Q4	DY6 (2022) Q1-Q4
Acute Hospital Utilization	Inactive	1.0	1.0	1.0
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0	1.0
Patients prescribed chronic concurrent opioids and sedatives prescriptions	1.0	1.0	1.0	1.0
Patients prescribed high-dose chronic opioid therapy	1.0	1.0	1.0	1.0
SUD Treatment Penetration (Opioid)	Inactive	1.0	1.0	1.0
Total earnable P4P AV per performance period	3.0	5.0	5.0	5.0

AV snapshot: Project 3B - reproductive and maternal/child health

Table 49: P4R AV earning potential (Project 3B)

P4R milestones and recurrent deliverables	Schedule of AVs									
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)		DY6 (2022)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0									
Completed strategy development for Domain I (health and community systems capacity building)	1.0									
Definition of evidence-based approaches or promising practices and target populations	1.0									
Completion of initial partnering provider list	1.0									
Completed implementation plan		1.0								
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0							
Completion and approval of QIP			1.0							
Description of training and implementation activities				1.0						
Description of scale and sustain transformation activities						1.0				
Description of continuous quality improvement methods to refine/revise transformation activities						1.0				
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0				
Demonstrate sustainability of transformation activities						1.0				
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0		
Total earnable P4R AVs per reporting period	5.0	4.0	6.0	5.0	4.0	8.0	4.0	4.0	3.0	3.0

Table 50: P4P AV earning potential (Project 3B)

P4P project metric	Schedule of AVs, by year			
	DY3 (2019) Q1- Q4	DY4 (2020) Q1- Q4	DY5 (2021) Q1-Q4	DY6 (2022) Q1-Q4
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0	1.0
Childhood Immunization Status (Combo 10)	Inactive	1.0	1.0	1.0
Chlamydia Screening in Women	1.0	1.0	1.0	1.0
Child and Adolescents Well-Child Visits (3-11 Years of Age)	Inactive	1.0	1.0	1.0
Contraceptive Care – Most & Moderately Effective Methods	Inactive	1.0	1.0	1.0
Contraceptive Care – Postpartum	Inactive	1.0	1.0	1.0
Mental Health Treatment Penetration (Broad Version)	1.0	1.0	1.0	1.0
SUD Treatment Penetration	1.0	1.0	1.0	1.0
Timeliness of Prenatal Care	Inactive	1.0	1.0	1.0
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Age	1.0	Inactive	Inactive	Inactive
Well-Child Visits in the First 15 Months of Life	Inactive	Inactive	Inactive	Inactive
Well-Child Visits in the First 30 Months of Life	Inactive	1.0	1.0	1.0
Total earnable P4P AV per performance period	5.0	10.0	10.0	10.0

AV snapshot: Project 3C - access to oral health services

Table 51: P4R AV earning potential (Project 3C)

P4R milestones and recurrent deliverables	Schedule of AVs									
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)		DY6 (2022)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0									
Completed strategy development for Domain I (health and community systems capacity building)	1.0									
Definition of evidence-based approaches or promising practices and target populations	1.0									
Completion of initial partnering provider list	1.0									
Completed implementation plan		1.0								
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0							
Completion and approval of QIP			1.0							
Description of training and implementation activities				1.0						
Description of scale and sustain transformation activities						1.0				
Description of continuous quality improvement methods to refine/revise transformation activities						1.0				
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0				
Demonstrate sustainability of transformation activities						1.0				
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0		
Total earnable P4R AVs per reporting period	5.0	4.0	6.0	5.0	4.0	8.0	4.0	4.0	3.0	3.0

Table 52: P4P AV earning potential (Project 3C)

P4P project metric	Schedule of AVs, by year			
	DY3 (2019) Q1- Q4	DY4 (2020) Q1- Q4	DY5 (2021) Q1-Q4	DY6 (2022) Q1-Q4
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0	1.0
Dental Sealants for Children at Elevated Caries Risk	Inactive	Inactive	1.0	1.0
Periodontal Evaluation in Adults with Chronic Periodontitis	Inactive	1.0	1.0	1.0
Primary Caries Prevention Intervention as Offered by Medical Provider: Topical Fluoride Application Delivered by Non-Dental Health Professional	1.0	1.0	1.0	1.0
Utilization of Dental Services	1.0	1.0	1.0	1.0
Total earnable P4P AV per performance period	3.0	4.0	5.0	5.0

AV snapshot: Project 3D - chronic disease prevention and control

Table 53: P4R AV earning potential (Project 3D)

P4R milestones and recurrent deliverables	Schedule of AVs									
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)		DY6 (2022)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0									
Completed strategy development for Domain I (health and community systems capacity building)	1.0									
Definition of evidence-based approaches or promising practices and target populations	1.0									
Completion of initial partnering provider list	1.0									
Completed implementation plan		1.0								
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0							
Completion and approval of QIP			1.0							
Description of training and implementation activities				1.0						
Description of scale and sustain transformation activities						1.0				
Description of continuous quality improvement methods to refine/revise transformation activities						1.0				
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0				
Demonstrate sustainability of transformation activities						1.0				
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0		
Total earnable P4R AVs per reporting period	5.0	4.0	6.0	5.0	4.0	8.0	4.0	4.0	3.0	3.0

Table 54: P4P AV earning potential (Project 3D)

P4P project metric	Schedule of AVs, by year			
	DY3 (2019) Q1- Q4	DY4 (2020) Q1- Q4	DY5 (2021) Q1-Q4	DY6 (2022) Q1-Q4
Acute Hospital Utilization	Inactive	1.0	1.0	1.0
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0	1.0
Asthma Medication Ratio	Inactive	1.0	1.0	1.0
Children's and Adolescents' Access to Primary Care Practitioners	1.0	Inactive	Inactive	Inactive
Child and Adolescent Well-Care Visits (3-21 Years of Age)	Inactive	1.0	1.0	1.0
Comprehensive Diabetes Care: Eye Exam (retinal) performed	Inactive	1.0	1.0	1.0
Comprehensive Diabetes Care: Hemoglobin A1c Testing	1.0	1.0	1.0	1.0
Comprehensive Diabetes Care: Medical Attention for Nephropathy	1.0	Inactive	Inactive	Inactive
Kidney Health Evaluation for Patients with Diabetes	Inactive	1.0	1.0	1.0
Medication Management for People with Asthma: Medication Compliance 75%	1.0	Inactive	Inactive	Inactive
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)	Inactive	1.0	1.0	1.0
Total earnable P4P AV per performance period	5.0	8.0	8.0	8.0

Appendix B: Project Toolkit for P4P metrics

The following table provides a high-level description for the Project Toolkit P4P metrics. Full measure specifications and measure production information can be referenced in the DSRIP Measurement Guide.

Table 55: Project Toolkit P4P metrics

Name of measure	Term used to reference the measure
National Quality Forum (NQF)#	Measures endorsed by NQF will have an identification number. A full list of NQF-endorsed measures are available through the Quality Positioning System (QPS).
Measure steward	An individual or organization that owns a measure is responsible for maintaining the measure. Measure stewards are often the same as measure developers, but not always. Measure stewards are also an ongoing point of contact for people interested in a measure.
Measure description	Summary information to provide high-level understanding of measure intent.
ACH P4P metrics for project incentives, by year	Outlines the DYs when the measure is "activated" or associated with project P4P incentives. P4P begins DY3; however, not all measures are "activated" at the same time.
Associated toolkit projects	Indicates the projects for which the metric is associated with project P4P incentives.
ACH high-performance metric	Indicates whether the metric is associated with earning incentives from the ACH high-performance pool.

Table 56: ACH project P4P metrics

Name of metric	NQF#	Measure steward	Measure description	ACH P4P metrics for project incentives, by year				Associated toolkit projects	ACH high-performance metric
				DY3 (2019)	DY4 (2020)	DY5 (2021)	DY6 (2022)		
Acute Hospital Utilization	N/A	NCQA (HEDIS)	The rate of acute inpatient discharges among Medicaid beneficiaries, 18 years of age and older, during the measurement year. Measure is expressed as a rate per 1,000 denominator member months.	Inactive	P4P	P4P	P4P	2A, 2B, 2C, 3A, 3D	N
All-Cause ED Visits per 1000 Member Months	N/A	DSHS (Research and Data Analysis (RDA) Division)	The rate of Medicaid beneficiary visits to an ED during the measurement year, including visits related to mental health and SUD. Measure is expressed as a rate per 1,000 denominator member months.	P4P	P4P	P4P	P4P	2A, 2B, 2C, 2D, 3A, 3B 3C, 3D	Y
Antidepressant Medication Management	0105	NCQA (HEDIS)	The percentage of Medicaid beneficiaries, 18 years of age and older, who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment	P4P	P4P	P4P	P4P	2A	Y

			during the measurement year.						
Asthma Medication Ratio	1800	NCQA (HEDIS)	The percentage of Medicaid beneficiaries, 5-64 years of age, who were identified as having persistent asthma and had a ratio of controller medication to total asthma medications of 0.50 or greater during the measurement year.	Inactive	P4P	P4P	P4P	2A, 3D	Y (DY4, DY5)
Children's and Adolescents' Access to Primary Care Practitioners	N/A	NCQA (HEDIS - modified)	The percentage of Medicaid beneficiaries, 12 months-19 years of age, who had an ambulatory or preventive care visit during the measurement year.	P4P	Inactive	Inactive	Inactive	2A, 3D	N
Child and Adolescent Well-Care Visits	N/A	NCQA (HEDIS - modified)	The percentage of Medicaid beneficiaries, 3-21 years of age, who had at least one comprehensive well-care visit during the measurement year.	N/A	P4P	P4P	P4P	2A, 3D	N
Child and Adolescent Well-Care Visits	N/A	NCQA (HEDIS - Modified)	The percentage of Medicaid beneficiaries, 3-11 years of age, who had at least one comprehensive well-care visit during the measurement year.	N/A	P4P	P4P	P4P	3B	Y

Childhood Immunization Status (Combo 10)	0038	NCQA (HEDIS)	The percentage of Medicaid beneficiaries who turned 2 years of age during the measurement year who, by their second birthday, received all vaccinations in the Combo 10 vaccination set.	Inactive	P4P	P4P	P4P	3B	N
Chlamydia Screening in Women	0033	NCQA (HEDIS)	The percentage of female Medicaid beneficiaries, 16-24 years of age, identified as sexually active and who had at least one test for chlamydia during the measurement year.	P4P	P4P	P4P	P4P	3B	N
Comprehensive Diabetes Care: Eye Exam (retinal) Performed	0055	NCQA (HEDIS)	The percent of Medicaid beneficiaries, 18-75 years of age, with diabetes (type 1 and type 2) who had a retinal or dilated eye exam by an eye care professional during the measurement year, or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement year.	Inactive	P4P	P4P	P4P	2A, 3D	N
Comprehensive Diabetes Care: Hemoglobin A1c Testing	0057	NCQA (HEDIS)	The percent of Medicaid beneficiaries, 18-75 years of age, with diabetes (type 1 and type 2) who received a Hemoglobin A1c (HbA1c) test during the measurement year.	P4P	P4P	P4P	P4P	2A, 3D	N
Comprehensive Diabetes Care: Medical	0062	NCQA (HEDIS)	The percent of Medicaid beneficiaries, 18-75 years of age, with diabetes (type 1 and type 2) who	P4P	Inactive	Inactive	Inactive	2A, 3D	N

Attention for Nephropathy			had a nephropathy screening test or evidence of nephropathy during the measurement year.						
Contraceptive Care – Most and Moderately Effective Methods	2903	US Office of Population Affairs	The percent of female Medicaid beneficiaries, 15-44 years of age, at risk of unintended pregnancy that are provided a most effective (i.e., sterilization, implants, intrauterine devices, or systems (IntraUterine Device (IUD) or IntraUterine System (IUS) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved method of contraception during the measurement year.	Inactive	P4P	P4P	P4P	3B	N
Contraceptive Care – Postpartum	2902	U.S. Office of Population Affairs	The percent of female Medicaid beneficiaries, 15-44 years of age, who had a live birth that are provided a most effective (i.e., sterilization, implants, intrauterine devices, or systems [IUD/IUS]) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved method of contraception within 3 and 60 days of delivery during the measurement year.	Inactive	P4P	P4P	P4P	3B	N

Dental Sealants for Children at Elevated Caries Risk	2508, 2509	Dental Quality Alliance (DQA)	The percent of Medicaid beneficiaries, 6-14 years of age, at elevated risk of dental caries who received a sealant on a permanent first molar tooth (age 6-9 years) or a sealant on a permanent second molar tooth (age 10-14 years) during the measurement year.	Inactive	Inactive	P4P	P4P	3C	N
Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence	2605	NCQA (HEDIS)	The percent of ED visits for Medicaid beneficiaries, 13 years of age and older, with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit. 2. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit. ED visit and follow-up must occur during the measurement year.	Inactive	P4P	P4P	P4P	2A, 2B, 2C	N

Follow-up After ED Visit for Mental Illness	2605	NCQA (HEDIS)	The percent of ED visits for Medicaid beneficiaries, 6 years of age and older, with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit. 2. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit. ED visit and follow-up must occur during the measurement year.	Inactive	P4P	P4P	P4P	2A, 2B, 2C	N
Follow-up After Hospitalization for Mental Illness	0576	NCQA (HEDIS)	The percent of discharges for Medicaid beneficiaries, 6 years of age and older, who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: 1. The percentage of discharges for which the member received follow-up within 7 days after discharge. 2. The percentage of	Inactive	P4P	P4P	P4P	2A, 2B, 2C	N

			discharges for which the member received follow-up within 30 days after discharge. Hospitalization discharge and follow-up must occur during the measurement year.						
Kidney Health Evaluation for Patients with Diabetes		NCQA (HEDIS)		Inactive	P4P	P4P	P4P	2A, 3D	N
Medication Management for People with Asthma: Medication Compliance 75%	1799	NCQA (HEDIS)	The percent of Medicaid beneficiaries, 5-64 years of age, who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for the treatment period during the measurement year. Rate are reported for the percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.	P4P	Inactive	Inactive	Inactive	2A, 3D	Y (DY3 only)
Mental Health Treatment Penetration (Broad Version)	N/A	WA DSHS (RDA)	The percent of Medicaid beneficiaries, 6 years of age and older, with a mental health service need identified within the past two years, who received at least one	P4P	P4P	P4P	P4P	2A, 2B, 3B	Y

			qualifying service during the measurement year.						
Patients Prescribed Chronic Concurrent Opioids and Sedatives Prescriptions	N/A	Bree Collaborative	The percent of Medicaid beneficiaries prescribed opioids and a concurrent sedative prescription, among beneficiaries prescribed chronic opioids.	P4P	P4P	P4P	P4P	3A	N
Patients Prescribed High-dose Chronic Opioid Therapy	N/A	Bree Collaborative	The percent of Medicaid beneficiaries prescribed chronic opioid therapy. Two rates reported according to dosage threshold: 1. Greater than or equal to 50mg morphine equivalent dosage in a quarter. 2. Greater than or equal to 90mg morphine equivalent dosage in a quarter.	P4P	P4P	P4P	P4P	3A	N
Percent Arrested	N/A	WA DSHS (RDA)	The percent of Medicaid beneficiaries, aged 18 and older, who were arrested at least once during the measurement year.	Inactive	P4P	P4P	P4P	2D	Y
Percent Homeless (Narrow Definition)	N/A	WA DSHS (RDA)	The percent of Medicaid beneficiaries who were homeless in at least one month during the measurement year. Narrow definition excludes "homeless with housing" living arrangement code from	P4P	P4P	P4P	P4P	2B, 2C, 2D	Y

			the Automated Client Eligibility System (ACES).						
Periodontal Evaluation in Adults with Chronic Periodontitis	N/A	Dental Quality Alliance (DQA)	The percent of Medicaid beneficiaries, ages 30 years and older, with history of periodontitis who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the measurement year.	Inactive	P4P	P4P	P4P	3C	N
Plan All-Cause Readmission Rate (30 Days)	1768	NCQA (HEDIS)	The percent of acute inpatient stays among Medicaid beneficiaries, 18 years of age and older, during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	P4P	P4P	P4P	P4P	2A, 2B, 2C	Y
Primary Caries Prevention Intervention as Offered by Medical Provider: Topical Fluoride Application Delivered by Non-Dental Health Professional	N/A	HCA	The percent of Medicaid beneficiaries, 0-5 years of age, who received a topical fluoride application from a professional provider (non-dental medical provider) during any medical visit during the measurement year.	P4P	P4P	P4P	P4P	3C	N

Statin Therapy for Patients with Cardiovascular Disease (Prescribed)	N/A	NCQA (HEDIS)	The percent of Medicaid beneficiaries, male 21-75 years of age and females 40-75 years of age, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) who were dispensed at least one high- or moderate-intensity statin medication during the measurement year.	Inactive	P4P	P4P	P4P	3D	N
SUD Treatment Penetration	N/A	DSHS (RDA)	The percent of Medicaid beneficiaries 12 years of age and older with an SUD treatment need identified within the past two years, and who received at least one qualifying SUD treatment during the measurement year.	P4P	P4P	P4P	P4P	2A, 2B, 3B	Y
SUD Treatment Penetration (Opioid)	N/A	DSHS (RDA)	The percent of Medicaid beneficiaries, 18 years of age and older, with an opioid used disorder treatment need identified within the past two years, who received medication assisted treatment (MAT) or medication-only treatment for OUD during the measurement year.	Inactive	P4P	P4P	P4P	3A	N
Timeliness of Prenatal Care	N/A	NCQA (HEDIS)	The percent of live birth deliveries that received a prenatal care visit in the first trimester, on the enrollment start date or within 42 days of	Inactive	P4P	P4P	P4P	3B	N

			enrollment during the measurement year.						
Utilization of Dental Services	N/A	DQA	The percent of Medicaid beneficiaries who received preventative or restorative dental services in the measurement year.	P4P	P4P	P4P	P4P	3C	N
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Age	1516	NCQA (HEDIS - modified)	The percent of Medicaid beneficiaries 3–6 years of age who had one or more well-child visits during the measurement year.	P4P	Inactive	Inactive	Inactive	3B	Y
Well-Child Visits in the First 30 Months of Life		NCQA (HEDIS - modified)	The percent of Medicaid beneficiaries who turned 30 months old during the measurement year and who had six or more well-child visits during their first 15 months of life and two or more visits between 15 to 30 months.	Inactive	P4P	P4P	P4P	3B	N

ATTACHMENT D: DSRIP FUNDING AND MECHANICS PROTOCOL

I. Accountable Communities of Health

a. Introduction

This demonstration aims to transform the health care delivery system through regional, collaborative efforts led by ACHs. ACHs are self-governing organizations with multiple community representatives that are focused on improving health and transforming care delivery for the populations that live within the region. Providers within ACH regions will partner to implement evidence-based programs and emerging innovations, as defined in the DSRIP Planning Protocol (Attachment C), that address the needs of Medicaid beneficiaries. ACHs, through their governing bodies, are responsible for managing and coordinating the projects undertaken with partnering providers as well as state reporting.

This protocol provides detail and criteria that ACHs and their partnering providers must meet in order to receive DSRIP funding and the process that the state will follow to ensure that ACHs will meet these standards.

b. ACH Service Regions

There are nine ACHs that cover the entire state, with the boundaries of each aligned with the state's Medicaid Regional Service Areas (RSA). The RSAs were designated in 2014 through legislation that required the state to continue regionalizing its Medicaid purchasing approach. The RSA geographic boundaries were designated by assessing the degree to which they:

- Support naturally occurring health care delivery system and community service referral patterns across contiguous counties;
- Reflect active collaboration with community planning that prioritizes the health and well-being of residents;
- Include a minimum number of beneficiaries (at least 60,000 covered Medicaid lives) to ensure active and sustainable participation by health insurance companies that serve whole region; and
- Ensure access to adequate provider networks, consider typical utilization and travel patterns, and consider the availability of specialty services and the continuity of care.

ACH Name	Counties in RSA
Better Health Together	Adams, Ferry, Lincoln, Pend Oreille, Spokane Stevens
Greater Columbia ACH	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, Yakima
SWACH	Clark, Klickitat, Skamania
Cascade Pacific Action Alliance	Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, Wahkiakum
Olympic Community of Health	Clallam, Kitsap, Jefferson
Healthier Here	King

Elevate Health	Pierce
North Sound ACH	Island, San Juan, Skagit, Snohomish Whatcom
North Central ACH	Chelan, Douglas, Grant, Okanogan

c. ACH Composition and Partnering Provider Guidelines

Each ACH consists of partnering providers. The commitment to serving Medicaid beneficiaries, as well as the diversity and expertise of those providers and social service organizations, is important in evaluating Project Plan applications.

d. The ACH serves as the lead for the projects with partnering providers that are participating in Medicaid transformation projects. The ACH must submit a single Project Plan application on behalf of the partnering providers, and serve as the single point of performance accountability in the Independent Assessor's evaluation of projects and metrics. *ACH Governance and Management*

Each ACH must describe its primary decision-making process, process for conflict resolution, and its structure (e.g., a Board or Steering Committee) that is subject to composition and participation guidelines as outlined in STC 23. Each ACH's primary decision-making body will be responsible for approving the selection of transformation projects. Each ACH will comply with STCs 22 and 23 in its decision-making structure, which compliance the state will review and approve as part of ACH certification.

The overall organizational structure of the ACH must reflect the capability to make decisions and oversee regional efforts in alignment with the following five domains, at a minimum:

- Financial
- Clinical
- Community
- Data and Performance Monitoring
- Program management and strategy development

The ACH's responsibilities include engaging stakeholders region-wide; supporting partnering providers in planning and implementing projects in accordance with requirements of the demonstration; developing budget plans for the distribution of DSRIP funds to partnering providers in accordance with the funding methodology provided in this protocol; collaborating with partnering providers in ACH leadership and oversight; and leading and complying with all state and CMS reporting requirements.

II. Projects, Metrics and Metric Targets

a. Overview of Projects

ACHs must select and implement at least four Transformation projects from the Project Toolkit (described in the DSRIP Planning Protocol [Attachment C]). ACHs must provide project details in the Project Plan application and describe how selected projects are directly responsive to the needs and characteristics of the Medicaid populations served in the region.

Projects described in the DSRIP Planning Protocol (Attachment C) are grouped into three domains: Health Systems and Community Capacity, Care Delivery Redesign, and Prevention and Health Promotion. The ACHs are responsible for demonstrating progress in relation to progress milestones and outcome metrics for each project.

b. Project Metrics

As part of their Project Plans, ACHs must develop timelines for implementation of projects, in alignment with state-specified process milestones included in Attachment C. Metrics that track progress in project planning, implementation, and efforts to scale and sustain project activities will be used to evaluate ACH milestone achievement.

ACHs must report on these metrics in their semi-annual reports (described in Section V). For each reporting period, ACHs are eligible to receive incentive payments for progress milestones and improvement toward performance metric targets. For designated performance metrics, ACHs will be awarded Achievement Values (AV), based on the mechanism described in Section IV of this protocol.

c. Outcome Metric Goals and Improvement Target

ACHs will have a performance goal for each outcome metric. On an annual basis, the state will measure ACH improvement from a baseline toward this goal to evaluate whether or not the ACH has achieved the metric improvement target. Each ACH will have its own baseline starting point. Both existing and new measures' baselines will be set based on performance during Demonstration Year (DY) 1.

Annual improvement targets for ACH outcome metrics will be established using one of two methodologies:

(1) Gap to Goal Closure: This methodology will be used for metrics that have available state or national Medicaid, or other comparable populations, 90th percentile benchmarks. Outcome targets will be based on these state or national performance benchmarks, whenever available, but adjustments may be made to reflect the socioeconomic and demographic characteristics of the populations serviced by ACHs, where possible.

The "gap" in this methodology is defined as the difference between the baseline (or end of prior DY) performance and the 90th percentile benchmark. Annual improvement targets will be an up to 10 percent closure of the gap year over year.

An example to illustrate the gap to goal methodology: If the baseline data for a measure is 52 percent and the goal is 90 percent, the gap to the goal is 38. The target for the project's first year of performance would be 38 times 10 percent, equaling a 3.8 percent increase in the result (target 55.8%). Each subsequent year would continue to be set with a target using the most recent year's data. For example, should an ACH meet or exceed the first year's target of 55.8 percent, the next annual target would be up to 10 percent of the new gap to the goal. This will account for smaller gains in subsequent years as performance improves toward the goal or measurement ceiling.

In cases where ACH performance meets or exceeds the performance goal (i.e., the 90 percent performance in the example above), incentives are earned based on continued

performance above the goal. If an ACH has already surpassed the goal in the baseline year, the measure will be dropped and value of the remaining measures rebased.

(2) Improvement-Over-Self: For those metrics without a state or national Medicaid benchmark available, including innovative metrics, the state will set a standard percent improvement relative to each ACH's previous DY performance. This percent improvement target will be determined on a metric-by-metric basis based on available evidence of a reasonable expectation for magnitude of change. Improvement targets for these metrics will be set to be consistent with the magnitude of change required to meet targets in the gap-to-goal methodology measures. The improvement-over-self-target for each metric will be consistent across each ACH.[1]

If an ACH baseline rate for an IOS metric reflects the maximum possible rate (100% or 0% depending on whether higher or lower rates indicate better outcomes) and thus an improvement target cannot be calculated, the measure will be dropped and the value of the remaining measures rebased.

III. Incentive Funding Formula and Project Design Funds

a. *Demonstration Year 1 (DY1)*

i. *Project Design Funds*

In accordance with STCs 35(i) and 45, during DY1, the state will provide project design funds to ACHs for completing the designated certification process. The design funds are a fixed component distributed equally across ACHs for completing the certification process described in Attachment C and can be used to develop specific and comprehensive Project Plans. This funding allows ACHs to begin to develop the technology, tools, and human resources to support the necessary capacity ACHs need to pursue demonstration goals in accordance with community-based priorities.

Design funds payments will total up to 25 percent of allowable expenditures in DY1 with payments distributed in two phases between June and September 2017. As described in the DSRIP Planning Protocol (Attachment C), ACHs are required to complete the two-phase certification process for receipt of design funds. In order to be eligible for incentive payments, beyond design funds, an ACH must submit and receive state approval of a Project Plan.

ii. *Project Funding*

[1] CMS approved 5.16.22, for DY5 and DY6 annual improvement targets for ACH outcome metrics will be established using the IOS methodology for all metrics given the differential disruption to the health care system across the nation and the associated impact to national data collection. Due to these factors, using a gap-to-goal method to set improvement targets would be problematic.

The state will distribute the remaining DY1 DSRIP funding (excluding state administrative expenses) to certified ACHs upon approval of the Project Plan application. The amount of DSRIP funding available for each ACH will be scaled based on application scoring by the Independent Assessor as outlined in STC 36.

b. *Demonstration Years 2 through 6 Funding and Project Valuation*

In accordance with STC 35(h), the state has developed criteria and methodology for project valuation by which ACHs will continue to earn incentive payments in DY 2 through 6 by reporting on and achieving progress measures and performance-based outcome metrics. Project valuation is calculated during DY1 once each certified ACH submits a Project Plan application detailing project selection and implementation strategies. Based on this content, the state determines maximum incentive payments allotted to each ACH, by project, which will be available for distribution to partnering providers. As described in STC 35, the annual maximum project valuation is determined based on the attributed number of Medicaid beneficiaries residing in the ACH RSA(s) and on the Project Plan application scores.

The maximum amount of ACH incentive funding is determined according to the methodology described in (c) below. Once each project is assigned a maximum valuation, the project's corresponding, individual progress measures and outcome metrics are valued according to the methodology described in (d) below.

Maximum ACH and project valuations are subject to monitoring by the state and CMS. In the event that an ACH does not meet the expected targets for each project's reporting-based progress measures and performance-based outcome metrics, the ACH's project valuation may be commensurately reduced from the maximum available project valuation. In addition, ACHs may receive less than their maximum available project valuation if DSRIP funding is reduced based on performance of the statewide measure bundle described in Section VII.

c. *Calculating Maximum ACH Project Valuation*

Each DY, a maximum statewide amount of DSRIP project funding will be identified. For approved tribal specific projects, a percentage of annual DSRIP funding will be allocated to tribal-specific projects in a manner consistent with this Protocol and the Tribal Protocol, which describes tribal projects and funds flow. Remaining project funds will be available to ACHs based on the methodology outlined below.

<u>Step 1: Assigning Project Weighting</u>

The state has weighed the projects in the Transformation Project Toolkit (Attachment C) relative to one another as a percentage of the total annual DSRIP project funding available, known as the project weight. ACHs must select at least four projects, including Project 2A (Bi-Directional Integration of Physical and Behavioral Health through Care Transformation), Project 3A (Addressing the Opioid Use Public Health Crisis) and least two additional projects, one from Domain 2 and one from Domain 3.

Each project has associated metrics that ACHs must achieve to earn funding tied to the project. An ACH's payment for project implementation is based on pay-for-reporting (P4R) in DY1 and DY2 and based on both P4R and pay-for-performance (P4P) in DY3, DY4[2], DY5, and DY6. The maximum amount of incentive funding that an ACH can earn is determined based on the ACH's project selection[3], the value of the projects selected, the quality and score of Project Plan applications, and the number of Medicaid beneficiaries[4] attributed to the ACH. Project weights outlined in Table 1 were assigned with consideration of the following factors:

- Alignment with statewide measures to better incentivize the achievement of statewide objectives.
- Number of Medicaid beneficiaries within scope and capacity of projects to address population need and improve population health.
- Potential cost-savings to ensure that the state's Medicaid per-capita cost is below national trends.
- Existence of evidence-based strategies to ensure a reduction in avoidable use of intensive services.
- Focus on quality of services, rather than quantity, to accelerate transition to value-based payment.

Table 1. Transformation Project Weighting

Project Weighting	
Project	Weight
2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation	32%
2B: Community-Based Care Coordination	22%
2C: Transitional Care	13%
2D: Diversions Interventions	13%
3A: Addressing the Opioid Use Public Health Crisis	4%
3B: Reproductive and Maternal and Child Health	5%
3C: Access to Oral Health Services	3%
3D: Chronic Disease Prevention and Control	8%

Projects listed in order of Project Weighting

Project 2A (Bi-Directional Integration of Care and Primary Care Transformation) represents the state's primary objective under Initiative 1 of the demonstration. Project 2A requires the highest level of integration of all other projects and, therefore, houses the largest corresponding set of P4P metrics. Furthermore, Project 2A has the potential to yield the

[2] Due to COVID-19 and related performance impacts in CY 2020, CMS approved flexibility for 2020 P4P achievement value calculations. The flexibility allows the state to compare results by metric (2019 regional results, 2019 statewide average, or the 2020 regional results). The Independent Assessor will apply whichever result provides the greatest AV calculation.

[4] For DY6, CMS approved a minimum regional threshold for project incentives. The minimum threshold is set at $5 million and the state will consider both the minimum threshold and the regional beneficiary calculation, applying the greater of the two.

greatest achievement of value for Medicaid members through an evidence-based approach—and is likely to result in significant cost-savings for both the state and federal government. Regions that have implemented fully integrated managed care are be better positioned to scale project 2A and are eligible for an enhanced DY1 valuation based on project plan scoring methodology.

Project 2B (Community-Based Care Coordination) has the potential to realize significant healthcare spending reductions while providing local services to many of the state's most vulnerable Medicaid beneficiaries. To earn payments for this project, an ACH must transition early in the demonstration to P4P.

The project weights of Project 2C (Transitional Care) and Project 2D (Diversion Interventions) are each 13 percent. Both projects allow ACHs to select one or more evidence-based approaches to result in cost-savings for a smaller population of Medicaid beneficiaries compared to Projects 2A and 2B. In addition, these two projects have a smaller number of measures moving to P4P throughout the demonstration period compared to other Domain 2 projects.

Project 3D (Chronic Disease Prevention and Control) has the greatest project weighting in Domain 3s, at 8 percent. Project 3D has the potential to yield significant results for a large population of Medicaid beneficiaries by including multiple chronic diseases within the project. By affecting a large population through an evidence-based model, Project 3D has the potential to result in significant cost savings.

Project 3B (Reproductive and Maternal and Child Health) impacts a large subpopulation of Medicaid beneficiaries. This project offers several optional evidence-based approaches to drive success and a suitable number of metrics to measure performance.

Project 3A (Addressing the Opioid Use Public Health Crisis) will affect a subset of the state's substance use disorder (SUD) population of Medicaid beneficiaries, anticipated to be proportionally smaller than most other Domain 3 projects, by aligning with Governor Inslee's Executive Order 16-09.[1] Based on public comments and feedback to the Project Toolkit (Attachment C), Project 3A has now been escalated as a required project for all ACHs.

Project 3C (Access to Oral Health Services) is primarily targeted at the adult population, who will benefit from the evidence-based approach selected by the ACH, and there is a defined number of P4R metrics that will be used to measure an ACH's performance.

Step 2: Calculating Maximum ACH Project Funding

In accordance with STC 28 and STC 35(b), the state developed an allocation methodology for maximum ACH project funding based on project selection, transformation impact of projects, and attribution based on residence. The state will use the defined RSA boundaries to determine beneficiary attribution for the funding methodology using the November 2017 client-by-month file. The relative level of Medicaid attribution determined at that time will determine maximum DSRIP funds per ACH throughout the demonstration, as outlined below. Maximum funding by project is calculated by multiplying the total state ACH project funds available by the respective project weight (see Table 1 for project weighting). A minimum threshold for calculating maximum regional ACH project and IHCP funding will

be set at $5 million per region for DY6. The state will consider both the minimum threshold and the regional beneficiary calculation, applying the greater of the two. Based on this change, the minimum threshold will apply to two of the nine ACHs and IHCP funding, resulting in a weighted decrease to the other ACHs.[5]

Maximum Statewide Funding by Project = [Total Annual Statewide ACH Project Funds Available by DY] x [Project Weight]

In order to determine the maximum annual ACH funding by project, the maximum annual statewide funding by project is multiplied by total Medicaid beneficiaries residing in the ACH RSA.

Maximum ACH Funding by Project = [Maximum Annual Statewide Funding by Project] x [Percent of Total Attributed Medicaid Beneficiaries]

This formula will be repeated for all selected projects, and the sum of selected project valuations equals the maximum amount of financial incentive payments each ACH can earn for successful project implementation over the course of the demonstration. Each ACH is required to select at least four projects, including Project 2A and Project 3A. If ACHs choose fewer than the total eight projects, project weights will be rebased proportionately for DY2 through DY6. This maximum ACH valuation will be earned upon achieving defined reporting-based progress measures and performance-based outcome metrics and may be reduced based on application of the statewide penalty described in Section VII.

For DY1, the maximum ACH Funding by Project will be adjusted based on Project Plan scores. Each ACH Project Plan will be scored by the Independent Assessor. The scoring criteria will be developed in conjunction with the Project Plan template (see DSRIP Planning Protocol).

d. Earning Incentive Payments

In DY2 through DY6, ACHs earn incentive payments for successful implementation and reporting of selected projects. Successful implementation is defined for each project as meeting the associated reporting-based progress measures and performance-based outcome metrics.

Within each payment period, ACHs are evaluated against these designated metrics and awarded Achievement Values (AV), which are point values assigned to each metric that is payment-driving. The maximum value of an AV is one (1) in the instance in which an ACH meets the designated metric.

The amount of incentive funding paid to an ACH will be based on the amount of progress made toward achieving its improvement target on each outcome metric. An ACH may achieve an AV based on meeting a minimum threshold of 25% of its gap-to-goal target in the year. If this performance threshold is not achieved, and ACH would forfeit the project incentive payment associated with that metric.

Enhanced AV valuation can be achieved if the ACH realizes a higher percentage of the gap-to-goal performance target, beyond the 25% threshold:

[5] This change was made in collaboration with the regional ACHs and partners. The impacts of the change are understood, and partners agree this will result in a more equitable incentive distribution in DY6.

- 100 percent achievement of performance goal (achievement value = 1)
- Less than 100 percent achievement of performance goal and at least 75 percent achievement of performance goal (achievement value = .75)
- Less than 75 percent achievement of performance goal and at least 50 percent achievement of performance goal (achievement value = .50)
- Less than 50 percent achievement of performance goal and at least 25 percent achievement of performance goal (achievement value = .25)
- Less than 25 percent threshold achievement (achievement value = 0)

To determine Total Achievement Value (TAV) for each project in a given payment period, the AVs earned within the project are summed according to their relative weighting as illustrated in Table 2. From there, the Percentage Achievement Value (PAV) is calculated by dividing the TAV by the weighted total of possible AVs for the project in that payment period. The purpose of the PAV is to represent the proportion of metrics an ACH has achieved for each project in each payment period and will be used to determine the distribution of dollars earned out of the maximum annual ACH project funding as follows:

Table 2. Example Calculation of Achievement Values

Measure/Metric	Achievement Value
Outcome Metric 1	0
Outcome Metric 2	1
Outcome Metric 3	0.5
TAV	**1.5**
PAV	**50.0%**

To support the expected outcomes from successful project implementation, ACHs are solely responsible for P4R progress measures in DY1 and DY2. The state will transition a robust set of outcome metrics to be P4P, meaning a portion of project funds are dependent on ACH demonstrating improvement toward performance targets in the out years. Table 3 illustrates the timing and distribution of transition to P4P:

Table 3. Transition to Pay-for-Performance, Percentage of Annual DSRIP Incentive Payment Allocation

Metric Type	DY1	DY2	DY3	DY4	DY5	DY6
P4R	100%	100%	75%	50%	25%	25%
P4P	0%	0%	25%	50%	75%	75%

e. Managed Care Integration

A primary goal of the demonstration is to support implementation of a fully integrated physical health and behavioral health managed care system. Although there are RSAs that have made progress toward integration, a majority of the state requires significant investments to achieve statewide integration of physical and behavioral health services by January 2020.

Regions that implement fully integrated managed care prior to 2020 are eligible to earn incentive payments above the maximum valuation for project 2A. To earn incentives above the maximum valuation for project 2A, regions must submit binding letters of intent to implement full integration. This will be reported in Project Plan submissions. The incentive payment is calculated using a base rate of up to $2 million and a per member rate based on total attributed Medicaid beneficiaries, with payments distributed to the ACH in the calendar year of completion.

Integration Incentive = [Base Rate] + [Member Adjustment x Total Attributed Medicaid Beneficiaries] x [Phase Weight]

The incentives for fully integrated managed care will be distributed in two phases associated with reporting on progress measures: binding letter(s) of intent, and implementation. These phases represent two key activities towards integration. ACHs and partnering providers are eligible for an incentive payment for reporting on the completion of each phase.

Table 4. Weighting of Integration Progress Measures by Phase

Phase Weights	
Phase 1: Binding Letter(s) of Intent	40%
Phase 2: Implementation	60%

f. Value-based Payment Incentives

In accordance with STCs 41 and 42 and the state's Value-based Roadmap (Attachment F), the state will set aside no more than 15 percent of annually available DSRIP funds to reward MCO and ACH partnering providers for provider-level attainment of VBP targets as well as progression from baseline as described in STCs 41 and 42. VBP targets reflect goal levels of adoption of Alternative Payment Models (APM) and Advanced APMs in managed care contracting.

In DY6 the state will no longer provide regional ACH incentives and statewide MCO incentives. This change was made due to the limited total funding available in DY6 and the significant advancement made DY1-DY5 surrounding VBP. The STCs state that no more than 15 percent of annually available DSRIP funds can be set aside to reward VBP progress, and the state is choosing not to use that flexibility in DY6. This change was discussed extensively with MCOs and ACHs.[6] There is a shared understanding that the change will ensure DSRIP funding is maximized in DY6 for provider incentives and sustainability efforts. In addition, the state believes there are adequate accountabilities and incentives in place to support continued VBP progress as outlined in the Apple Health Appendix, including the managed care withhold. It is important to note that this change only relates to MCO and ACH VBP incentives under DSRIP. The VBP adoption targets remain for statewide accountability and are reinforced through the Apple Health Appendix and the state's managed care withhold program.

IV. ACH Reporting Requirements

[6] MCOs and ACHs will be officially notified of this DY6 change once approved.

These activities are detailed below.

a. Pay for Reporting for ACH Project Achievement

Two times per year, ACHs seeking payment under the demonstration shall submit reports that include the information and data necessary to evaluate ACH projects using a standardized reporting form developed by the state. ACHs must use the document to report on their progress against the milestones and metrics described in their approved Project Plans. Based on these reports, as well as data generated by the state on performance metrics, the state will calculate aggregate incentive payments in accordance with this protocol. The ACH reports will be reviewed by state and the Independent Assessor. Upon request, ACHs will provide back-up documentation in support of their progress.

These reports will be due as indicated below after the end of each reporting period:

- DY1-DY5: For the reporting period encompassing January 1 through June 30 of each year; the semi-annual report and the corresponding request for payment must be submitted by the ACH to the state before July 31.
- DY1-DY5: For the reporting period encompassing July 1 through December 31 of each year; the semi-annual report and the corresponding request for payment must be submitted by the ACH to the state before January 31.
- DY6: The first P4R report and corresponding request for payment must be submitted by the ACH to the state before April 8.
- DY6: The second P4R report and corresponding request for payment must be submitted by the ACH to the state before October 7.

The state shall have 30 calendar days after these reporting deadlines to review and approve or request additional information regarding the data reported for each milestones/metric and measure. If additional information is requested, the ACH shall respond to the request within 15 calendar days and the state shall have an additional 15 calendar days to review, approve, or deny the request for payment, based on the additional information provided. The state shall schedule the payment transaction for each ACH within 30 calendar days following state approval of the semi-annual report. Approved payments will be transferred to the Financial Executor until the ACH provides direction for payment distribution to partnering providers.

The state must use this documentation in support of claims made on the MBES/CBES 64.9 Waiver form, and this documentation must be made available to CMS upon request.

V. State Oversight Activities

The state will provide oversight to ensure accountability for the demonstration funds being invested in Washington State, as well as to promote learning with the state and across the country from the work being done under the MTP demonstration. Throughout the demonstration, the state and/or its designee will oversee the activities of ACHs and submit regular reports to CMS pursuant to STC 37.

Each ACH must enter into a contract with the Washington State Health Care Authority

(HCA) to be eligible to receive project design funds, as well as other incentive funding under the demonstration. This contract sets forth the requirements and obligations of the ACHs as the leads for DSRIP and other partnering providers. The contract addresses reporting requirements, data sharing agreements, performance standards, compliance with the STCs of the demonstration, and the ACH's agreement to participate in state oversight and audit activity to ensure program integrity of the demonstration. In the contract, HCA requires ACHs to participate in semi-annual reporting outlined in this protocol as a condition for qualifying for demonstration funds.

The state will support ACHs by providing guidance and support on the state's expectations and requirements. Additionally, state activities designed to ensure program integrity are detailed below:

a. *Quarterly Operational Reports*

The state will submit progress reports on a quarterly basis to CMS. The reports will present the state's analysis of the status of implementation; identify challenges and effective strategies for overcoming them; review any available data on progress toward meeting metrics; describe upcoming activities; and include a payment summary by ACH as available. The reports will provide sufficient information for CMS to maintain awareness regarding progress of the demonstration.

b. *Learning Collaboratives*

Annual learning collaboratives will be sponsored by the state to support an environment of learning and sharing among ACHs. Specifically, the collaboratives will promote the exchange of strategies for effectively implementing projects and addressing operational and administrative challenges. ACHs will be required to participate and contribute to learning collaboratives as specified in STCs 37(c) and 45(a)(v).

c. *Program Evaluation*

In accordance with STCs 35 and 107, the state will develop an evaluation plan for the DSRIP component of the draft evaluation design. The state will contract with an independent evaluator to evaluate the demonstration. The evaluator will be selected after a formal bidding process that will include consideration of the applicant's qualifications, experience, neutrality, and proposed budget. Evaluation drafts and reports will be submitted in accordance with deadlines in section 7 of the STCs.

VI. Statewide Performance and Unearned DSRIP Funding

a. *Accountability for State Performance*

The state is accountable for demonstrating progress toward meeting the demonstration's objectives. Funding for ACHs and partnering providers may be reduced in DY3, DY4[7], DY5 and DY6 if the state fails to demonstrate quality and improvement on the

[7] Due to COVID-19 impacts, Statewide accountability has been waived for DY 4. At-risk funding is therefore reduced from 10% to 0% for DY4.

statewide measures listed below. STC 44 specifies the amount of annual DSRIP funding at risk based on statewide performance on these measures. The funding reductions will be applied proportionally to all ACHs based on their maximum Project Funding amount.

A statewide performance goal will be established for the statewide metrics. The state will be accountable for achieving these goals by the end of the demonstration period. During DY3 and DY4[7], annual assessment of quality and improvement from a defined baseline toward these goals will be used to measure and evaluate whether or not the statewide metric improvement target has been achieved.

Statewide Accountability Metrics

1. Mental Health Treatment Penetration
2. Substance Use Disorder Treatment Penetration
3. Outpatient Emergency Department Visits per 1000 Member Months
4. Plan All-Cause Readmission Rate (30 days)
5. ~~Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life~~[8]
5. Child and Adolescents Well-Care Visits 3-11 Years of Age
6. Antidepressant Medication Management
7. Medication Management for People with Asthma (5 – 64 Years)
8. Controlling High Blood Pressure[9]
9. ~~Comprehensive Diabetes Care - Blood Pressure Control~~[10]
10. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control

The state will establish a baseline performance for each measure. The state will adapt the Quality Improvement Score (QIS) methodology, originally developed by HCA for measuring MCO performance, to determine statewide performance across the statewide accountability measures for the demonstration. Each measure is assessed for both achievement of quality and improvement on an annual basis beginning DY3. The weighted sum of all the individual measure quality improvement scores will yield the overall QIS.

The overall QIS is then used to indicate whether a reduction of funding is warranted, and to calculate the percentage of funding at risk that should be reduced for that demonstration year. Annual improvement will reflect closing of the relative gap between prior performance year and the goal by up to 10 percent each year, as described in Attachment C, Section III(c). Quality will be assessed based on existing national benchmark standards where possible. For newer, innovative measures that do not have established national estimates, quality will be determined based on available evidence of reasonable expectation for magnitude of change.

[8] In 2021, NCQA Hedis® retired Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life. This measure was replaced with Child and Adolescents Well-Care visits 3 – 11 Years of Age. This change will apply to DY 4 and DY 5 results.
[9] Controlling high blood pressure has been removed from Statewide accountability QIS counts. The measure is inactive for DY3-DY5.
[10] Comprehensive Diabetes Care: Blood Pressure Control is retired by NCQA® starting 2022 performance period. HCA is still determining an adequate replacement and will provide an update when approved.

If the state fails to achieve its annual quality improvement score on a given statewide accountability metric, funding will be reduced by the amount tied to the QIS.

The draw of the FFP match for all at-risk funds under statewide accountability metrics, or reporting of payments on the CMS-64 form, will not occur until the QIS have been approved by the state and CMS. The state will submit the QIS and supporting documentation to CMS for review and approval. CMS will have 90 calendar days to review and approve the QIS. Once the at-risk payments are approved, the state will disburse the portion of the withheld at-risk funds that were earned, and the state will report such expenditures on the CMS 64 form and draw down FFP accordingly. The state may not claim FFP for any at-risk expenditures until CMS has issued formal approval.

b. *Reinvestment of Unearned DSRIP Funding*

DSRIP funding that is unearned because the ACH failed to achieve certain performance metrics for a given reporting period may be directed toward DSRIP High Performance incentives. Unearned project funds directed to high performers will be used to support the scope of the statewide DSRIP program or to reward ACHs whose performance substantively and consistently exceeds their targets as measured according to a modified version of the QIS described above. The state does not plan to withhold any amounts to subsidize this reinvestment pool.

VII. Demonstration Mid-point Assessment

In accordance with STC 21, a mid-point assessment will be conducted by the Independent Assessor in DY3. Based on qualitative and quantitative information, and stakeholder and community input, the mid-point assessment will be used to systematically identify recommendations for improving individual ACHs and implementation of their Project Plans. If the state decides to discontinue specific projects that do not merit continued funding, the project funds may be made available for expanding successful project plans in DY 4 through DY 6.

ACHs will be required to participate in the mid-point assessment and adopt recommendations that emerge from the review. The state may withhold a percentage or all future DSRIP incentive funds if the ACH fails to adopt recommended changes, even if all other requirements for DSRIP payment are met.

Value-based Purchasing (VBP) Roadmap Apple Health Appendix

2021 update

February 2022

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Purpose

The Apple Health Appendix reflects specific initiatives and changes pertaining to the Medicaid (Apple Health) program, in alignment with the Health Care Authority's (HCA's) VBP Roadmap.[1] In Washington State, Apple Health is the name for Medicaid. When referencing Washington's Medicaid program in this document, it will be referred to as Apple Health.

This document describes how Apple Health is changing, with the support of the Medicaid Transformation Project (MTP), the targets for VBP attainment, and the related incentives under the Delivery System Reform Incentive Payment (DSRIP) program. (The DSRIP program is for managed care organizations (MCOs) and Accountable Communities of Health (ACHs).)

This document addresses the following topics:

- Identified VBP targets and approach for measuring, categorizing, and validating progress toward regional ACH and statewide MCO attainment of VBP goals.
- Alternative payment models (APMs) deployed between MCOs and health care providers to reward performance consistent with DSRIP objectives and measures.
- Use of DSRIP measures and objectives by HCA in its contracting strategy approach for managed care plans.
- Measurement of MCOs based on utilization and quality that is consistent with DSRIP objectives and measures.
- Inclusion of DSRIP objectives and measures reporting in MCO contract amendments.
- Evolution toward further alignment with the Medicare and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) and other advanced APMs.
- Approaches that MCOs and HCA will use with providers to encourage practices consistent with DSRIP objectives, measures, and VBP targets.

In accordance with the special terms and conditions (STCs) of Washington's Section 1115 Medicaid demonstration waiver (called MTP), HCA will update the Apple Health Appendix annually to capture best practices and incorporate lessons learned into HCA's overall vision for delivery system reform. The appendix is a living document throughout the duration of MTP. It is subject to change and adjustment to ensure that Washington State can achieve its VBP goals.

Introduction

Apple Health and VBP reform

To reach the goals defined in the VBP Roadmap (different than the Apple Health Appendix), Apple Health must play a leading role. One main goal for HCA is to drive and sustain delivery system transformation by shifting 90 percent of state-financed health care into value-based arrangements by the end of 2021.

On January 9, 2017, Washington State and the Centers for Medicare & Medicaid Services (CMS) reached agreement on a groundbreaking, five-year project that allows the state to invest in comprehensive Medicaid delivery and payment reform efforts through DSRIP.

[1] Learn more about HCA's roadmap activities and paying for health and value strategy on the HCA website. If you would like a copy of the first edition of HCA's VBP Roadmap, please contact J.D. Fischer.

VBP strategies are foundational to MTP and serve as a vehicle for delivery system reform activities. HCA's commitment to advancing VBP strategies extends beyond MTP. This document covers efforts to increase adoption of VBP models statewide, along with those required under MTP's STCs.

As Washington continues to transition the health care purchasing strategy for Apple Health, HCA recognizes that a comprehensive and successful transformation requires a multi-layered approach that addresses the needs of MCOs, individual providers, and Medicaid beneficiaries. Initiatives under MTP, including community led delivery system reform strategies, play a crucial role in promoting overall system transformation.

Alignment and Health Care Payment (HCP) & Learning Action Network (LAN)

HCA strives to align its efforts with the perspectives of MCOs and providers. These partners are integral to implementing new purchasing methodologies. As HCA implements VBP strategies, Medicare is making significant strides in implementing similar VBP reforms. Likewise, HCA—through the Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) programs and multiple commercial payers in the state—are building VBP into their contracting strategies.

Providers must frequently navigate all these systems, which presents significant opportunities to align VBP methodologies across payer markets. This requires that HCA leverage purchasing power through Apple Health, PEBB, and SEBB to ensure that system reforms support and reinforce each other without leading to unnecessary burden for providers. Aligning the transition to VBP with other payers, where feasible, simplifies implementation for providers and allows them to achieve the greatest impact for their clinicians and patients.

The primary tool for multi-payer alignment is the use of the Refreshed HCP-LAN APM Framework[2] across all of HCA's books of businesses. These categories form the framework for the implementation of VBP in Washington by defining payment models subject to incentives and penalties, aligned with HCA's delivery system transformation goals. This framework recognizes a variety of approaches that can advance value-based care and provide flexibility to providers to participate in value-based payment models. The framework also addresses the circumstances of the services providers give and the communities they serve.

By adopting a national framework, Washington ensures that providers do not face conflicting guidance on how to classify payment models. This uniformity with national standards will enhance provider engagement and reduce administrative burden for providers learning to operate under VBP methodologies.

Advancing Washington State's Apple Health VBP goals

Key levers and strategies that drive and support VBP adoption among Apple Health providers include:

- Apple Health MCO contract requirements
- MTP and the DSRIP program
- The state's role as a convener
- VBP strategies for rural communities

A central component of implementing VBP is incentivizing MCOs to adopt VBP with network providers through their contract with HCA. One way to do this is an MCO withhold, where HCA withholds a portion of

[2] Learn more about the HCP-LAN APM Framework refresh.

the MCO's monthly premium. MCOs may earn the withheld funds by achieving defined targets for quality, VBP adoption, and provider incentive payments.

The shift from fee-for service (FFS) to VBP also requires delivery system changes. Time-limited DSRIP funds available through MTP allow providers to make these changes through investment in the delivery system transformation process and build provider capacity and infrastructure to succeed in VBP arrangements.

In turn, VBP adoption can reinforce and sustain DSRIP-funded delivery system transformation investments. This occurs through longer-term payer, provider, member, and community partnerships, as well as investments in population health management capabilities. The goal is a transformed system that improves the health and well-being of Washington communities.

HCA is also pursuing targeted strategies for specific provider entities and settings. For example, on July 1, 2017, HCA converted 16 federally qualified health centers (FQHCs) to a value-based payment methodology. Under this payment methodology, FQHCs are incentivized to manage the health of their population according to select quality metrics and are held accountable for performance on these measures.

Rural transformation efforts

On September 10, 2021, CMS announced that Washington State was one of four state awardees for the Community Health Access and Rural Transformation (CHART) Model grant.[3] HCA is the lead agency for the CHART Model, which will test whether an aligned all-payer capitated APM and a community care redesign plan designed by the community will improve access to whole-person care, decrease population health disparities, and reduce costs. HCA will test this model in the North Central region of Washington State, which includes Chelan, Douglas, Grant, and Okanogan counties.

Under the CHART Model, HCA will partner with Participant Hospitals (PHs), North Central community and Tribal leaders, and payers on the CHART Advisory Council to build a Community Transformation Plan (CTP) that meets North Central community's needs. The CTP will feature evidence-informed innovative care delivery models and strategies to improve access to care, quality of care, and health outcomes for all North Central residents.

The COVID-19 pandemic further underscores the need for more predictably financing of services that prioritize value and population health. This model will advance appropriate care, meet community needs, and support rural providers though the health system transformation process. Focus areas include:

- Redesigning rural health system financing
- Enhancing population health management
- Addressing the rural health care workforce
- Leveraging digital health, telehealth, and secure information exchange

By changing the way providers are paid and aligning with incentives to transform the delivery system, Washington will build sustainable solutions for payers and providers that increase health access across rural communities. Through these strategies, MCOs and providers are supported and rewarded for advancing VBP during MTP and beyond.

MTP - statewide accountability

The STCs outlines the requirements for Washington State pertaining to VBP withhold amounts based on statewide advancement of VBP adoption and quality metric goals.

[3] Learn more about the CHART Model on the CMS website.

- **What this means:** if Washington State does not achieve the targets within the statewide accountability framework, the maximum available DSRIP funds will not be earned. The amount at risk is five percent in demonstration year (DY)3, ten percent for DY4, and increases to 20 percent in DY5.
    - Statewide performance across the 10 quality measures determines 80 percent of the funding "at risk."
    - Attainment of statewide VBP targets determines 20 percent of the funding "at risk."

MCO contract requirements: VBP withhold

A primary way to advance state VBP goals is through Apple Health MCO contract requirements. HCA currently contracts with five MCOs, paying them a per-member per-month (PMPM) premium to deliver Medicaid services to many of the state's Medicaid beneficiaries. According to HCA's contractual arrangement, each MCO must negotiate VBP arrangements with network providers. To ensure accountability, HCA withholds a percentage of each MCO's PMPM premium. MCOs may earn back the withheld funds by demonstrating quality improvement and implementing VBP arrangements with providers.

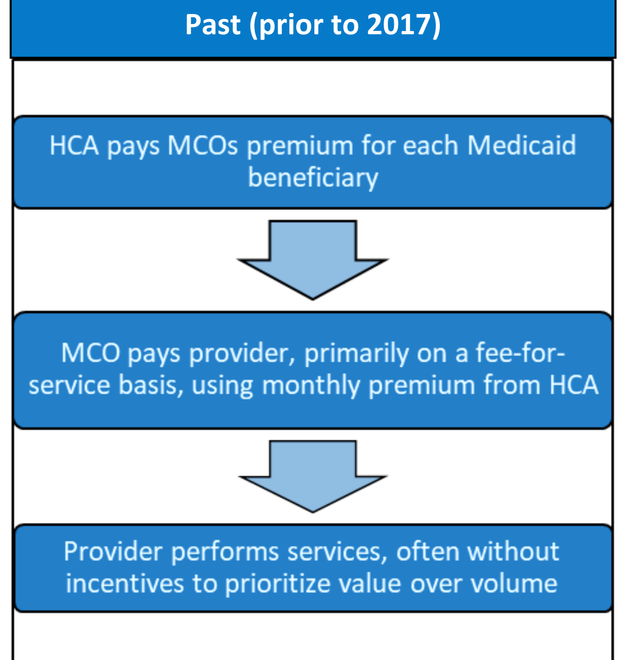
The structure of the MCO withhold reinforces the quality emphasized by CMS and MTP. It incentivizes the adoption of VBP methodologies between the MCOs and providers, with a focus on regional VBP adoption and provider accountability, and an additional emphasis on quality improvement. By incentivizing VBP in the MCO contracts through the withhold program, along with the other efforts described in this document, HCA expects VBP adoption to expand and continue well beyond MTP.

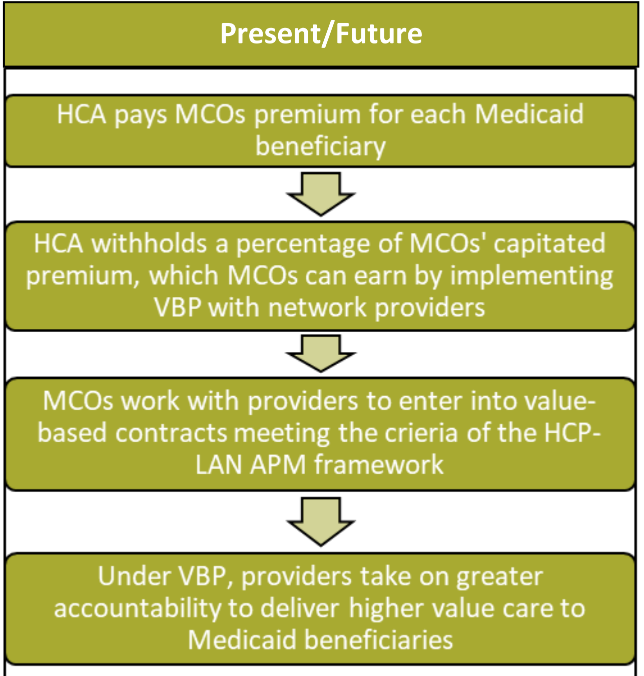
Consistent with federal requirements defined under 42 CFR 438.6(b), HCA ensures that through the VBP withhold, MCO performance is reasonably achievable. This results in actuarially sound MCO rates so that rates appropriately cover all reasonable and expected costs for each MCO. HCA's contracted actuaries include confirmation of the soundness of the rates in the rate certification provided to CMS.

MCO contract withhold framework

Under the withhold, a percentage of each MCOs' monthly PMPM premium is withheld, pending achievement of certain targets.

Figure 1: HCA and MCO contracts: past, present, future





The total percentage withhold is established each year (table below). The amount withheld may be earned back in three ways, each of which seeks to advance VBP:

- **VBP adoption (12.5 percent):** the VBP portion of the withhold focuses on the percent of an MCO's total payments to providers within a recognized VBP arrangement. The original target for this element aimed to increase the percent of VBP arrangements from 30 to 90 percent by 2021. Because of the COVID-19 pandemic, HCA decreased the 2021 MCO VBP adoption target to 85 percent to provide flexibility to MCOs and providers to focus on maintaining access. Qualifying VBP arrangements must meet the definition of Category 2C or higher within the HCP-LAN categorization.
- **Provider incentives (12.5 percent):** the provider incentives portion of the withhold focuses on the percent of funding, within recognized VBP arrangements, that is directly conditioned on meeting quality and financial metrics. Up to 12.5 percent of the provider incentives portion of the withhold may be earned back by linking qualifying provider incentive payments to quality and financial attainment or losses. The target was set at 0.75 percent of assessed payments in 2017 and increased to 1.25 percent for 2020 and 2021. See table 1 for more details.
- **Quality improvement (75 percent):** House Bill 1109 (2019) required changes to the quality improvement portion of the withhold. Beginning in 2020, the quality improvement portion of the withhold may be earned back by achieving top national Medicaid quartile scores or demonstrating statistically significant improvement, as determined by an external quality review organization.

Following receipt of quality performance metric results, on or before July 1 after the performance year, HCA will determine the percentage of the withhold earned back by the MCO, based on the MCO's achieving quality improvement targets. Up to 75 percent of the withhold may be earned by achieving quality improvement targets. The amount of the withhold earned back is based on the proportion of measures for which the MCO achieved either top national Medicaid quartile or statistically significant improvement.[4]

These three components of HCA's withhold program, as well as the annual target percentages that must be met for MCOs to receive the full withhold amount are outlined in the table below and described in detail in MCO contracts.

Table 1: MCO contract withhold targets: VBP adoption, provider incentives, and quality improvement

VBP adoption	
Year	Target
2017	30%
2018	50%
2019	75%
2020	85%
2021	85%
2022	90%

Provider incentives	
Year	Target
2017	.75%
2018	1%
2019	1%
2020	1.25%
2021	1.25%
2022	1.25%

Quality improvement	
Year	Target
2017	0.2
2018	0.2
2019	0.2
2020	100%
2021	100%
2022	100%

Note: because of COVID-19, the percentage of total VBP adoption target in DY5 is downgraded from 90 percent to 85 percent as of August 14, 2020. This means the target will not change from 2020 to 2021.

[4] The measures are under review for contract year 2021. They were not available at the time of this update (October 1).

MCO VBP data submission requirements

To assess MCO performance against the MCO contract withhold components, MCOs are required to provide VBP performance data as outlined in Exhibit D: VBP of the MCO contracts. The reporting covers data pertaining to the adoption and intensity of value-based payment methodologies by the MCO. They submit data to an external third-party independent assessor (IA) to validate performance under the VBP exhibit. The data for each component of the withhold is as follows:

- **VBP adoption:** MCOs report the dollar amounts of regional and statewide payments to providers under value-based arrangements in each category of APMs as defined under the HCP-LAN Framework.
- **Provider incentives:** MCOs report on the extent of regional and statewide payment incentives and payment disincentives represented in their VBP contracts with providers, as a share of total provider payments.
- **Quality improvement:** the quality improvement portion of the withhold relies on provisions in the MCO contracts, related to the submission of clinical quality data.

Medicaid VBP adoption is calculated based on the share of MCO payments to providers that are made through VBP arrangements in HCP-LAN Category 2C or higher, for the purposes of:

- The state's MCO withhold program
- MCO DSRIP VBP incentives
- ACH DSRIP VBP incentives
- State accountability for DSRIP VBP targets

Validation of MCO VBP data

This IA is responsible for validating data submitted by the MCOs for the VBP adoption and provider incentives portions of the withhold. For 2021, measuring calendar 2020 VBP adoption, MCOs were required to submit to the IA:

- **VBP performance data:** MCOs complete a template provided by HCA with VBP performance data relating to the VBP adoption and provider incentives.
- **Supplemental packet:** MCOs provide documentary support for a sample of 45 providers identified by the IA. The MCO identifies the categorization of each provider contract according to the HCP-LAN Framework, with supporting documentation from the provider contract to illustrate the categorization and qualifying incentives.

The table on the next page is an example of how MCOs report their payments to providers by ACH region and APM category.

Table 2: MCO VBP performance data template

Medicaid total assessed payments by APM category														
Category			Region: Accountable Communities of Health											
APM category	APM Sub-category	Strategy	Better Health Together	Cascade	Greater Columbia	HealthierHere	North Central	North Sound	Olympic	Elevate Health	SWACH	Out-of-State	All
1 FFS - no link to quality	1	Fee-for-service											
2 FFS - link to quality	2A	Foundational payments for infrastructure & operations											
	2B	Pay-for-reporting											
	2C	Rewards for performance											
3 APMs built on FFS architecture	3A	APMs with upside gainsharing											
	3B	APMs with upside gainsharing and downside risk											
	3N	Risk-based payments - no link to quality											
4 Population-based payment	4A	Condition-specific, population-based payment											
	4B	Comprehensive population-based payment											
	4C	Integrated finance & delivery systems											
	4N	Capitated payments - no link to quality											
Total annual payments													

The figure below illustrates the methodology by which HCA assesses MCO withhold performance.

Figure 2: methodology for determining the amount of the withhold earned

2% PMPM Withhold

25% - VBP

75% - QIS

12.5% VBP Attainment

12.5% Provider Incentives

Quality Measures

1 / 2 / 3 / 4 / 5 / 6 / 7

Top Quartile?

y/n y/n y/n y/n y/n y/n y/n

C (# y)

If "NO"

If "NO"

Qualifying Value-Based Payments

Qualifying Provider Incentives

Quality score improvement

y/n y/n y/n y/n y/n y/n y/n

D (# y)

A%

B%

A / Target x 0.02*PMPM*0.125

B / Target x 0.02*PMPM*0.125

(C+D) / 7 x 0.02*PMPM*0.75

No greater than 1

No greater than 1

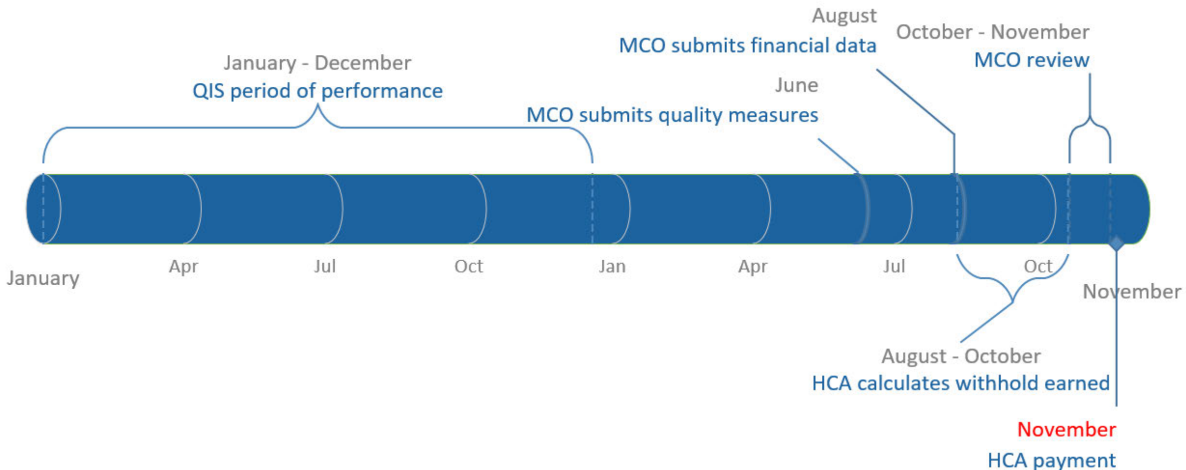
SUM

Withhold Earnback

Timeline

To allow time for MCOs to gather and report the required data, the assessment of performance occurs from August through November of the year after performance year. The two-year performance and review period continues on a rolling basis as shown, so the following performance year begins while HCA reviews the data for the prior performance year.

Figure 3: timeline for MCO VBP data submission, validation, and payment



For example, MCOs will report on 2021 data in August 2022. The validation process is conducted, with the process completed and payment of the percentage of the withhold earned to be scheduled within HCA's payment systems by November 30, 2022.

Supporting VBP advancement through MTP

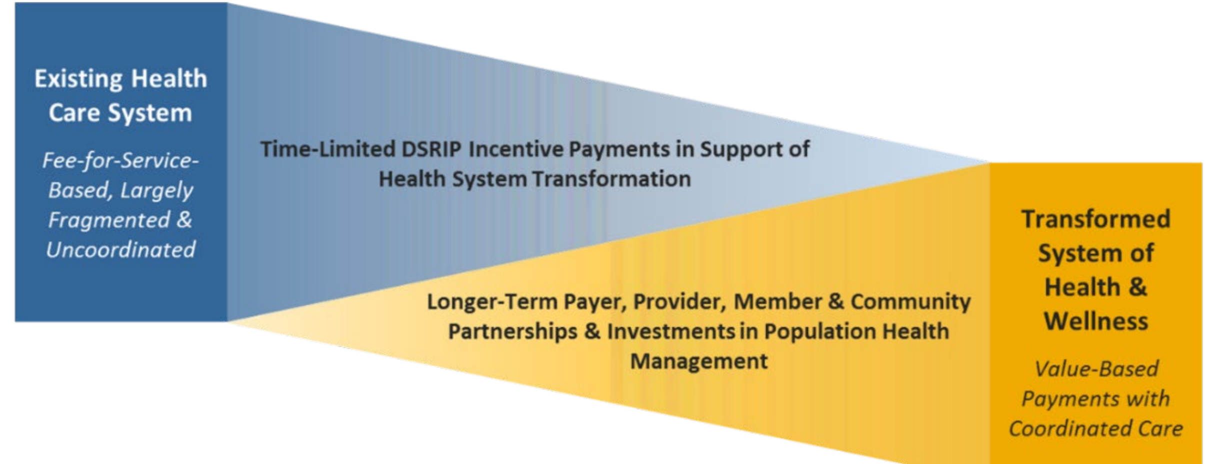
VBP advancement overview

Under MTP, the DSRIP program provides resources to providers to move along the VBP continuum. Investment in foundational strategies that promote provider readiness for VBP is necessary to ensure the sustainability of MTP.

To encourage MCOs and providers to pursue VBP arrangements, DSRIP incentives are available for MCO and ACH achievement of VBP adoption targets as defined in the STCs. VBP adoption targets under MTP are based on the percentage of payments to providers that fall into Categories 2C of the HCP-LAN Framework, starting in DY1, with progressive targets through DY5.

Ultimately, DSRIP funds allow providers to make delivery system changes required for the implementation of VBP strategies, while VBP contracts can help sustain these changes by financially rewarding their outcomes.

Figure 4: DSRIP program and VBP



Advancing the shift toward VBP arrangements in place of traditional FFS models is a primary component of DSRIP accountability during MTP. This is highlighted below for the following entities:

- Washington is accountable for advancing quality outcomes and VBP adoption goals. In DY3-5, a portion of DSRIP incentives are at risk, depending on statewide performance in the following:
    - Demonstration of physical and behavioral health integration in managed care.
    - Improvement and attainment of quality targets across a set of quality metrics.
    - Improvement and attainment of defined statewide VBP targets.
- MCOs are eligible to earn DSRIP VBP incentives for reporting data required to assess MCO and ACH VBP adoption levels (per MCO contract requirements) and achievement and improvement toward annual VBP adoption targets.
    - MCOs can earn incentives for VBP adoption through DSRIP, like their contractual expectations.
- ACHs can also earn DSRIP VBP incentives through reporting of regional efforts to advance VBP, as well as achievement and improvement toward annual VBP adoption targets.

For more details about the DSRIP accountability framework, see the DSRIP Measurement Guide.

Statewide accountability for VBP advancement

Beginning in 2019 (DY3), a portion of statewide DSRIP funding is at risk,[5] depending on the state's advancement of VBP adoption and performance on a set of quality metrics. If the state does not achieve its targets, available DSRIP funding will be reduced in accordance with the STCs.

By the end of 2021 (DY5), 90 percent[6] of total Medicaid MCO payments to providers must be made through designated VBP arrangements for the state to secure maximum available DSRIP incentives.

Definition of achievement: statewide VBP adoption targets are consistent with HCP-LAN Category 2C or higher VBP arrangements. VBP adoption is measured by two factors: improvement toward and achievement of the annual target. If the VBP adoption target is achieved, then the full VBP portion of the statewide accountability withhold is earned. If the target is not achieved, a portion of the withhold can still be earned based on the state's improvement in VBP adoption from the prior year using the improvement scoring methodology as presented in equation 2.

The remainder of this section describes how a portion of the withhold is earned and calculated when the VBP adoption target is not met.

Table 3: annual statewide VBP adoption target and scoring weights

	VBP adoption target (HCP-LAN 2C or higher)	Scoring weights	
		Improvement	Achievement
DY3	75%	50%	50%
DY4[7]	85%	75%	25%
DY5	90%	75%	25%

[5] Because of COVID 19, statewide accountability for DY4 has been waived. This eliminated at-risk loss of dollars from 10 percent to zero (0), effective June 8, 2020.
[6] HCA is pursuing an amendment to downgrade statewide VBP target to 85 percent, consistent with MCO contract changes for 2021.
[7] February 24, 2022, CMS approved a scoring weight adjustment for DY4, DY5 and DY 6.

Note: because of COVID-19, HCA is asking CMS to downgrade the DY5 target for total VBP adoption from 90 percent to 85 percent. This would mean the target would not change from 2020 to 2021.

Table 4: statewide accountability VBP adoption - measurement years

DY	Performance year	Baseline year
3	2019	2018
4	Waived	Waived
5	2021	2020

Data source: according to their contract requirements with HCA, MCOs must attest to their VBP adoption levels annually by reporting total payments in each HCP-LAN category. The IA will calculate and validate statewide performance according to this annual data source. The statewide accountability VBP baseline year is the year prior to the performance year. This timeline aligns with MCO VBP adoption assessment according to the contractual agreement with HCA.

Payments to providers are defined as total Medicaid payments to providers (in dollars) for services, including inpatient, outpatient, physician/professional, and other health services, excluding any pass-through payments or other services carved out from MCO contracts. This amount excludes payments related to case payments, administrative dollars, Washington State Health Insurance Pool, premium tax, Safety Net Assessment Fund, provider access payment, or trauma funding.[8]

Calculating the level of VBP adoption: VBP adoption is calculated based on the share of MCO payments to providers made through VBP arrangements in HCP-LAN Category 2C or higher.[9]

Equation 1: level of VBP adoption (%)

$$\text{Level of VBP adoption (\%)} = \frac{\text{MCO payments to providers (in \$) made through VBP arrangements at or above category 2C}}{\text{Total MCO payments to providers (in \$)}}$$

The state is measured on achievement of VBP adoption targets, as well as improvement over the state's prior year VBP adoption level. If the state meets the VBP adoption target for the performance year, then the improvement score is 100 percent. If the state does not meet the VBP adoption target for the performance year, then the improvement score is calculated as the percent change from the baseline year to the performance year (equation 2). The weighted improvement score is measured by rewarding improvement over the baseline up to 100 percent of the improvement weight, which for DY4 would equal a maximum of 75 percent of the at-risk dollars as presented in Table 3.

Equation 2: VBP improvement score

$$\text{Improvement Score} = \frac{\text{PY VBP adoption actual} - \text{Baseline}}{\text{PY VBP adoption target} - \text{Baseline}}$$

[8] For calendar year (CY) 2017, HCA included payments for pharmacy service in the numerator and denominator when calculating the level of VBP adoption. In 2018, pharmacy was removed from the MCO PMPM, so as of 2018, all such payments are excluded when calculating the level of VBP adoption.
[9] Payments for behavioral health services are included when paid by an MCO, including integrated MCOs. Payments for behavioral health services paid by behavioral health organizations prior to integration are not included.

Where the calculation of the **improvement score** produces a negative percentage, the improvement score is zero (0) percent. The improvement score is capped at 100 percent. However, if achievement is not met, then improvement score is capped at 75 percent.

The overall VBP performance score is calculated by first finding the VBP adoption target score and the VBP adoption actual score for the performance period, and then multiplying each score by the relevant scoring weights defined in Table 3.

The example below illustrates the portion of funds associated with VBP adoption earned by the state with an overall performance score of 82 percent. This performance would earn the state 46 percent of the 20 percent of overall dollars at-risk for statewide performance.

Table 5: example calculation of statewide accountability VBP adoption

DY4 VBP adoption assessment (DY4 VBP target = 85%)	Value/score	Calculation
DY4 performance	82%	
DY3 (baseline)	77%	
Adoption target	85%	
Improvement score	61%	Based on “equation 2” graphic above (0.82 – 0.77) / (0.85 - 0.77)
Overall VBP score	46%	(Achievement Score * Weight) + (Improvement Score * Weight) = (0 * 25%) + (61% * 75%) or equivalent to 0% + 46%

For more information about the overall statewide accountability approach and components, see the DSRIP Measurement Guide.

DSRIP incentives for MCO VBP achievement

Washington’s MCOs are critical partners in delivery system reform efforts, particularly to ensure the state’s success in meeting its VBP goals. As stated in the STCs, MCOs are expected to serve in a leadership or supportive capacity in every ACH. This ensures delivery system reform efforts are coordinated across all necessary sectors—those providing payment, delivering services, and providing critical, community-based supports.

In support of MTP, MCOs will demonstrate improvement toward and achievement of the state’s VBP targets and will play a critical role in the success and sustainability of Washington’s DSRIP program.

Available incentives

MCOs are expected to participate in delivery system reform efforts as a matter of business interest and contractual obligation to the state. For this reason, they do not receive incentive payments for participation in ACH-led transformation projects. However, MCOs are eligible to earn MCO VBP incentives (through the challenge pool) for achieving annual MCO VBP targets. The amount of incentives available to an individual MCO is determined by the attributed statewide managed care member months under signed Apple Health contracts for the performance year.[10]

Table 6: annual DSRIP funding available for MCO DSRIP VBP incentives

DY1	DY2	DY3	DY4	DY5

[10] Annual DSRIP incentives are based on best available information and subject to change. In MCO contracts, these incentives are referred to as base earnable funds.

N/A	$8,000,000	$8,000,000	$8,000,000	$8,000,000

MCO VBP incentives are earned according to pay-for-reporting (P4R) and pay-for-performance (P4P) expectations. Each year, MCOs have a defined portion of incentives available for achieving P4R criteria and P4P targets. The percent of available incentives split between P4R and P4P is defined by the STCs.

Table 7: annual percent of potential earnable MCO DSRIP VBP incentives, by P4R and P4P

MCO DSRIP VBP incentives	DY2	DY3	DY4	DY5
P4R	50%	25%	0%	0%
P4P	50%	75%	100%	100%

The managed care contracts, including HCA's Apple Health Managed Care, Apple Health Integrated Managed Care, and Apple Health Foster Care, further specify how the incentives are distributed. If more than one of these contracts is effective between HCA and the MCO, the incentives earned will not be calculated separately for each contract. Instead, the incentives are calculated as a single payment, based on data aggregated from each of MCO's applicable Apple Health contract(s).

Assessment of progress and performance

The performance year for determining whether MCOs completed milestones in support of advancing VBP and achieved VBP targets is aligned with a given DY. The assessment period will occur during fall (October–December), following the performance year.

P4R

MCOs are eligible to earn MCO VBP incentives for P4R in DY2 and DY3 only (no VBP incentives were available in DY1). These incentives are available to the MCOs for the complete and timely reporting of data required to assess the MCO progress toward meeting VBP adoption targets. The required data is specified in contract between HCA and the MCO.

P4P

For DY2-5, the P4P portion of MCO VBP incentives are available for successful achievement of and improvement toward specified VBP adoption targets. Each MCO is measured based on MCO-provided data (validated by the IA) and must meet performance expectations for the given year.

Performance targets, as well as improvement and achievement weighting for MCO VCP score determination, are outlined below.

Table 8: MCO VBP adoption targets

Year	Performance targets	
	HCP-LAN 2C or higher performance target	**HCP-LAN 3A-4B performance subtarget**
DY1	30%	N/A
DY2	50%	10%
DY3	75%	20%
DY4	85%	30%

DY5	90%[11]	50%

MCO improvement and achievement are weighted differently throughout MTP. MCO improvement toward VBP adoption targets is more heavily weighted in the early years, while credit for full achievement of those targets is increasingly weighted in the later years.

Table 9: MCO VBP P4P score weights

Year	Calculation weight		
	Achievement score	Achievement subset score	Improvement score
DY1	40%	0%	60%
DY2	35%	5%	60%
DY3	45%	5%	50%
DY4[12]	20%	5%	75%
DY5	20%	5%	75%

Based on its performance, the MCO is eligible to earn all or part of the available MCO VBP incentives. HCA and the IA will use data, which the MCOs are contractually required to submit, to identify the following:

- **Achievement score:** an achievement score for each MCO is calculated annually. If the MCO has reached or exceeded the HCP-LAN 2C or higher performance target for the performance year, then the achievement score will be 100 percent. If not, the achievement score is zero (0) percent.
- **Achievement subset score:** in DY2-5, HCA will assess whether the MCO has met the annual achievement subset criteria. In DY3, the achievement subset criteria requires that the MCOs have at least one VBP contract as a MACRA APM. In DY4 and 5, the achievement subset criteria requires that the MCOs have at least one VBP contract in Category 3B or above and including at least one of the following features:
  - More than nominal risk for shared losses
  - Payments tied to provider improvement or attainment on metrics from the Washington Statewide Common Measure Set using HCA quality improvement model or similar tool
  - Care transformation requirements, including state-level best practices
  - Use of certified electronic health record (EHR) technology in support of VBP methods
- **Improvement score:** an improvement score for each MCO is calculated annually. If the MCO has met the performance target for the DY, the improvement score is 100 percent. If the MCO has not met the performance target for the performance year, the improvement score is calculated as the percent change from the baseline year to the performance year towards the change in performance target. See Table 5 for more information.
  The improvement score is capped at 100 percent. Where the prior calculation produces a negative percentage, the improvement score is zero (0) percent. However, if achievement is not met, then improvement score is capped at 75 percent.

[11] HCA submitted a revision to CMS to maintain the target score of 85 percent from DY4-5. This is pending approval.
[12] February 24, 2022, CMS approved a scoring weight adjustment DY4, DY5 and DY6.

- **Eligibility for MCO VBP incentives (performance subtarget):** MCOs must also meet a minimum threshold of VBP adoption in Category 3A and above (performance subtarget) to earn any MCO VBP incentives in DY4 and 5. The performance subtarget is also applied as a threshold for distribution of remaining funds only in DY2 and 3. This is described in the secondary process below.

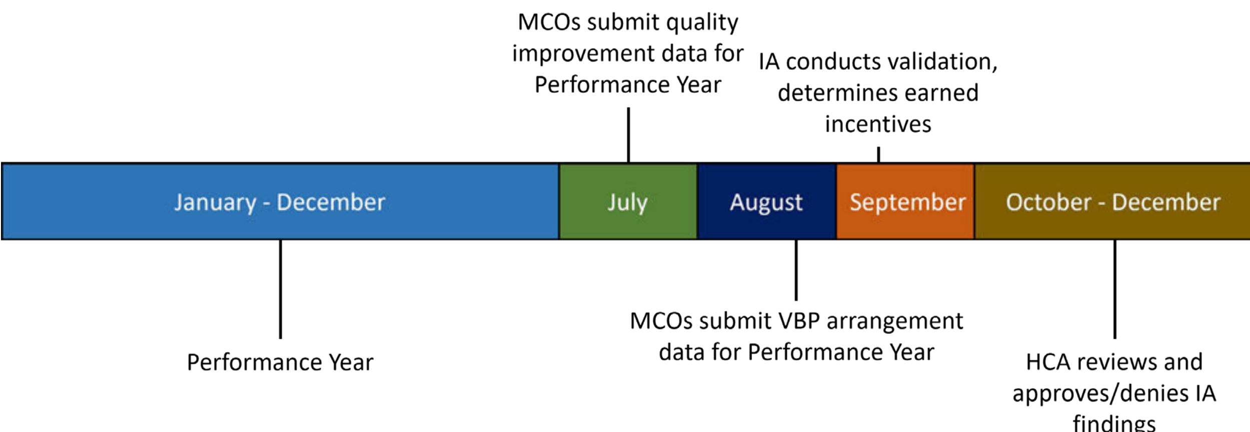
Table 10: annual HCP-LAN 3A-4B subtarget threshold for MCO DSRIP VBP incentives

	DY1	DY2	DY3	DY4	DY5
HCP-LAN 3A–4B performance subtarget	N/A	Eligibility: remaining funds Target= 10%	Eligibility: remaining funds Target= 20%	Eligibility: all funds Target= 30%	Eligibility: all funds Target= 50%

Incentive payment determination

The IA is responsible for determining whether reporting and performance expectations have been met.

Figure 5: assessment timeline for MCO VBP incentives



Distribution of remaining incentives

If there are any remaining MCO VBP incentives for a given performance year after initial allocation, a secondary process is initiated to allocate the unearned incentives. Each MCO is eligible to earn a share of any remaining incentives, based on achievement of the factors defined below.

Table 11: MCO eligibility to earn remaining MCO DSRIP VBP incentives

HCP-LAN 3A-4B performance subtarget	Relative quality improvement performance
The MCO must meet the HCP-LAN 3A-4C performance subtarget for the performance year. • If the MCO has not met the annual performance subtarget, they will not be eligible for any of the remaining incentives. • If the MCO has met the annual performance subtarget, they are eligible for a percentage of remaining incentives.	If the MCO meets the HCP-LAN 3A-4C **performance subtarget**, the MCO will receive a percentage of remaining MCO VBP incentives. This percentage is determined by the MCO's relative performance on the set of quality measures, as defined in MCO contracts with HCA. The state and IA will use the quality metric results to determine the amount of remaining incentives earned for eligible MCOs.

Important: MCOs must meet the HCP-LAN 3A-4C **performance subtarget** during DY4 and 5 to be eligible for any MCO VBP incentives, as part of the primary VBP adoption assessment. This is in addition to any remaining incentives, as part of the secondary process.

DSRIP incentives for ACH VBP achievement

Provider readiness for VBP models and contracts are critical to meet statewide and regional VBP targets, as well as other state VBP goals. ACHs serve in a supportive role to help assess and support provider VBP readiness and practice transformation, and to connect providers to relevant training and resources. ACHs are awarded incentives for demonstrated improvement and achievement of VBP adoption targets in the ACH region. During DSRIP, ACHs are accountable for investing resources to support partnering providers. For example, ACHs should be distributing earned incentives to support their partnering provider needs in moving along the VBP continuum.

Under DSRIP, transformation efforts are driven by ACHs and coalitions of partnering providers as they select and implement a set of strategies from the MTP Project Toolkit to address regional health needs. To be successful, ACHs must integrate foundational cross-cutting health system and community capacity building elements that address workforce, systems for population health management, and financial sustainability through VBP.

Across the project stages, providers partnering with their ACH are eligible to receive incentive payments by contributing to the completion of project milestones and regional improvement on quality and outcome measures. The incentives earned by providers allow them to make the investments necessary to be successful in the project, as well as promote efforts to scale and sustain strategies that prove to improve whole-person health of their communities. To be financially sustainable, however, other sources of funding must be identified to sustain these strategies, which could come through success in VBP contracts.

While VBP arrangements vary in complexity and provider risk, all require that providers can effectively measure and influence the quality and cost of care provided. The presence and maturity of many underlying capabilities influence whether providers succeed under their VBP arrangements. ACHs have made efforts to understand the current state of VBP capabilities among their provider partners, and how ACHs can leverage DSRIP funds to support development of capabilities moving forward. ACHs determine the allocation methodology for earned VBP incentive DSRIP funds among partnering providers in their region.

Available incentives

ACH can earn VBP incentives for P4R and P4P. ACH VBP incentives are funded through the reinvestment pool. Potential earnable ACH VBP incentives are distributed evenly across all nine ACHs. However, ACHs will earn incentives based on VBP performance outcomes. All unearned incentives will be redirected to the high-performance pool. Annual DSRIP incentives are based on best available information, and subject to change.

Table 12: annual DSRIP funding available for ACH VBP incentives

DY1	DY2	DY3	DY4	DY5
N/A	$3,600,000	$4,500,000	$5,400,000	$6,300,000

Note: both ACH VBP and integration incentives are funded through the reinvestment pool. Earned incentives for ACHs that achieve key integration milestones may affect the amount of ACH VBP incentives available for a given year.

ACHs are eligible to earn VBP incentives through reported progress on VBP milestones (P4R), and improvement toward and achievement of VBP adoption targets (P4P) in their regions. With VBP adoption, ACHs are rewarded on reported progress in the early years and rewarded more on full attainment of targets in later years. The table below indicates the percent of VBP incentives available to ACHs for P4R and P4P throughout the transformation.

Table 13: annual percent of potential earnable ACH VBP incentives, by P4R and P4P

ACH VBP incentives	DY1	DY2	DY3	DY4	DY5
Pay-for-reporting (P4R)	100%	75%	50%	25%	0%
Pay-for-performance (P4P)	0%	25%	50%	75%	100%

Assessment of progress and performance

P4R

ACHs report on VBP P4R milestones as part of their semi-annual reports. ACH VBP incentives for P4R are earned by providing complete and timely evidence of milestone completion for the annual reporting period. ACH VBP P4R milestones evolve as the transformation progresses. Note that P4R milestones phase out as accountability transitions to demonstrating performance against VBP targets in the later years.

Table 14: ACH VBP P4R milestones

Milestone	Reflective of activities that occurred during:
• N/A (none; no DSRIP funding allocated to VBP incentives for DY1).	DY1 (2017)
• Inform providers of VBP readiness tools to assist their move toward value-based care. • Connect providers to training and/or technical assistance (TA) offered through HCA, the Healthier Washington Collaboration Portal, MCOs, and/or the ACH. • Support assessments of regional VBP attainment by encouraging/incentivizing completion of the state provider survey. • Support providers to develop strategies to move toward value-based care.	DY2 (2018)
• Identification and support of providers struggling to implement practice transformation and move toward value-based care. • Support providers to implement strategies to move toward value-based care. • Continued support of regional VBP attainment assessments by encouraging/incentivizing completion of the state provider survey.	DY3 (2019)
• Continued support of regional VBP attainment assessments by encouraging/incentivizing completion of the state provider survey. • Continued identification and support of providers struggling to implement practice transformation and move toward value-based care.	DY4 (2020)
• N/A (all incentives reward performance; no incentives for reporting)	DY5 (2021)

P4P

The IA calculates VBP adoption by ACH region each year for the prior measurement year. The calculation is based on data provided by MCOs. HCA and IA obtain the data used to calculate regional ACH VBP achievement from annual MCO reporting on VBP adoption, both by region and by HCP-LAN category.

The resulting data is validated by the IA and aggregated across all MCOs by region and HCP-LAN category. ACH achievement of regional VBP adoption targets is contingent on MCO VBP adoption performance. ACHs are expected to engage with MCOs and providers in their region to encourage VBP adoption but are not expected to be directly involved in VBP contracts themselves.

ACH VBP P4P incentives are associated with VBP adoption targets, as required by the STCs. Regional VBP adoption is calculated based on the share of MCO payments to providers that are made through VBP arrangements in the HCP-LAN Category 2C or higher.

Table 15: ACH VBP adoption targets

Year	Performance targets	
	HCP-LAN 2C or higher adoption target	HCP-LAN 3A-4B adoption subtarget
DY1	30%	N/A
DY2	50%	10%
DY3	75%	20%
DY4	85%	30%
DY5	90%	50%

Achievement of annual ACH VBP P4P outcomes will consider full achievement of VBP adoption targets and improvement from prior year performance toward VBP adoption targets.

Table 16: ACH VBP P4P score weights

Year	Calculation weight		
	Achievement score	Achievement subset score	Improvement score
DY1	N/A	N/A	N/A
DY2	35%	5%	60%
DY3	45%	5%	50%
DY4[13]	20%	5%	75%
DY5	20%	5%	75%

The amount of ACH VBP P4P incentives earned by the ACH based on performance will reflect the following components:

- Achievement of ACH VBP adoption target (HCP-LAN 2C or higher performance target)
- Achievement of defined subset criteria
- Improvement from prior year VBP adoption
- Minimum threshold for ACH VBP incentives (HCP-LAN 3A-4C performance subtarget)

Based on its performance, an ACH is eligible to earn all or part of the available incentives for ACH VBP P4P. HCA and IA will use data the MCOs are contractually required to identify the following:

- **Achievement score:** an achievement score for each ACH region is calculated annually. If the ACH region has reached or exceeded the HCP-LAN 2C-4C performance target for the performance year, the achievement score will be 100 percent. If not, the achievement score is zero (0) percent.
  - **Achievement subset score:** in DY2-5, HCA will assess whether the ACH region has met the annual achievement subset criteria. If the achievement subset criteria have been met, the achievement subset score will be 100 percent. If the achievement subset criteria have not been met, the achievement subset score will be zero (0) percent.

[13] February 24, 2022, CMS approved a scoring weight adjustment DY4, DY5 and DY6.

- **Improvement score:** an improvement score for each ACH region is calculated annually. If the ACH region has met the performance target for the DY, then the improvement score is 100 percent. If the ACH region has not met the performance target for the performance year, then the improvement score is calculated as the percent change from baseline year to the performance year towards the change in performance target.

  The improvement score is capped at 100 percent. Where the prior calculation produces a negative percentage, the improvement score is zero (0) percent. See Figure 5 for more information. However, if achievement is not met, then improvement score is capped at 75 percent. ACHs must also meet a minimum threshold of VBP adoption in Category 3A and above (performance subtarget) to earn any ACH VBP incentives in DY4 and 5.

Table 17: annual HCP-LAN 3A-4B subtarget threshold for ACH VBP incentives

	DY1	DY2	DY3	DY4	DY5
HCP-LAN 3A – 4B Subtarget	N/A	None	None	30%	50%

Incentive payment determination

P4R

The achievement of ACH VBP P4R milestones is assessed by the IA. Each VBP P4R milestone is associated with one (1.0) achievement value (AV). The percentage of VBP P4R funds earned for the year is equal to the percent of VBP P4R AVs earned out of the total possible number of AVs.

ACHs attest to milestones and provide evidence of completion (e.g., narrative responses, lists of activities), which are assessed on a binary (complete/incomplete) scale. The period for achieving P4R milestones is during the same DY.

Table 1: schedule of ACH VBP P4R milestone AVs

ACH VBP P4R milestones	DY2 Quarter (Q)1-Q4	DY3 Q1-Q4	DY4 Q1-Q4
Inform providers of VBP readiness tools to assist their move toward value-based care.	1.0	-	-
Connect providers to training and/or TA offered through HCA, the Healthier Washington Collaboration Portal, MCOs, and/or the ACH.	1.0	-	-
Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey.	1.0	1.0	1.0
Support providers to develop strategies to move toward value-based care.	1.0	-	-
Identification and support of providers struggling to implement practice transformation and move toward value-based care.	-	1.0	-
Support providers to implement strategies to move toward value-based care.	-	1.0	-
Continued identification and support of providers struggling to implement practice transformation and move toward value-based care.	-	-	1.0
	4.0	**3.0**	**2.0**

To identify the earned VBP P4R incentives for each ACH, the average AV for all P4R milestones that apply in the year (the percent AV completion) is multiplied by the ACH VBP incentives associated with P4R in the measurement year. In the example below, an ACH that earns three out of four possible AVs for the reporting period would earn 75 percent of available ACH VBP incentives associated with P4R. Refer to the DSRIP Measurement Guide for details.

Table 19: example ACH VBP P4R AV calculation (for reporting period DY2)

ACH VBP P4R milestones for reporting period DY2 Q1-Q4	Earned AV	Possible AV
Inform providers of VBP readiness tools to assist their move toward value-based care.	0.0	1.00
Connect providers to training and/or TA offered through HCA, the Healthier Washington Collaboration Portal, MCOs, and/or the ACH.	1.0	1.00
Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey.	1.0	1.00
Support providers to develop strategies to move toward value-based care.	1.0	1.00
Total achievement value (TAV)	**3.0**	4.0
Percentage achievement value (PAV)	(3.0 / 4.0) = 75%	100%

Earned incentives are distributed annually to ACHs, aligned with the timing of payment cycles for ACH project incentive payments.

P4P

The IA calculates the final ACH VBP P4P score by adding the weighted scores for improvement, performance target, and performance subset target achievement. The final score for all components will determine the proportion of potential ACH VBP P4P incentives earned by an ACH for a given performance year. Full credit is earned by meeting or exceeding the defined target for the associated year. ACHs do not earn additional incentives for exceeding improvement or performance expectations. Examples of ACH VBP incentive calculations are available in the DSRIP Measurement Guide.

ACHs earn VBP P4P incentives on an annual basis. Earned incentives are distributed in alignment with earned project P4P and VBP P4R incentive payments. Because of the data compilation and validation process, there is an approximate 18-month lag between the end of the performance year and when ACH VBP P4P incentives are paid.

Distribution of remaining incentives

If a region does not meet progress (P4R) or performance (P4P) expectations, the ACH's unearned VBP incentives will be used to fund ACH high-performance incentives.

State role as connector

Recognizing the importance of alignment between VBP strategies and delivery system reform efforts, HCA continues to play a connector role between ACHs and MCOs. Priorities include preparing partners for VBP readiness and ensuring delivery system reform investments and efforts align with and advance contractual and payment strategies. HCA facilitates monthly sessions with MCOs and launched a work group that includes MCOs and ACHs. HCA's goal with this work group is to help promote information sharing and alignment surrounding contractual expectations, payment, and support being offered to partners.

ACH/HCA Learning Symposium

As part of the STCs, ACHs and HCA will host an annual Learning Symposium, which encourages cross-collaboration and information sharing between HCA, ACHs, partners, and others. Like last year, ACHs are playing a larger role in developing and putting on the event. The event will take place virtually on November 2-4, 2021, with sessions focused on:

- Social determinants of health
- COVID-19 impacts
- Tribal partnerships

- Youth-focused initiatives
- The future of ACHs
- Washington's MTP waiver renewal

The Learning Symposium supports advancement of MTP objectives with a focus on statewide collaboration.

Understanding the payer and provider experience

Understanding the payer and provider experience with VBP is crucial to monitor progress along the VBP continuum. Every year, HCA issues Paying for Value surveys to Washington State plans/payers and providers. Core objectives of the surveys are to:

- Track both health plan and provider experience in moving toward the state's goal of paying for health and value.
- Identify explanatory factors, such as enablers and barriers, which may promote or block desired progress.

HCA is responsible for performing analysis of data collected from provider survey respondents. Individual organization responses are not shared publicly. HCA summarizes a few key findings from the Paying for Value surveys in the VBP Roadmap. The surveys are available on HCA's Tracking success page. Results from the 2021 Paying for Value surveys will be available in the fall of 2021.

For MTP to be successful, an in-depth understanding of the provider perspective is necessary. Provider feedback informs transformation project plan design in the planning stage and can inform transformation activities throughout the implementation and scale/sustain stages.

In their role as convener, ACHs are positioned to support statewide assessment of provider experience in moving to VBP arrangements by encouraging and incentivizing completion of the provider survey among their partnering providers.

Annual update

HCA updates this document on an annual basis. Upcoming editions will include more information on progress made toward achieving state and MTP VBP adoption targets, as well as the state's role in assuring alignment with MACRA and other advanced APM updates.

Resources

- Learn more about VBP, roadmap activities, and HCA's paying for health and value strategy on the HCA website.
- Learn more about Washington's MTP.
- Sign up to receive announcements about VBP or MTP.

Attachments

The next page shows Attachment A: the HCP-LAN APM Framework and HCA's VBP standard.

Attachment A: HCP-LAN APM Framework and HCA's VBP standard

Figure 6: refreshed HCP-LAN APM Framework for VBP or APMs

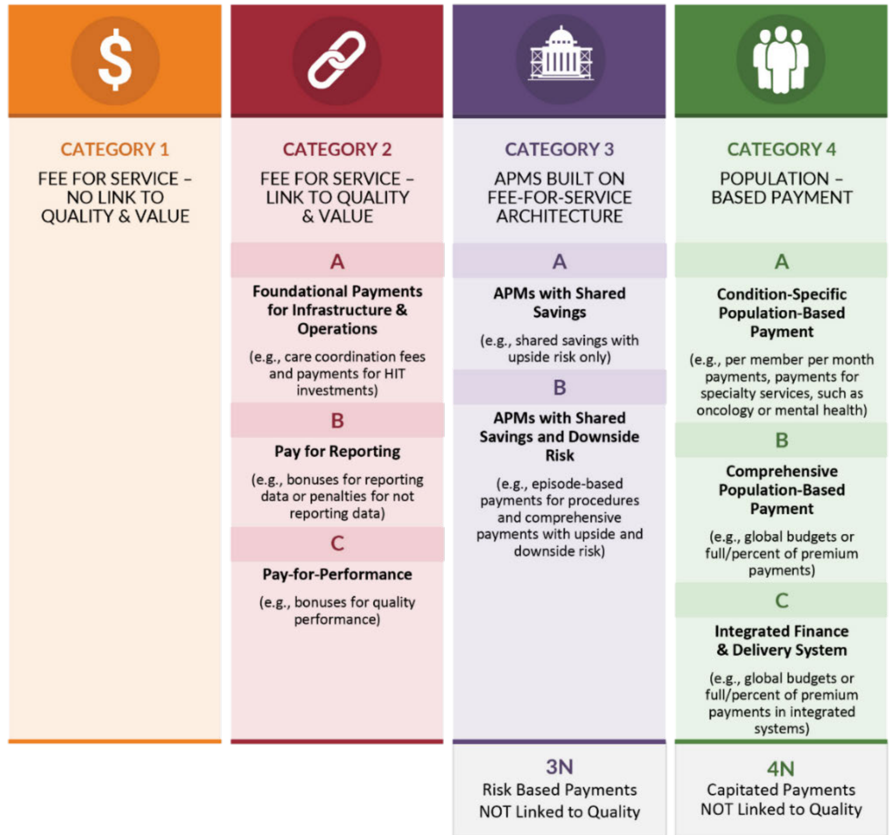
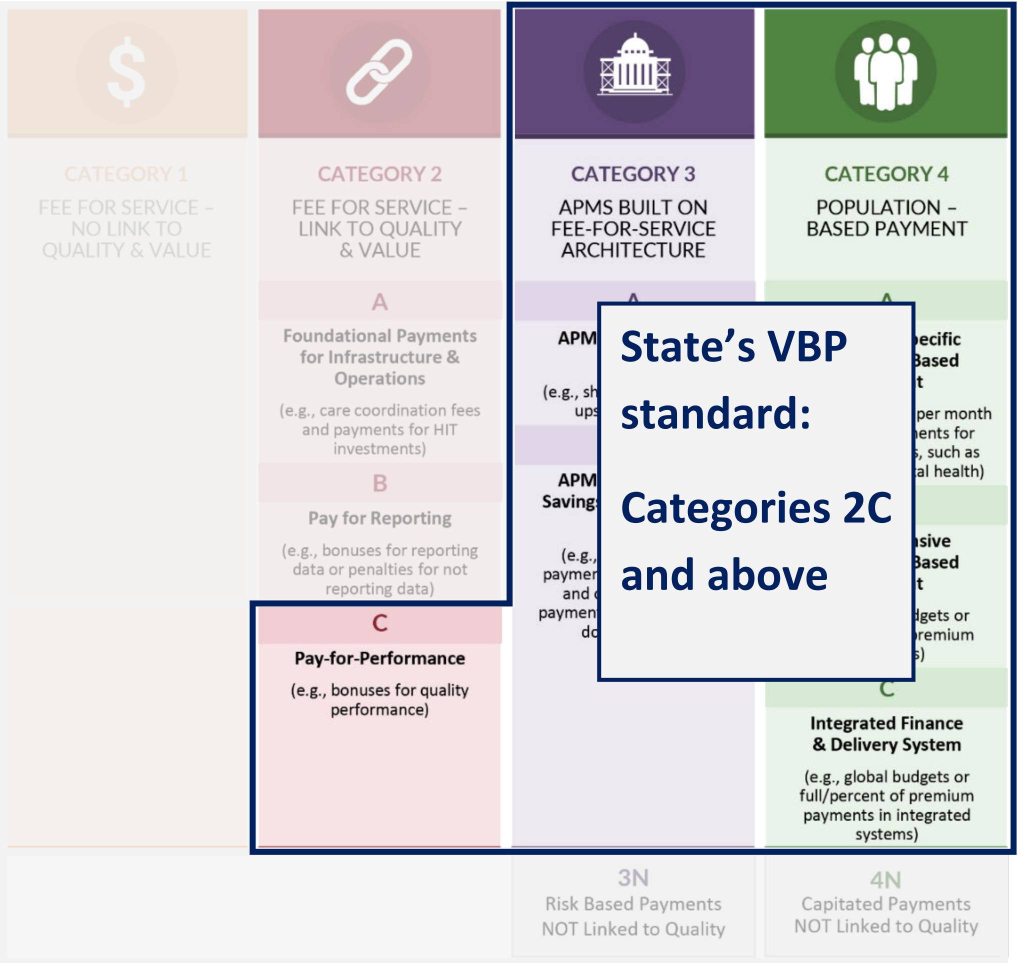


Figure 7: Washington State's VBP standard



ATTACHMENT F
Financial Executor Role

In coordination with HCA and representatives of the state's nine ACHs, the contracted financial executor (FE) shall be responsible for administering a funding distribution plan as described in Attachment D.

ACHs, through their governing bodies, are responsible for managing and coordinating with partnering providers. The ACHs must meet the qualifications set forth in STCs 21 - 23 and must meet the targets enumerated in Attachment C in order to earn incentive payments. In addition, ACHs will certify as to whether or not the partnering providers have met the milestones required for earning incentive payments within their region. The ACH will also certify to the independent assessor whether or not partnering providers have achieved the milestones (see STC 21). The independent assessor (IA) will review the ACH's certification and make recommendations to the state related to distribution of payment. Once the state affirms the recommendations from the IA, it will send the incentive payments to the FE for distribution to the partnering providers.

The contracted FE will perform the work and complete the deliverables outlined below.

1. Establish a system for recording, processing, distributing and reporting on the payment of incentive funds and other financial transactions between HCA, ACHs and partnering providers in accordance with Attachment D.

   1.1. Establish a standardized process and forms to track payments to partnering providers and instruct partnering providers and ACHs in their use.

   1.2. The distribution of funds must comply with all applicable laws and regulations, including, but not limited to, the following federal fraud and abuse authorities: the anti-kickback statute (sections 1128B(b)(1) and (2) of the Social Security Act (the "Act")); the physician self-referral prohibition (section 1903(s) of the Act); the gainsharing civil monetary penalty (CMP) provisions (sections 1128A(b)(1) and (2) of the Act); and the beneficiary inducement CMP (section 1128A(a)(5) of the Act); as well as with HCA and Washington state rules and generally accepted accounting principles.

2. Provide financial accounting and banking management support for all incentive payments.

   2.1. Establish and maintain appropriate accounts as directed by HCA for the tracking of incentive payment receipts and holding of funds and issuance of payments.

   2.2. Regularly track and report on all transactions from such accounts, including but not limited to payments, receipts, refunds and reconciliations.

3. Distribute earned funds in a timely manner to partnering providers in accordance with HCA-approved funding distribution plans.

3.1. Upon instruction and approval from the ACH, issue payments to partnering providers within 14 business days.

3.2. Respond to inquiries from ACHs and partnering providers regarding payments made or owed amounts, within 5 business days.

3.3. Identify, record, resolve and report on any under- or over-payments, including issuing requests for refunds if necessary.

3.4. Record and regularly report to ACHs on funds processed and payments made.

4. Submit scheduled reports to HCA and ACHs on the distribution of transformation project payments, fund balances and reconciliations–in accordance with relevant state and federal rules.
5. Develop and distribute budget forms to partnering providers for receipt of incentive funds.
6. As requested, assist HCA in responding to inquiries from CMS regarding financial transactions and any audits that may be required.

ATTACHMENT G
Intergovernmental Transfer (IGT) Protocol

I. Preface

As part of this demonstration, the Delivery System Reform Incentive Payment (DSRIP) program is to provide incentives for Medicaid providers to create and sustain an integrated, high performing health care delivery system that can effectively and efficiently meet the needs of Medicaid beneficiaries and low income uninsured individuals in their local communities by improving care, improving health and reducing costs. The non-federal share of these payments will come from intergovernmental transfers (IGT) from public hospitals, other local government or tribal funds, or funds that the state has earned by claiming federal match on expenditures for Designated State Health Programs (DSHP).

In accordance with STC 87(d), the state may use IGTs to the extent that such funds are derived from state, tribal, or local monies and are transferred by units of government, which can include a governmentally operated provider, within the state. The state provides assurance that the matching non-federal share of funds for the demonstration is state/local/tribal monies and that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Social Security Act, 42 CFR §433.51 and applicable regulations. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid State Plan.

The IGT protocol (this document, Attachment E) describes the methodology and guidelines by which the state may use IGT as a source of funding for the non-federal share of demonstration expenditures.

II. IGT Process and the Role of the Accountable Communities of Health (ACH)

Under this demonstration, the state will make performance-based funding available to regionally-based ACHs and their partnering providers with the goal of transforming the delivery system for Medicaid beneficiaries. The ACHs will be responsible for coordinating the efforts of partnering providers in their community to create and implement regional project plans to transform the Medicaid delivery system. The project plans will be reviewed by a third-party Independent Assessor, who will make recommendations to the state as to whether the plans should be approved.

Approved project plans that meet the milestones outlined in the project will be eligible for incentive payments under the demonstration. A component of the non-federal share of these payments will come from IGTs. The responsibility of the Financial Executor

includes distributing earned incentives in a timely manner to participating providers in accordance with each ACH's budget plan.

DSRIP payments are made twice per year and are always paid using the same process. The incentive payment amounts are determined by two reporting periods per demonstration year, where ACHs report the metrics and milestones achieved by their transformation projects. The state, with support from the Independent Assessor, will review reports to calculate the incentive payments earned by the ACH. Once incentive amounts are calculated, the state will calculate the non-federal share amount to be transferred by an IGT contributor based on ACH budget plans in order to draw the federal funding for incentive payments related to the achievement of milestones and metrics. Within 14 calendar days after notification by the state of the identified non-federal share amount, the IGT contributor will make an intergovernmental transfer of funds. The state will pay an amount equivalent to the non-federal and federal shares of the incentive payment to the ACH and its partnering providers. The state will then draw the federal funding based on those disbursements. If the IGT is made within the appropriate and approximate 14-day timeframe, the incentive payment will be disbursed within approximately 30 calendar days. The total computable incentive payment must remain with the ACH partnering providers and will not be returned to or retained by the state.

III. IGT Funding Conditions

IGTs from governmentally operated providers must be in an amount not to exceed the non-federal share of title XIX payments. No pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

An agreement will be executed between the Health Care Authority (HCA), Washington's Medicaid agency, and each IGT contributing entity. The agreement will identify the annual estimated commitments by each IGT contributor. Funds will be transferred from each IGT contributor and will be under the administrative control of HCA. The state will provide copies of the signed IGT agreements between the state and the public entity providing the IGT funds to the CMS regional office.

IGT contributions for purposes of DSRIP are eligible for a 50 percent federal match. The IGT contributor will, by signature, attest that the IGT contribution is not derived

from Federal receipts and that they will maintain records to document the source of non-federal share and furnish those records to HCA and CMS as necessary.

Additionally, the IGT contributor must identify the allowable funding source, over the course of a given DSRIP Year, to support the IGT commitment for DSRIP.

IGT funding as described under this demonstration does not have any interaction with existing provider assessment arrangements, with regard to the federal 6% cap. Incentive payments will also not impact upper payment limit (UPL) or state/hospital specific Disproportionate Share Hospital (DSH) caps. Additionally, IGTs will not interact with existing Certified Public Expenditure (CPE) arrangements or any upper payment limit requirements with governmental (public) hospitals as long as the IGTs are not considered an expenditure for the provision of a hospital service for hospitals that CPE. CPEs are expenditures made for the provision of a Medicaid service and certifying providers can receive no service payments above their certified costs. The IGTs are the expense of financing the non-federal share for other Medicaid purposes, and the public hospitals may not claim the transfer of funds to the Medicaid agency as a Medicaid uncompensated hospital service cost under the State Plan or the waiver since their service costs are fully satisfied.

ATTACHMENT H
Indian Health Care Provider (IHCP) Protocol
(Formerly known as the "Tribal Engagement and Collaboration Protocol")

I. RESTATEMENT OF NATIONAL POLICY

In Section 3 of the Indian Health Care Improvement Act (codified at 25 U.S. Code § 1602), Congress declared that "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to American Indians:

1. To ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;
2. To raise the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives;
3. To ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;
4. To increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service area is raised to at least the level of that of the general population;
5. To require that all actions under this chapter shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this chapter and the national policy of Indian self-determination;
6. To ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; and
7. To provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service."

II. DEFINED TERMS

1. **Accountable Community of Health** or **ACH** has the meaning set forth in the Special Terms and Conditions for the Washington State Medicaid Transformation Project Section 1115(a) Medicaid Demonstration.

2. **American Indian/Alaska Native** or **AI/AN** means "Indian" as defined in 25 U.S. Code § 1603(13).

3. **Community Health Aide Program** or **CHAP** refers to that program authorized under 25 U.S. Code § 1616l.

4. **Indian Health Care Provider** or **IHCP** has the meaning set forth in 42 C.F.R. § 438.14(a).

5. **Indian Health Service or IHS** means the agency within the U.S. Department of Health and Human Services responsible for providing federal health services to AI/ANs.

6. **Tribe** means "Indian tribe" as defined in 25 U.S. Code § 1603(14).

7. **Urban Indian Health Program** or **UIHP** means an Urban Indian Organization as defined in 25 U.S. Code § 1603(29) that receives IHS funding to provide health care services to AI/ANs.

III. DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM

1. **Objectives.** With the IHCP specific projects, the state and the tribes and UIHPs seek to achieve the following interests in Medicaid transformation.

   a. ***Collaborative Medicaid Transformation***. Due to treaty obligations and the special trust responsibility, tribes have government-to-government relations with both federal and state governments and IHS facilities and UIHPs have the right to be solicited for advice on Medicaid matters that affect them or their AI/AN patients. In addition, under chapter 43.376 of the Revised Code of Washington, state agencies are required to make reasonable efforts to collaborate with Indian tribes in the development of policies, agreements, and program implementation that directly affect tribes. In recognition of these relationships and requirements, the Medicaid Transformation Demonstration will support the tribes', IHS facilities', and UIHPs' planning efforts by allocating a total of $5,400,000 of Demonstration Year 1 (DY1) incentive payment funds to support the planning and various infrastructure investments related to IHCP-specific projects.

   b. ***IHCP Health Systems and Capacity.*** In recognition of the complexity of IHCP health systems due to the legacy of the IHS Resource and Patient Management System (RPMS) and federal reporting requirements under the Government Performance and Results Act of 1993, the Medicaid Transformation Demonstration will provide incentive payments for achieving milestones that reflect the development of more effective health systems and greater capacity within IHCPs to support and expand the coordination of physical and behavioral health care and social services for Medicid clients and to enable IHCPs to help reduce unnecessary use of intensive services and settings by Medicaid clients without impairing health outcomes. To support financial sustainability, investments in IHCP health systems and capacity will be made in ways that maximize their access and availability to as many tribes, IHS facilities, and UIHPs as possible using information technology protocols and platforms in common use with the state Medicaid program and providers, while respecting individual tribal government needs. Potential investments areas include:

      i. <u>Workforce Capacity and Innovation</u>

         A. *CHAP Board*. Support for the creation of a certification board, similar to the Community Health Aide Certification Board (as defined in 25 U.S. Code § 1616l) in Alaska, to oversee the training

and continuing education for Dental Health Aide Therapists, Behavioral Health Aides, Community Health Aides, and other mid-level providers.

B. *CHAP Education*. Support for the creation of an education program, housed within an established institution of higher education, for various community health aides, including behavioral health aides.

C. *CHAP Provider Implementation*. Support for incorporating new CHAP Board-certified providers into tribal health programs.

ii. Health Systems

A. *Electronic Behavioral Health Records*. Support for the installation of electronic behavioral health records that interface with electronic health records.

B. *Clinical Data Repository*. Support for the creation of the system interfaces for tribal health programs, IHS facilities, and UIHPs to export and import client clinical data into one or more clinical data repositories including state-contracted data repositories (such as Link4Health operated by OneHealthPort and the Emergency Department Information Exchange (EDIE) operated by CollectiveMedical Technologies, Inc.).

C. *Population Health Management*. Support for the creation of a population health management tool for tribal health programs, IHS facilities, and UIHPs to use, drawing data from clinical data repositories and other state-contracted data repositories (such as Link4Health operated by OneHealthPort and the Emergency Department Information Exchange (EDIE) operated by CollectiveMedical Technologies, Inc.).

c. ***Financial Sustainability***. The tribes, IHS facilities, and UIHPs will be given greater flexibility in how they assure the sustainability of the transformation projects undertaken through the Medicaid Transformation Project demonstration in recognition of the special trust responsibility and the following recent CMS guidance, which the state is in the process of implementing:

i. CMS State Health Official Letter #16-002, dated February 26, 2016; and

ii. CMS Frequently Asked Questions (FAQs): Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives (SHO #16-002), dated January 18, 2017.

d. ***Statewide Improvement of Behavioral Health for AI/AN Medicaid Clients***. In recognition of the significant health disparities in AI/AN mental health and substance use disorder and intergenerational trauma (collectively, behavioral health), the special trust responsibility, and the significant investments tribes and UIHPs have made in integrating physical and behavioral health despite enduring decades of severe underfunding, the Medicaid Transformation Project demonstration will offer flexibility outside of the approved DSRIP Planning Protocol to support culturally relevant IHCP-specific innovations that seek to improve the behavioral health of Medicaid-enrolled AI/ANs statewide by providing directed support for each IHCP to implement IHCP-specific physical and behavioral health and social service innovations identified in the following resources:

   i. The National Tribal Behavioral Health Agenda (https://www.nihb.org/behavioral_health/behavioral_health_agenda.php);

   ii. The Urban Indian Health Institute (UIHI) Report: "Supporting Sobriety Among American Indians and Alaska Natives: A Literature Review – February 2014" (http://www.uihi.org/download/supporting-sobriety-among-american-indians-alaska-natives-literature-review-february-2014/?wpdmdl=11604); and

   iii. The UIHI Report: "Addressing Depression Among American Indians and Alaska Natives: A Literature Review – August 2012" (http://www.uihi.org/download/addressing-depression-among-american-indians-alaska-natives-literature-review/?wpdmdl=11408).

e. ***Other Tribal- or IHCP-Specific Objectives*** as may be agreed upon by the Centers for Medicare and Medicaid Services, the state, and the proposing tribes and/or IHCPs.

2. **Timeline.**

   a. ***IHCP Planning Funds Plan***. No later than December 31, 2017, the tribes and IHCPs will submit to the state a consolidated IHCP Planning Funds Plan. Upon review and acceptance of the IHCP Planning Funds Plan, the state will issue $5,400,000 out of Demonstration Year 1 incentive payment funds in accordance with the instructions received from the tribes and IHCPs. To be accepted by the state, the IHCP Planning Funds Plan must include:

      i. Statewide Inventory of Indian Health and Indian Health Care, which includes:

         A. An inventory of the health needs, including the behavioral health needs, of the different AI/AN communities in Washington State,

both tribal and non-tribal (such as urban), with a particular focus on the barriers to care for Medicaid-covered AI/ANs;

B. An inventory of the physical health care, behavioral health care, dental care, and social service resources available at tribes, IHS facilities, and UIHPs in Washington State;

C. An inventory of the data, health information technology, and population health management systems at tribes, IHS facilities, and UIHPs in Washington State and analogous social service/case management data and information systems at tribes in Washington State;

D. An inventory of the evidence-based and promising practices, including behavioral health-related practices, that have been used by tribes, IHS facilities, and UIHPs to improve health care and health outcomes for their clients; and

E. An inventory of the barriers (federal and state laws and regulations, practical impacts of Medicaid and Medicare programs, etc.) to implementing these evidence-based and promising practices, including behavioral health-related practices.

ii. Plan for Statewide Improvement of AI/AN Behavioral Health, which includes:

A. A framework based on the National Tribal Behavioral Health Agenda;

B. Strategies within the framework that build on the services available at tribes, IHS facilities, and UIHPs, and on the evidence-based and promising practices that have been used by tribes, IHS facilities, and UIHPs to improve AI/AN behavioral health and behavioral health care;

C. Anticipated investments in data, health information technology, and population health management systems at tribes, IHS facilities, and UIHPs and analogous social service/case management data and information systems at tribes to enable tribes, IHS facilities, and UIHPs to implement the strategies and evidence-based and promising practices; and

D. Explanations of how these strategies and investments will achieve the objectives of the Medicaid Transformation Demonstration.

iii. Instructions for Payment of Earned IHCP Planning Funds, including:

A. *Decision Making*. The tribes and UIHPs have agreed that decisions regarding payment of earned IHCP Planning Funds will be made by majority vote of tribes and UIHPs, with each having one vote to be held by the AIHC delegate from the tribe or UIHP unless the tribe or UIHP directs that vote to be held by someone else. If the IHCP Planning Funds are earned before the tribes and UIHPs agree on how to allocate the funds, the state will not allocate the earned funds until the tribes and UIHPs instruct the state on whom will receive the funds and in what amounts.

B. *Funding Priorities*. The tribes and UIHPs have agreed that the IHCP Planning Funds will be allocated to support the following:

- Work that was done to earn the IHCP Planning Funds, including completion of the Tribal Protocol;

- Work that needs to be done to complete the IHCP Projects Plan, with one portion allocated equally to every tribe and UIHP in the state and the remaining portion allocated based on percentage of a total, such AI/AN Medicaid clients or IHS User Population; and

- Infrastructure investments to increase the ability of all tribes and UIHPs to attain the milestones in the IHCP Projects Plan, such as the CHAP Board and the clinical data repository/population health management.

b. ***IHCP Projects Plan***. No later than October 1, 2018, the tribes and IHCPs will submit to the state a consolidated IHCP Projects Plan, which will include both a statewide default project focused on statewide improvement of behavioral health for AI/AN and any additional projects that the tribes and IHCPs agree upon. Upon acceptance of the IHCP Projects Plan, the state will issue incentive payments upon achievement of the milestones in the IHCP Projects Plan in accordance with the instructions received from the tribes and IHCPs.

3. **Process.** The following provisions supersede the various protocols related to the DSRIP program:

a. ***ACH Certification - Tribal Requirement***. The State will require every ACH to adopt and demonstrate compliance with the Model ACH Tribal Collaboration and Communication Policy, , or a policy agreed upon in writing by the ACH and every IHCP in the ACH region, as part of the ACH certification process.

b. ***Application to IHCPs***. The term “ACH” in the DSRIP Planning Protocol will be interpreted to include IHCPs where appropriate to enable IHCPs to participate in the DSRIP Program in accordance with the terms of this Tribal Protocol.

c. ***No Requirement for Tribal Certification***. The State will not require any IHCP to undergo the ACH certification process in order to participate in the DSRIP Program. HCA will work with IHCPs to maintain compliance with federal requirements applicable to IHCPs participating in the DSRIP Program.

d. ***DSRIP Program Models***. For IHCPs participating in the DSRIP Program, the State will accept evidence-based or promising care models developed for, or tailored to, AI/AN clients that otherwise meet the requirements of the Transformation Project Toolkit (Attachment C to the Special Terms and Conditions for the Washington State Medicaid Transformation Project Section 1115(a) Medicaid Demonstration).

e. ***DSRIP Program Guidance and Technical Assistance for IHCPs***. The State will work with the Tribal Coordinating Entity to provide targeted guidance and technical assistance to help IHCPs implement one or more projects in the IHCP’s regional ACH Project Plan or the IHCP Projects Plan or both, including appropriate milestones and outcome measurement goals that qualify for incentive payments.

f. ***Regional Health Needs Inventories (RHNIs) and Regional Health Improvement Plans (RHIPs)***. In respect for the sovereignty and representative governmental processes of tribes and their knowledge of their citizens and their systems, the State will accept tribe-developed alternatives to formal RHNIs or RHIPs as a demonstration of population health needs for participation in the DSRIP Program. In respect for the complex systems of IHCPs and their unique role in helping the U.S. Department of Health and Human Services meet its federal trust responsibility to AI/ANs (including urban Indians and AI/ANs not living near their Indian reservations or villages), the State will accept IHCP-developed alternatives to formal RHNIs or RHIPs as a demonstration of population health needs for participation in the DSRIP Program.

g. ***No Required Projects for IHCPs***. The State will support tribes and IHCPs in their choices of DSRIP Program projects. IHCPs will not be required to implement either of the required projects listed in the Transformation Project Toolkit, nor will they be required to implement a minimum number of projects as provided for in the Transformation Project Toolkit.

h. ***Statewide Tribal-IHCP Projects***. The State encourages and will support IHCPs in a statewide IHCP effort to implement one or more projects in the IHCP Projects Plan, with incentive payments for collaborative sharing of expertise and individual IHCP efforts.

i. ***Financial Sustainability***. In respect for the sovereignty of Tribes and their responsibility in meeting the health needs of their clients, the State will not require IHCPs to adopt value-based payment methodologies, nor will the State be required to include IHCPs in value-based payment incentive programs, in meeting the financial sustainability requirements of the demonstration. In respect for the complex systems of IHCPs and their unique role in helping the U.S. Department of Health and Human Services meet its federal trust responsibility to AI/ANs (including urban Indians and AI/ANs not living near their Indian reservations or villages), the State will not require IHCPs to adopt value-based payment methodologies in meeting the financial sustainability requirements of the demonstration. For IHCPs, the State will accept alternative financial sustainability models.

j. ***Performance Measurement***. The State will accept Government Performance and Results Act (GPRA), and/or Universal Data System (UDS) measures in lieu of comparable statewide common performance measures when such substitution will reduce duplicative reporting and avoid excessive administrative burden on IHCPs.

4. **Funding and Mechanics.** The following provisions supercede the various protocols related to the DSRIP program:

   a. ***Application to IHCPs***. The term "ACH" in the DSRIP Program Funding and Mechanics Protocol will be interpreted to include IHCPs where appropriate to enable IHCPs to participate in the DSRIP Program in accordance with the terms of this Tribal Protocol.

   b. ***IHCP Incentive Funds***. Notwithstanding STC 28 and STC 35(b) and in accordance with DSRIP Funding and Mechanics Protocol III(c), the state will use the ratio of AI/AN Medicaid enrollees to total Medicaid enrollees to determine the percentage of the maximum statewide amount of DSRIP project funding to allocate to IHCP-specific projects (also referred to in the DSRIP Funding and Mechanics Protocol as tribal-specific projects).

IV. MEDICAID ALTERNATIVE CARE AND TAILORED SUPPORTS FOR OLDER ADULTS

1. **Eligibility to Provide Health Care Services and Acceptance of Tribal Attestation.** To the extent that services provided under the Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) programs are health care services, the state will accept any IHCP as a provider eligible to receive payment under the MAC and TSOA programs for health care services furnished to an AI/AN on the same basis as any other provider qualified to participate as a provider of health care services under the MAC and TSOA programs in accordance with 25 U.S.C. § 1647a(a)(1). To the extent permitted by federal and state law, the state will accept tribal attestation of compliance with state provider

requirements for health care services if a tribe establishes provider entity standards with comparable client protections.

2. **Exemption from Washington State Licensure.** To the extent that services provided under the MAC and TSOA programs are provided by licensed health professionals, the state will accept health professionals employed by the tribe who are licensed in another state and are performing services described in the contract or compact of the Indian health program under Indian Self-Determination and Education Assistance Act in accordance with 25 U.S.C. § 1621t.

3. **Client Presumptive Eligibility Assessments.** To the extent that any IHCP has the capacity and desire to perform presumptive eligibility assessments under the MAC and TSOA programs in accordance with federal and state requirements, the state will pay the standard case management rate for such activity.

4. **Client Services.** To the extent that any IHCP has the capacity and desire to provide client services under the MAC and TSOA programs in accordance with federal and state requirements (including federal conflict of interest rules), the state will pay the Medicaid contracted provider rate for each service.

5. **Coordination with IHCPs.** The state will make available to IHCPs training dates, information, and curriculum pertaining to the MAC and TSOA programs.

V. FOUNDATIONAL COMMUNITY SUPPORTS

1. **Eligibility to Provide Health Care Services and Acceptance of Tribal Attestation.** To the extent that services provided under the Foundational Community Supports program are health care services, the state and its administrative entity will accept any IHCP as a provider eligible to receive payment under the Foundational Community Supports program for health care services furnished to an AI/AN on the same basis as any other provider qualified to participate as a provider of health care services under the Foundational Community Supports program in accordance with 25 U.S.C. § 1647a(a)(1). To the extent permitted by federal and state law, the state will accept tribal attestation of compliance with state provider requirements for health care services if a tribe establishes provider entity standards with comparable client protections.

2. **Exemption from Washington State Licensure.** To the extent that services provided under the Foundational Community Supports program are provided by licensed health professionals, the state will accept health professionals employed by the tribe who are licensed in another state and are performing services described in the contract or compact of the Indian health program under Indian Self-Determination and Education Assistance Act in accordance with 25 U.S.C. § 1621t.

3. **Client Services.** To the extent that any IHCP has the capacity and desire to provide client services under the Foundational Community Supports program in accordance with federal

and state requirements, the state will pay the Medicaid contracted provider rate for each service through the administrative entity.

4. **Coordination with IHCPs.** The state will make available to IHCPs training dates, information, and curriculum pertaining to the Foundational Community Supports program. The state will facilitate one or more meetings between IHCPs and the Foundational Community Supports program administrative entity and providers to increase mutual understanding of capacity and systems related to the Foundational Community Supports program.

ATTACHMENT I
Foundational Community Supports Program

Per STC's 59-67, the following protocol outlines the services and payment methodologies for the Foundational Community Supports (FCS) Program. Under this program, the state will provide a set of Home and Community Based Services (HCBS), including Community Support Services (CSS), and Supported Employment-Individual Placement and Support (IPS), to populations that meet the needs-based criteria specified below. These services include HCBS that could be provided to the individual under a 1915(i) state plan amendment (SPA).

Community Support Services (CSS)

Target Criteria
CSS eligibility is available to Medicaid clients age 18 or older who meet the following needs-based criteria that would otherwise be allowable under a 1915(i) SPA:

Needs-Based Criteria
Individual meets at least one of the following health needs-based criteria and is expected to benefit from CSS:

1) Individual assessed to have a behavioral health need, which is defined as one or both of the following criteria:
   a) Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a mental illness; and/or

b) Substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment. The ASAM is a multi-dimensional assessment approach for determining an individual's need for SUD treatment.

2) Individual assessed to have a need for assistance, demonstrated by the need for:
   a) Assistance with three or more Activities of Daily Living (ADLs) defined in WAC 388-106-0010, one of which may be body care, and/or
   b) Hands-on assistance with one or more ADLs, one of which may be body care.
3) Individual assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support).

AND

Individual has at least one of the following risk factors:

1) Homelessness, defined as living in a place not meant for human habitation, a safe haven, or an emergency shelter, as these terms are understood or defined in 24 CFR 578.3:
   a) For at least 12 months, or
   b) On at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months.

2) History of frequent and/or lengthy stays in the settings defined in 24 CFR 578.3, or from, a skilled nursing facility as defined in WAC 388-97-0001.
   a) Frequent is defined as more than one contact in the past 12 months.
   b) Lengthy is defined as 90 or more consecutive days within an institutional care facility.
3) History of frequent adult residential care stays, where
   a) Frequent is defined as more than one contact in the past 12 months.
   b) Adult residential care includes
      i) Residential treatment facilities defined in WAC 246-337-005,
      ii) Adult residential care, enhanced adult residential care, or assisted living facilities defined in WAC 388-110-020, and
      iii) Adult family homes defined in WAC 388-76-10000.
4) History of frequent turnover of in-home caregivers, where within the last 12 months the individual utilized 3 or more different in-home caregiver provider agencies and the current placement is not appropriate for the individual.
5) A Predictive Risk Intelligence System (PRISM) Score of 1.5 or above
   a) The PRISM Risk Score uses diagnosis, prescription, age, and gender information from claims and encounter data to create an index of a client's expected future medical expenditures relative to the expected future medical expenditures of a comparison group (disabled Medicaid adults). The algorithm uses risk factor categories developed at University of California, San Diego known as the Chronic Illness and Disability Payment System (CDPS) and MedicaidRx, which were deemed by the Society of Actuaries to be effective methods of risk adjustment. The PRISM risk score is updated on a monthly basis by the Washington State Department of Social and Health Services' Research and Data Analysis division using the past fifteen months of claims, encounter, and demographic data. A risk score of 1.5 means that an individual's expected future medical expenditures will be 50 percent greater than that of the average Medicaid disabled client. The PRISM risk score was approved by CMS for targeting clients for the Health Home Program and Financial Alignment Dual Demonstration.

Service Definitions for HCBS That Could Be Provided under a 1915(i) SPA

Community Support Services (CSS) benefits package. CSS includes services that would otherwise be allowable under a Section 1915(i) authority, are determined to be necessary for an individual to obtain and reside in an independent community setting, and are tailored to the end goal of maintaining individual recipients' personal health and welfare in a home and community-based setting. CSS may include one or more of the following components:

Pre-tenancy supports:

a. Conducting a functional needs assessment identifying the participant's preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual), assistance in budgeting for housing/living expenses, assistance in connecting the individual with social services to assist with filling out applications and submitting appropriate documentation in order to obtain sources of

income necessary for community living and establishing credit, and in understanding and meeting obligations of tenancy.

b. Assisting individuals to connect with social services to help with finding and applying for housing necessary to support the individual in meeting their medical care needs.
c. Developing an individualized community integration plan based upon the functional needs assessment as part of the overall person-centered plan. Identifying and establishing short and long-term measurable goal(s), and establishing how goals will be achieved and how concerns will be addressed.
d. Participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed.
e. Providing supports and interventions per the person-centered plan:
    - Including the purchase of pay-as-you-go cell phone devices as a means to access telehealth services for pre-tenancy supports.

Tenancy sustaining services:

a. Service planning support and participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed.
b. Coordinating and linking the recipient to services including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end of life planning; and other support groups and natural supports.
    - Including the purchase of pay-as-you-go cell phone devices as a means to access telehealth services for pre-tenancy supports.
c. Entitlement assistance including assisting individuals in obtaining documentation, navigating and monitoring application process, and coordinating with the entitlement agency.
d. Assistance in accessing supports to preserve the most independent living such as individual and family counseling, support groups, and natural supports.
e. Providing supports to assist the individual in the development of independent living skills, such as skills coaching, financial counseling, and anger management.
f. Providing supports to assist the individual in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.
g. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
h. Connecting the individual to training and resources that will assist the individual in being a good tenant and lease compliance, including ongoing support with activities related to household management.

The CSS benefit does not include:

a. Payment of rent or other room and board costs;
b. Ongoing minutes or data plans for cell phone devices;
c. Capital costs related to the development or modification of housing;

d. Expenses for utilities or other regular occurring bills;
e. Goods or services intended for leisure or recreation;
f. Duplicative services from other state or federal programs
g. Services to individuals in a correctional institution.

Supported Employment – Individual Placement and Support

Target Criteria
IPS eligibility include Medicaid clients age 16 or older who meet the following criteria that would otherwise be allowable under a 1915(i) SPA:

Needs-based criteria

Individual meets at least one of the following health needs-based criteria and is expected to benefit from IPS:

1) Individual assessed to have a behavioral health need, which is defined as one or both of the following:
   a) Mental health needs, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support), resulting from the presence of a mental illness.
   b) Substance use needs, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment. The ASAM is a multi-dimensional assessment approach for determining an individual's need for SUD treatment.
2) Individual assessed to have a need for assistance demonstrated by the need for:
   a) Assistance with three or more Activities of Daily Living (ADLs) defined in WAC 388- 106-0010, one of which may be body care, and/or
   b) Hands-on assistance with one or more ADLs, one of which may be body care.
3) There is objective evidence of physical impairments because of which the individual needs assistance with basic work-related activities, including one or more of the following: Sitting, standing, walking, lifting, carrying, handling, manipulative or postural functions (pushing, pulling, reaching handling, stooping or crouching), seeing, hearing, communicating, remembering, understanding and following instructions, responding appropriately to supervisors and co-workers, tolerating the pressures of a work setting, maintaining appropriate behavior, using judgment, and adapting to changes in a routine work setting.

AND

Individual has at least one of the following Risk Factors:

1) Unable to be gainfully employed for at least 90 consecutive days due to a mental or physical impairment.
2) An inability to obtain or maintain employment resulting from age, physical disability, or traumatic brain injury.
3) More than one instance of inpatient substance use treatment in the past two years.
4) At risk of deterioration of mental illness and/or substance use disorder, including one or more of the following:

a) Persistent or chronic risk factors such as social isolation due to a lack of family or social supports, poverty, criminal justice involvement, or homelessness.
b) Care for mental illness and/or substance use disorder requires multiple provider types, including behavioral health, primary care, long-term services and supports, and/or other supportive services.
c) Past psychiatric history, with no significant functional improvement that can be maintained without treatment and/or supports.

5) Dysfunction in role performance, including one or more of the following:
   i) Behaviors that disrupt employment or schooling, or put employment at risk of termination or schooling suspension.
   ii) A history of multiple terminations from work or suspensions/expulsions from school.
   iii) Cannot succeed in a structured work or school setting without additional support or accommodations.
   iv) Performance significantly below expectation for cognitive/developmental level.

Service Definitions for HCBS That Could Be Provided under a 1915(i) SPA

Supported Employment – Individual Placements and Support (IPS) benefit package: The IPS benefit package will be offered to eligible clients through a person-centered planning process where eligible services are identified in the plan of care. IPS includes services that would otherwise be allowable under a Section 1915(i) authority, and are determined to be necessary for an individual to obtain and maintain employment in the community. IPS services are individualized and may include any combination of the following services:

Pre-employment services

a. Pre-vocational/job-related discovery or assessment
b. Person-centered employment planning
   - Including the purchase of pay-as-you-go cell phone devices as a means to access telehealth services for pre-employment services.
c. Individualized job development and placement
d. Job carving
   - Job carving is defined as working with client and employer to modify an existing job description— containing one or more, but not all, of the tasks from the original job description when a potential applicant for a job is unable to perform all of the duties identified in the job description.
e. Benefits education and planning
   - Benefits education and planning is defined as counseling to assist the client in fully understanding the range of state and federal benefits they might be eligible for, the implications that work and earnings would have for continued receipt of these benefits, and the client's options for returning to work.
f. Transportation (only in conjunction with the delivery of an authorized service)

Employment sustaining services

a. Career advancement services
   - Career advancement services are defined as services that expand opportunities for professional growth, assist with enrollment in higher education or credentialing

and certificate programs to expand job skills or enhance career development, and assist the individual in monitoring his/her satisfaction with employment, and determining level of interest and opportunities for advancement with current employer, and/or changing employers for career advancement.

b. Negotiation with employers
    - Negotiation with employers is defined as services where a provider identifies and addresses job accommodations or assistive technology needs with the employer on behalf of the individual. Job accommodations can include the following: adjusting work schedule to reduce exposure to triggering events (i.e., heavy traffic triggering symptoms of agoraphobia); providing a private area for individuals to take breaks if they experience an increase in symptoms; access to telephone to contact support person if needed while at work; adjusting job schedule to accommodate scheduled appointments; and small, frequent breaks as opposed to one long one. Assistive Technology can include the following: bedside alarms, electronic medication reminders while at work or at home, and use of headset/iPod to block out internal or external distractions.
c. Job analysis
    - Job analysis is defined as the gathering, evaluating, and recording of accurate, objective data about the characteristics of a particular job to ensure the specific matching of skills and amelioration of maladaptive behaviors.
d. Job coaching
e. Benefits education and planning
    - Benefits education and planning is defined as counseling to assist the client in fully understanding the range of state and federal benefits they might be eligible for, the implications that work and earnings would have for continued receipt of these benefits, and the clients' options for returning to work.
f. Transportation (only in conjunction with the delivery of an authorized service)
g. Asset development
    - Asset development is defined as services supporting the client's accrual of assets that have the potential to help clients improve their economic status, expand opportunities for community participation, and positively impact their quality of life experience. Assets as defined as something with value that is owned by an individual, such as money in the bank, property, and retirement accounts.
h. Follow-along supports
    - Follow-along supports are defined as on-going supports necessary to assist an eligible client to sustain competitive work in an integrated setting of their choice. This service is provided for, or on behalf of, a client, and can include communicating with the client's supervisor or manager, whether in the presence of the client or not (if authorized and appropriate). There is regular contact and follow-up with the client and employer to reinforce and stabilize job placement. Follow along support and/or accommodations are negotiated with an employer prior to client starting work or as circumstances arise.
        - Including the purchase of pay-as-you-go cell phone devices as a means to access telehealth services for follow-along supports.

The IPS benefit does not include:

a. Generalized employer contacts that are not connected to a specific enrolled individual or an authorized service
b. Employment support for individuals in sub-minimum wage, or sheltered workshop

settings
c. Facility-based habilitation or personal care services
d. Wage or wage enhancements for individuals
e. Duplicative services from other state or federal programs
f. Ongoing minutes or data plan for cell phone devices

HCBS Supported Employment

IPS services defined in this protocol shall adhere to 42 CFR 440.180(c)(2)(iii), 441.302(i) and 441.303(h).and shall not include habilitation services such as facility-based day habilitation or personal care. Furthermore, services are to be provided in conjunction with a client's existing services and supports, and are therefore separate from special education or related services defined under sections 602 (16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401 (16 and 17)) or as services under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. section 730).

HCBS requirements

a. **Person-Centered Planning.** The state agrees to use person-centered planning processes to identify eligible clients' Foundational Community Supports needs and the resources available to meet those needs, and to identify clients' additional service and support needs.
b. **Conflict of Interest.** The state agrees that the entity that authorizes the services is external to the agency or agencies that provide FCS services. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.
c. **Home and Community-Based Setting Requirements.** The state will assure compliance with the home and community-based settings requirements for those services that could be authorized under section 1915(i).

Provider Qualifications

Contracted providers must ensure staff providing FCS services maintain appropriate qualifications in order to effectively serve FCS enrollees. Below are typical provider qualifications, however they may be substituted with appropriate combination of education, experience and skills, as determined by the provider contract.

Provider	Education (typical)	Experience (typical)	Skills (preferred)	Services
Community Support Services Providers	Bachelor's degree in a human/social services field; may also be an Associate's degree in a relevant field, with field experience.	1-year case management experience, or Bachelor's degree in a related field and field experience.	Knowledge of principles, methods, and procedures of services included under community support services (as outlined above), or comparable services meant to support client ability obtain and maintain residence in independent community settings.	Pre-tenancy supports; tenancy sustaining services (as outlined above).
Supported Employme nt – IPS Providers	Bachelor's degree in a human/social services field; may also be an Associate's degree in a relevant field, with field experience.	1-year case management experience, or Bachelor's degree in a related field and field experience.	Knowledge of principles, methods and procedures of services included under supported employment – individual placement and support (as outlined above), or comparable services that support client ability to obtain and maintain employment.	Pre-employment services; employment sustaining services (as outlined above).

Payment Methodologies
HCA will reimburse a Third-Party Administrator (TPA) for the CSS and IPS services provided at the CSS and IPS rates. The rates shall not exceed the amount expended by the TPA for the direct service costs incurred by the provider. Rates may vary by region and may be developed based on a target cost per CSS and IPS service, along with variables such as geographic location, FCS-related travel costs, intensity of services, and duration of services or contracted provider per unit costs.

The TPA is required to submit quarterly reports and an annual report to HCA. Ongoing quarterly/annual reporting will include, at a minimum: (i) Number of FCS beneficiaries broken out by program (CSS and IPS supported employment); (ii) Number of new CSS and IPS supported employment person-centered service plans; (iii) Percent of clients receiving CSS and/or IPS supported employment services whose needs are re-assessed annually; and (iv) Amount of funds spent on CSS and IPS supported employment services. The purpose of the reports is to demonstrate that the program is conducted in compliance with the requirements set forth in the STCs and post-approval protocols, attachments, any agreement between HCA and the TPA, and policy letters and/or guidance from HCA.

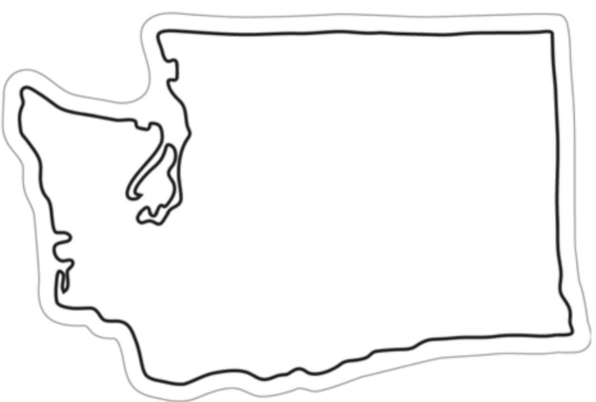
The TPA will invoice HCA for FCS services provided to a specific Medicaid beneficiary. As part of this invoicing process, the TPA must submit documentation to HCA of the Medicaid beneficiary's eligibility status, the dates of service, and the types of service that were provided.

The TPA is required to ensure FCS providers meet minimum documentation standards and cooperate in any evaluation activities by HCA, CMS, or their contractors. The state assures that there is no duplication of federal funding and the state has processes in place to ensure there is no duplication of federal funding.

ATTACHMENT J

Medicaid Transformation Project Demonstration Evaluation Design

Washington State Medicaid Transformation Project
Section 1115(a) Medicaid Demonstration



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Medicaid Transformation Project Demonstration Evaluation Design

Washington State Medicaid Transformation Project Section 1115(a) Medicaid Demonstration

APPROVED October 26, 2017

Last Updated April 26, 2019

Section 1: Overview of the Medicaid Transformation Project Demonstration

On January 9, 2017, the Centers for Medicare and Medicaid Services (CMS) approved Washington State's request for a Section 1115 Medicaid demonstration entitled Medicaid Transformation Project. The activities under the Demonstration are targeted to transform the health care delivery system to address local health priorities, deliver high-quality, cost-effective care that treats the whole person, and create sustainable linkages between clinical and community-based services. The Demonstration will test changes to payment, care delivery models and targeted services. The Demonstration is approved through December 21, 2021.

Over the next five years, Washington will:

- Integrate physical and behavioral health purchasing and service delivery to better meet whole person needs;
- Convert 90 percent of Medicaid provider payments to reward outcomes instead of volume;
- Support provider capacity to adopt new payment and care models;
- Implement population health strategies that improve health equity; and
- Provide new targeted services that address the needs of the state's aging populations and address key determinants of health.

The state will address the aims of the Demonstration through three programs:

- Delivery System Reform Incentive Payment (DSRIP) Program: Transformation through Accountable Communities of Health
- Long Term Services and Supports (LTSS) - Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)
- Foundational Community Supports (FCS) -Targeted Home and Community-Based Services (HCBS) for eligible individuals.

DSRIP Program: Transformation through Accountable Communities of Health

This initiative aims to transform the health care delivery system through regional, collaborative efforts led by ACHs. ACHs are self-governing organizations comprised of multiple community representatives, and focused on improving health and transforming care delivery for the populations that live within the region. Providers within ACH regions will partner to implement evidence-based programs and promising practices, as defined in the DSRIP Planning Protocol (Attachment C), that address the needs of Medicaid beneficiaries.

Each ACH, through its partnering providers, is required to implement at least four transformation projects from the Transformation Project Toolkit and participate in statewide capacity building efforts to address the needs of Medicaid beneficiaries. Project performance will be measured based on state-defined milestones and metrics that track project planning, implementation, and sustainability. Transformation projects are spread across three domains:

- ***Domain 1: Health Systems and Community Capacity Building:*** This domain addresses the core health system capacities to be developed or enhanced to support delivery system transformation. Domain 1 outlines three required focus areas to be implemented and expanded across the delivery system, inclusive of all provider types, to benefit the entire Medicaid population.

- ***Domain 2: Care Delivery Redesign:*** Transformation projects within this domain focus on innovative models of care that will improve the quality, efficiency, and effectiveness of care processes. Person-centered approaches and integrated models are emphasized. Domain 2 includes one required and three optional projects. ACHs are required to select at least one of the optional projects for a minimum of two Domain 2 projects in total.
- ***Domain 3: Prevention and Health Promotion:*** Transformation projects within this domain focus on prevention and health promotion to reduce disparities and achieve health equity across regions and populations. Domain 3 includes one required and three optional projects. ACHs are required to select at least one of the optional projects for a minimum of two Domain 3 projects in total.

The domains, and the strategies defined within each domain, are interdependent. Domain 1 is focused on system wide planning and capacity building to reinforce transformation projects. Domain 1 strategies are to be tailored to support efforts in Domain 2 and Domain 3; projects in Domain 2 and Domain 3 integrate and apply Domain 1 strategies to the specified topics and approaches. In addition to the foundational activities in Domain 1, the Transformation Project Toolkit includes eight projects areas.

TABLE 1.

Menu of Transformation Projects

Domain 1	Health and Community Systems Capacity Building	
		Financial Sustainability through Value-based Payment
		Workforce
		Systems for Population Health Management
Domain 2	Care Delivery Redesign	
Project	2A	Bi-directional Integration of Physical and Behavioral Health through Care Transformation *(Required)*
Project	2B	Community-Based Care Coordination
Project	2C	Transitional Care
Project	2D	Diversion Interventions
Domain 3	Prevention and Health Promotion	
Project	3A	Addressing the Opioid Use Public Health Crisis *(Required)*
Project	3B	Reproductive and Maternal/Child Health
Project	3C	Access to Oral Health Services
Project	3D	Chronic Disease Prevention and Control

In support of delivery system reform and alignment with the aims of the overall demonstration, this initiative seeks to achieve the following objectives:

- ***Health Systems and Community Capacity.*** Create appropriate health systems capacity in order to expand effective community based-treatment models; reduce unnecessary use of intensive services and settings; and support prevention.
- ***Financial Sustainability through Participation in Value-based Payment.*** Accelerate the transition to paying for value across the continuum of Medicaid services to assure the sustainability of the transformation activities under DSRIP, and support the success of Alternative Payment Models required by the state for Medicaid managed care plans (see: STC 41, Table 1).
- ***Bi-directional Integration of physical and behavioral health.*** Achieve comprehensive integration of physical and behavioral health services through new care models.
- ***Community-based Whole-person Care.*** Use or enhance existing services in the community to promote care coordination across the continuum of health for beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.
- ***Improve Health Equity and Reduce Health Disparities.*** Implement prevention and health promotion strategies for targeted populations to address health disparities and achieve health equity.

Long Term Services and Supports (LTSS) - Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)

Washington is a national leader in providing long-term services and supports (LTSS) to help people remain in their homes and communities, saving billions of dollars over the past two decades. Our LTSS system has sustained AARP's ranking of second in the nation for its high performance, while at the same time ranking among the lowest (34th) in cost. However, our population is aging, increasing the number of individuals who will be in need of these services. By 2040, the number of people 65 and older will more than double. As we age, we often need assistance with daily tasks such as bathing and medication reminders in order to stay in our own homes and communities rather than in expensive institutional care. While we will continue to provide more intensive services to those who need them, the Demonstration will help Washington State prepare for the "age wave." It will test new services and expand existing services traditionally provided outside of Medicaid that support unpaid family caregivers.

This "next generation" system of care will help protect people's savings and provide more support for family members and other unpaid caregivers who provide approximately 80 percent of care to people in need of long-term services and support. The majority of Washingtonians are uninsured for LTSS, with no affordable options for coverage. Individuals and their families often have no practical way to prepare financially for future LTSS needs, except by impoverishing themselves so they are eligible for full-scope Medicaid benefits. To highlight the importance of supporting unpaid caregivers, if just one-fifth of these caregivers stopped providing care, it would double the cost of LTSS in Washington State. Providing care for a family member can be among the most rewarding things a person can do, but it also has challenges. A high proportion of caregivers show increases in stress and effects on their own physical and mental health.

The Demonstration will offer additional choices that are intended to:

- Preserve and promote choice in how individuals and families receive services
- Support families in caring for loved ones while increasing the well-being of caregivers
- Delay or avoid the need for more intensive Medicaid-funded LTSS when possible

Medicaid Alternative Care (MAC) will provide support for unpaid family caregivers who support individuals who are eligible for Medicaid but choose to wrap services around their unpaid caregiver as an alternative to other forms of traditional paid services. This benefit package will provide supports enabling unpaid caregivers to continue to provide high-quality care while also focusing on their own health and well-being. It will include needed services such as training, support groups, respite services, and help with housework, errands, supplies, and home-delivered meals.

Tailored Supports for Older Adults (TSOA) will establish a new eligibility category and benefit package for individuals at risk of future Medicaid LTSS use, who currently do not meet Medicaid financial eligibility criteria, but do meet functional criteria for care. It is designed to help individuals and their families avoid or delay impoverishment and the future need for Medicaid LTSS services, while providing support to individuals and unpaid family caregivers. As with MAC, TSOA will include supports such as training, support groups, respite services, and help with housework, errands, supplies, and home-delivered meals. Individuals who do not have unpaid caregivers will receive services such as personal care, adult day services and home delivered meals.

Foundational Community Supports (FCS) -Targeted Home and Community-Based Services (HCBS) for Eligible Individuals

Demonstration HCBS, Community Transition Services (CTS) and Community Support Services (CSS), will help Medicaid beneficiaries reside in stable community settings.[1] The goal is to enhance the availability of services

[1] Potential changes to the FCS protocol are currently being reviewed with CMS. This document references FCS program descriptions reflected in the originally approved STCs, for purposes of illustrating the proposed evaluation approach. The final evaluation approach will reflect the actual design of the implemented FCS program.

for those who are the most vulnerable and have complex care needs. The CTS and CSS benefits will provide services that link qualifying Medicaid enrollees to appropriate services, and one-time supports necessary for individuals to avoid more intensive care placements and move into stable community settings. The Demonstration -funded CTS and CSS benefits will not supplant existing services currently available to eligible populations. It will be targeted to serve specific high-risk populations and achieve the following outcomes:

- Support those who are unable to reside in stable community settings
- Decrease dependence on costly or restrictive institutional or residential care
- Provide continuity of care by reducing incidents of eviction and provider turnover
- Support those at highest risk for adverse outcomes

Demonstration-funded supported employment services will help Medicaid enrollees with physical, behavioral, or LTSS service needs gain and maintain stable employment. These services will include individualized job coaching and training, employer relations, and assistance with job placement. Informed by stakeholder engagement and population analysis, four outcomes have been identified and corresponding target populations are proposed. Targeted outcomes include:

- Helping individuals stay engaged in the labor market,
- Preventing the escalation of behavioral health service needs,
- Supporting those with significant long-term services and supports needs, and
- Supporting vulnerable youth and young adults.

In order to be eligible for these services, individuals must receive a needs assessment and meet well-defined housing or employment support need criteria, along with additional risk criteria.

Section 2: Evaluation Goals and Objectives

This section describes the overarching framework for evaluation of Demonstration impacts on delivery systems, clinical care, health outcomes, and costs in Washington State. Evaluation activities will be led by an independent external evaluator and supported by state agency teams with complementary data management and analytic subject matter expertise. Detailed design elements related to qualitative evaluation and quasi-experimental evaluation of ACH projects will be determined in conjunction with the independent external evaluator, and after detailed project design information becomes available from ACH project plans. The evaluation will encompass both an assessment of the impact of the Demonstration on the entire delivery system and evaluation of specific projects implemented under all three initiatives. Evaluation goals will include:

- **Assessment of overall Medicaid system performance under the DSRIP program** in developing community capacity to support health system transformation. This will be based on an assessment of post-demonstration changes in statewide performance levels, relative to pre-demonstration baseline performance levels, across the following measurement domains:[2]
  - Access to primary care, behavioral health care, and other preventive health care services;
  - Quality of care;

[2] At this time we cannot commit to a comparison-group approach to measuring statewide Demonstration impacts, primarily due to uncertainty about the availability of the national T-MSIS data necessary for identifying comparison groups and measuring outcomes for beneficiaries drawn from Medicaid populations in other states. At the time of this writing, we note that the evaluation of the impact of Washington State's Health Home program on Medicaid program costs conducted for CMS by RTI, which takes a comparison-state approach using T-MSIS data, is two years overdue as a result of T-MSIS data limitations. We also note that a within-state contemporaneous comparison group cannot be used to measure overall Demonstration impacts, given the statewide scope of the Demonstration.

- Reduction in use of costly ED, inpatient, or institutional care, including through the reduction of utilization for ambulatory care sensitive conditions and reduction of utilization disparities for persons with behavioral health risk factors;
  - Social outcomes including housing stability and employment measured using beneficiary-level administrative data drawn from the State's rich integrated data environment (described further below); and
  - Overall Medicaid expenditures on a per beneficiary per month basis.

- **Assessment of progress toward meeting VBP penetration targets.** This assessment is expected to be both qualitative and quantitative in nature, based on data sources such as provider surveys, focus groups, key informant interviews, and document review.[3] The independent external evaluator will assess the extent of use of VBP in contracting, the effectiveness of readiness support provided to providers, and the impact of use of VBP approaches on provider/plan behavior, patient health outcomes, and patient experience. This activity will leverage the assessments of the role of VBP approaches at the project scale, as outlined in the project-level evaluation design detail in Section 5.
- **Assessment of the impact of the Demonstration on the development of the workforce capacity needed to support health system transformation.** This assessment is also expected to be both qualitative and quantitative in nature, based on data sources such as:
  - Provider network adequacy information supplied by MCOs;
  - Performance metrics related to access to services, quality of care, and reduction in use of costly inpatient or institutional care; and
  - Provider surveys, focus groups, and key informant interviews, leveraging assessment of workforce capacity at the project scale as outlined in the project-level evaluation design detail in Section 5.
- **Assessment of the impact of the Demonstration on provider adoption and use of health information technology.** The methodology for assessing impacts in this area will be determined by the independent external evaluator and is expected to leverage provider surveys, focus groups, and/or key informant interviews to assess whether the Demonstration has affected the use of electronic and interoperable health information exchange to promote care coordination, targeted services, and positive outcomes of clinical care. As required by STC 109(b), this assessment will examine the extent to which the Demonstration has enhanced the state's health IT ecosystem to support delivery system and payment reform and the impact on ACH and provider partners' governance, financing, policy/legal issues and business operations. This evaluation activity would include providers who are and are not eligible for the Medicaid EHR Incentive Program, with a focus on use of HIT to improve health outcomes for high-risk populations including persons with co-occurring physical and behavioral health conditions. This activity will leverage the assessments of the role of HIT at the project scale, as outlined in the project-level evaluation design detail in Section 5.
- **Measurement of project-level impacts at the state and ACH level.** Outcomes will be assessed for project-specific target populations at the state and ACH level. Outcome measures will be produced centrally leveraging the state's rich integrated data environment and capacity for performance measure production. Evaluation will not rely on aggregation of performance measures produced separately by ACHs. This allows great flexibility in the creation of valid comparison groups for use in the application of quasi-experimental evaluation techniques, as described below. For projects that are undertaken by multiple ACHs, a comparative analysis will be undertaken to help determine key drivers of outcomes, dependencies and environmental factors that might contribute to positive or negative outcomes for

[3] More detail concerning the types of documents expected to be reviewed is contained in Section 3.

specific projects.[4] As described in the sections that follow, the state will leverage its nation-leading internal analytic capacity and integrated data environment to support the independent external evaluator and provide a data infrastructure able to:

- Identify beneficiary-level project participation, including potentially overlapping participation across multiple projects and initiatives;
- Measure project outcomes at the ACH-project scale using statistically valid quasi-experimental evaluation designs; and
- Assess differences in outcomes across ACHs within project areas based on factors such as differences in target populations (i.e., actual populations served).

- **Rapid-cycle project implementation support (formative evaluation).** Timely implementation reports will especially be useful to inform efforts early in the project implementation process. These reports will be available to CMS if requested. The design and frequency of these reports will be determined in collaboration with the independent external evaluator and ACH partners. An example set of implementation reports would include monthly or quarterly health risk factor profiles of the populations engaged in specific projects/initiatives, compared to target population benchmarks. Such reports would help assess levels of engagement and potential differences across ACHs in the composition of engaged beneficiaries that could inform the early stages of project implementation. Early implementation reports will be mainly used to identify and mitigate risks or take advantage of opportunities to improve project implementation. Later implementation reports will also be used to inform the broader analysis of project impacts and outcomes, in advance of delivery of STC-required evaluation reports in the fourth and fifth years of the Demonstration. These implementation support activities reflect formative evaluation of the development and early implementation of Demonstration-funded initiatives and component projects.

Detailed project-level specification of required evaluation design components is contained in Section 5 and Appendix 1, including project-level descriptions of:

- Initiative and project goals and objectives
- Target populations
- Evaluation questions and testable hypotheses
- Data strategies, data sources and data collection frequency
- Outcome metrics
- The statistical framework for measuring project impacts
- Potential subgroup analyses to assess disparities and differences in beneficiary engagement and project impacts.

At the state level, data will be analyzed to determine if the Demonstration has affected the pre-Demonstration trajectory of measures of access to care, quality of care, health and social outcomes, and Medicaid cost measures. This will be based on an assessment of post-demonstration changes in statewide performance levels, relative to pre-demonstration baseline performance levels, across the range of measurement domains described in the previous section.[5] While project-specific evaluations will use quasi-experimental program evaluation techniques focused on targeted project populations, the statewide analysis will include a broader

[4] Note that the CMS response to the prior evaluation design draft assumed that ACHs could choose different outcome measures for the same project. However, we anticipate using the same set (or at least a highly overlapping set) of centrally produced measures for all ACH projects within a given project type.

[5] Note that the CMS response to the prior evaluation design draft suggested use of an approach in the spirit of a regression-discontinuity design which would include comparative data on the population "just over the eligibility threshold" for the purposes of state-level evaluation. While this approach may be feasible in the context of evaluating specific projects, it would not be feasible for the evaluation of statewide impacts due to the lack of access to health care encounter data for persons not enrolled in Medicaid.

Medicaid population perspective reflecting the potential combined impact of all activities undertaken under the Demonstration. The statewide impact evaluation will also focus on higher-risk beneficiaries who are expected to be significantly positively impacted by Demonstration initiatives, including but not limited to beneficiaries with SMI or co-occurring disorders, with multiple chronic conditions, with functional needs for LTSS services, living in underserved areas, or experiencing baseline disparities in health outcomes. Washington State has significant experience identifying and measuring disparities in access, quality, and health outcomes across these populations.

While the evaluation may not be able to completely isolate the effects of the Demonstration from other policy and program changes and investments under the SIM Grant, differences in timing, specific areas of impact, and target populations will facilitate the measurement of impacts associated with initiatives under the Demonstration. For example, the financial integration of behavioral and physical health services is being instituted under SIM and is expected to be completed by 2020. The financial integration of behavioral and physical health services is seen as a critical support for the effective integration of clinical care. Financial integration is being phased regionally, which will provide the opportunity to compare the effectiveness of Demonstration projects at the ACH scale across regions at the same stage of financial integration. Through the identification of appropriate comparison groups by region, the evaluation should be able to isolate the impact of Demonstration initiatives from financial integration impacts. As discussed further below, propensity score matching methodologies will be used in project-level analyses to ensure the identification of appropriate comparison groups for measuring impacts.

Section 3. Overview of Major Evaluation Components and Activities

This section provides additional detail about the major evaluation activities expected to be undertaken across all three initiatives by the independent external evaluator and state agency evaluation support teams. We start with a description of qualitative methods used to support project implementation and inform quantitative evaluation analyses, and then turn to describing the rigorous quantitative evaluation methods that will leverage the State's advanced integrated analytical environment. Section 5 and Appendix 1 provide detailed project-specific mapping of demonstration hypotheses (STC 108), domains of focus (STC 109), research questions, testable hypotheses, outcome measures, and data sources, for both quantitative evaluation components, along with mapping of demonstration hypotheses, domains of focus, research questions, and testable hypotheses for qualitative evaluation components.

Qualitative analysis. Evaluation activities will include qualitative analysis of program implementation and operations to support both formative evaluation deliverables and quantitative analysis of program impacts. Qualitative analysis will address program implementation questions such as:

- How programs are designed;
- The level of readiness for the program among stakeholders;
- The effectiveness of VBP readiness support for providers and the impact of use of VBP approaches on provider/plan behavior and patient health outcomes;
- Provider capacity development, including domains such as HIT acquisition and use, VBP use, workforce availability, and workforce readiness/training;
- How acquisition and use of HIT and health information exchange technologies impact service delivery transformation; and
- Efforts to make the organizational changes necessary to support system transformation.

Qualitative analysis will help inform our understanding of why the Demonstration and its component projects did or did not achieve the expected effects, by exploring:

- Experiences of beneficiaries, providers, and other key stakeholders through focus groups, key informant interviews, and survey methods;
- Contextual changes that might affect outcomes;
- Unintended programmatic side effects; and
- How faithfully projects were implemented.

Qualitative analysis will help make more accessible findings from the quantitative impact analysis, by reinforcing quantitative findings in a non-technical format (e.g., through key-informant quotes, rather than statistics), helping to open the "black box" of program effects.

The design and execution of qualitative methods supporting the evaluation will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Subjects for qualitative data collection and analysis are expected to include beneficiaries, providers, ACH staff/administrators, MCO staff/administrators, and state agency staff. Individual ACH projects are expected to define strata for sampling of subjects for qualitative analyses, to ensure representation from targeted beneficiaries and providers.

Quantitative analyses leveraging integrated administrative data. The evaluation will leverage the integrated administrative data maintained in the Department of Social and Health Services Integrated Client Databases (ICDB) to support quasi-experimental evaluation across all three initiatives, including evaluation at the ACH-project scale. The ICDB was explicitly designed to support quasi-experimental evaluation of health and social service interventions in Washington State, and has been widely used in evaluation studies published in peer-reviewed journals.[6]

The ICDB contains nearly 20 years of individual-level, massively dimensional data for nearly 6 million persons residing in Washington State over that time span. It contains data from approximately 20 administrative data systems, including the State's ProviderOne MMIS data system and all other data sources necessary to implement the quantitative evaluation design described in this document, except in a few areas discussed below where new data collection may be required.

More specifically, the ICDB contains:

- Service event level utilization data across all Medicaid funded delivery systems (physical, mental health, substance use disorder, long-term services and support, and developmental disability services);
- Expenditure data at the service event and per-member per-month level of aggregation by major service modality, for all Medicaid beneficiaries over the time period relevant to this evaluation (with a few caveats related to issues like the methods for applying pharmacy rebates);
- Risk factors associated with chronic and acute disease conditions, including mental illness and substance use disorders, derived from the CDPS and Medicaid-Rx risk models and related tools;[7]
- Assessment data on functional support needs, cognitive impairment, and behavioral challenges for persons receiving LTSS services;
- Data on "social outcomes" including arrests, employment and earnings, and homelessness and housing stability;
- Client demographics (age, gender, race/ethnicity);

[6] For a recent example, see Jingping Xing, Candace Goehring and David Mancuso. Care Coordination Program For Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs Care Coordination Program For Washington State. Health Affairs, 34, no.4 (2015):653-661.

[7] For more information about the CDPS and Medicaid-Rx, visit http://cdps.ucsd.edu/.

- Medicaid enrollment by detailed coverage category;
- MCO enrollment or fee-for-service Medicaid coverage status;
- Medicare Parts A, B, and D integration for persons dually enrolled in Medicaid and Medicare; and
- Geographic residential location spans which are critical to regional attribution models.
- With regard to CMS reviewer questions pertaining to how frequently data is collected, the ICDB is updated on a quarterly basis. The ICDB analytical data infrastructure is complemented by a suite of HEDIS and related metric measurement algorithms that currently regularly produce most of the quantitative outcome metrics listed in Section 5 and Appendix 1 on at least a semi-annual basis for all Medicaid beneficiaries in Washington State meeting measure specification requirements. Furthermore, the state agency teams maintaining the ICDB have deep expertise in identity management processes that may be necessary to link new ad hoc data sources required for ACH project attribution.

Among the advantages to leveraging the State's nation-leading integrated analytical data environment is the elimination of dependencies on ACHs for data collection and measurement, which otherwise would likely result in variation across projects in data integrity and measurement quality. We also note that the State's analytical environment can readily absorb new and changing measurement concepts, and apply those concepts retroactively for all relevant history to maintain consistent time series for analysis. For example, the addition of "FUA" and "FUM" metrics first implemented in the HEDIS® 2017 provided the state with useful new tools to assess coordination of physical and behavioral health care for persons with co-occurring conditions, and we retroactively produce those measures for prior time periods. Given the active work underway by NQF and NCQA, driven by CMS support, to improve the breadth of quality and outcome measures related to behavioral health conditions, if new measures are developed and released in 2018 or 2019 we would be able to retroactively engineer those measures into baseline time periods for the entire qualifying Medicaid population. This is one of the factors that support the expectation that the measure sets described in this design document may be modified if better performance measurement tools become available in the evaluation window.

Primary data collection for research questions that cannot be addressed using administrative data. Evaluation activities are expected to include key informant interviews, focus groups, stakeholder surveys, document review, and other activities as necessary to inform the qualitative analysis of initiative and project design and implementation. Qualitative analysis will be particularly important in evaluating the impact of DSRIP activities on progress toward meeting VBP penetration targets, the development of workforce capacity, and provider adoption and use of the state's health IT.

Methods such as key informant interviews, focus groups, and stakeholder surveys are expected to be used to assess the extent to which DSRIP funding has enhanced the state's health IT ecosystem to support delivery system and payment reform, with a focus on governance, financing, resolution of policy and legal barriers, and impacts on business operations. As noted elsewhere, the design and execution of qualitative methods supporting the evaluation will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments.

Subjects for key informant interviews and focus groups will be identified through consultation with State subject matter experts, and are expected to span the range of Demonstration activities and participants. Data will be collected from state agency staff, ACHs, MCOs, provider organizations, local health jurisdictions, tribes, and other key public and private stakeholders as identified.

Documentation will be identified in consultation with subject matter experts within HCA. Documents would include, but not be limited to, annual updates to the VBP roadmap; the annual VBP provider[8] survey; available documentation and data on provider adoption of VBP; consumer experience surveys, such as the CAHPS[9] survey, provided to Medicaid clients; the HIT strategic roadmap and updates to the operational plan; ACH project plans and implementation plans; Independent Assessor assessments of plans, semi-annual review of ACH progress against miles stones and metrics included in approved project plans, any documents associated with at risk projects, mid-point assessment, and other documents created by the Independent Assessor related to the challenge pool and the reinvestment pool including annual assessments of MCO and ACH performance; and all quarterly reports submitted by HCA to CMS.

In addition, caregiver and care receiver survey data collection is planned to support evaluation of the MAC and TSOA programs. Survey data will mitigate the impact on the evaluation of the absence of comparable health service utilization data for non-Medicaid clients, and lack of LTSS-related functional assessment data for Medicaid clients not receiving LTSS services. More detail about the design and data collection and analysis processes for these surveys is contained in Section 5.

Statewide beneficiary project attribution model. Given the scale of the initiatives and projects supported by the Demonstration, a statewide project attribution data infrastructure will be necessary to support evaluation – in particular evaluation of the Demonstration at the ACH-project scale. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration -funded projects across all three initiatives. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs described below.

The attribution model will be based on regularly updated claims, encounters, Medicaid eligibility, and residential location data processed through the ICDB, supplemented where necessary with regularly updated ACH project-specific data streams (e.g., monthly participating beneficiary and/or provider rosters) for ACH projects where claims and encounters processed into the ICDB are not sufficient to identify participating beneficiaries. For initiatives 2 and 3, we have determined that data identifying utilization of Demonstration services will be available through information routinely integrated into the ICDB – for example, supportive housing and supported employment encounters submitted by the third-party administrator (Amerigroup) into the ProviderOne (MMIS) system.

Final evaluation design determination. The statewide evaluation will identify whether the Demonstration impacted key metrics from a macro state-level perspective. However, it remains critical from the long-term sustainability perspective to understand which ACH projects positively impacted outcomes for participants, even if they were not implemented at a scale to produce statistically significant changes at the ACH or statewide geographic scale. This is critical information to identify which interventions should be supported or expanded after the demonstration ends.

Finalizing many components of the detailed evaluation design at the project scale will need to be deferred until after ACH project implementation plans are available in the spring of 2018, and will be done in

[8] HCA issues an annual value-based payment (VBP) survey to track progress towards the state's paying for value goals, and to identify barriers impeding desired progress. The provider survey will offer valuable insight into the challenges providers face as they consider adopting new payment arrangements and guide state health care purchasing strategies in support of overcoming those challenges. The commercial health plan survey will help HCA track progress towards our paying for value goals, with particular insight into non-state purchased health care programs. The MCO survey will establish a statewide and regional (designated by Accountable Communities of Health) baseline of VBP attainment for requirements under the new Apple Health contracts and VBP incentives under the Medicaid Transformation Demonstration Project, respectively.

[9] The State uses the Adult CAHPS Survey and the Child and Child with Chronic Conditions Survey for Apple Health Medicaid enrollees, with adult and child surveys rotated every other year.

collaboration with the independent external evaluator. This timing is necessary because much of critical information for finalizing the evaluation design is dependent on knowing what types of projects will be implemented by ACHs. Project-level evaluation designs cannot be completed until we know the answers to questions including:

- Which interventions have been selected?
- How program participants will be targeted?
- Which providers will be participating?
- How much capacity will be developed to serve the targeted population?
- What level of engagement in the target population is likely to be achieved?
- Are other ACHs targeting similar populations for their initiatives?

At this point we can provide a discussion of evaluation design options, with recognition that specific design choices are dependent on currently unknown parameters and guidance from the independent external evaluator.

For example, if we knew that a particular ACH project was going to serve a relatively high proportion of a well-defined target population, and we knew that population was not a target for projects in some of the other ACHs, we would likely consider an intent-to-treat difference-of-difference design where we would compare relative changes in the entire target population in both the implementing ACH and the comparison ACHs that did not target this population. The intent-to-treat aspect of the design and the geographic variation in implementation would be instruments available to us to reduce the impact of selection bias on estimated project impacts.

However, if an ACH project were designed to reach only a small proportion of the potential target population in that ACH, an intent-to-treat approach would wash out the effect of the project on "treated" beneficiaries, by including their experience with the vastly larger number of untreated beneficiaries in the target population. From one perspective, the intent-to-treat approach would answer the question of whether the intervention impacted outcomes in the larger ACH target population. With low intervention penetration, the answer would likely be "no." But the question of whether the intervention impacted outcomes for those who engaged in the project is still highly relevant from the perspective of determining which interventions should be supported or expanded after the demonstration ends. And to address the question of impacts on the treated population, we would likely use a propensity score matching approach to identify an untreated comparison group. In the context of low intervention penetration, it might be appropriate to draw comparison group members from within the ACH implementing the intervention being evaluated, particularly if the ACH also implemented broad-based health system delivery redesign and community capacity building initiatives that are unique to the region.

These types of considerations will be worked through with the support of the independent external evaluator, after ACH project designs become available. We expect CMS to provide input and concur in the appropriateness of the final evaluation designs.

Propensity-score methods to estimate project-specific impacts. Propensity score matched comparison group designs will be broadly deployed across all project areas that are amenable to impact analysis using administrative data, including MMIS-derived health service utilization data, LTSS assessment data, and linked "social determinant" outcome data.[10] Evaluation of Transformation project impacts at the ACH level is necessary to:

- Understand variation in outcomes across ACHs,

[10] Examples of propensity-score impact analyses using the types of linked administrative data available for the Demonstration evaluation can be found here: https://www.dshs.wa.gov/sesa/research-and-data-analysis. For a recently published specific example, see: https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-8-33.pdf.

- Understand the degree to which improvements can be attributed to the specific activities undertaken under the Demonstration, and
- Inform post-Demonstration resource priorities in the state authorizing environment.

A matched comparison group is expected to be created for each ACH project, based on the characteristics of the target population for the specific intervention. The pre-post boundary for the treatment group will be based on the point at which they engage in the intervention. The pre-post boundary for the comparison group will be defined through the matching process, as described below. The matching process will generally proceed through the following steps:

- **Comparison frames for matching are identified by an initial broad set of criteria that align with the project targeting criteria.** For example, if an ACH intervention is targeting persons discharged from a hospital setting for improved care transitions, the starting point in defining the matching frame will be the identification of other qualifying discharges in the intervention "intake window", potentially both within and outside of the ACH (based on overarching evaluation design considerations discussed above). Similarly, if a care coordination intervention targets a particular set of beneficiaries using well-defined risk criteria, this initial stage of the process will identify all person-months for persons not receiving the intervention where the person meets the targeted risk criteria in the relevant baseline window (e.g., has PRISM risk scores within the eligibility range in the prior 12 month period). This approach to building a "person-month" frame for matching against the "person-months" associated with entry into the intervention by persons comprising the treatment group is illustrated in the evaluation of the precursor to the State's Health Home Program (Health Affairs, April 2015).[11] This approach leverages the richness of the State's integrated data environment and design of its analytical data infrastructure, which supports data management techniques that scan all relevant persons at all relevant points in time (months in this case) where they might be a "best" match to a person who entered the specific intervention under study at the time when they entered the intervention. The RDA project team supporting the independent external evaluator has extensive experience using these techniques for producing the high-volume of rigorous project evaluations required by the Demonstration.
- **Key predictors of engagement within the pooled intervention and comparison matching frame are examined to ensure inclusion of appropriate measurement dimensions in the PS model.** This includes creating an extensive set of "engagement predictors" that are determined, ex ante, to be potentially relevant to the matching process. This set of predictors is generally expected to span a wide range of the measurement domains contained with the State's ICDB, which may include:
  - Service utilization data across all Medicaid funded delivery systems (physical, mental health, substance use disorder, long-term services and support, and developmental disability services);
  - Expenditure data at the "major modality" (e.g., IP hospitalization, OP ED visits, etc.) per-member per-month level;
  - Risk factors associated with chronic and acute disease conditions, including mental illness and substance use disorders, derived from the CDPS and Medicaid-Rx risk models;
  - Data on functional support needs, cognitive impairment, and behavioral challenges for persons receiving LTSS services when applicable;
  - Data on arrests, employment and earnings, and homelessness and housing stability when applicable;
  - Client demographics (age, gender, race/ethnicity);
  - Medicaid enrollment by detailed coverage category; and
  - Urban/rural/frontier characteristics of the beneficiary's residential location.

[11] Jingping Xing, Candace Goehring and David Mancuso. Care Coordination Program For Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs Care Coordination Program For Washington State. Health Affairs, 34, no.4 (2015):653-661.

- Application of machine learning techniques (e.g., stepwise logistic or lasso regression) to determine the final propensity score model.
- Propensity score matching using procedures in the R programming language (e.g., the Matchit procedure). For some interventions, exact matching may be required for key variables.

Project-level utilization and cost analyses generally will be conducted using a difference-of-difference design, where the pre-to-post change in experiences for beneficiaries receiving a particular intervention will be compared against the change experienced by the matched comparison group. As described above, for analyses using a difference-of-difference design the pre-post boundary for the treatment group will be based on the point at which they engage in the intervention. The pre-post boundary for the comparison group will be defined through the matching process, which uses a person-month matching frame for matching against the "person-months" associated with entry into the intervention by persons comprising the treatment group. This approach leverages the richness of the State's integrated data environment and design of its analytical data infrastructure, which support data management techniques that scan all relevant persons at all relevant points in time (months in this case) where they might be a "best" match to a person who entered the specific intervention under study. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. Outcome metrics and measurement approaches will be partially aligned with those used for determining ACH performance payments, where feasible.

In response to comments received on the prior draft of this document, we want to emphasize the appropriateness (and critical importance) of matching based on pre-treatment utilization patterns in evaluating many of the interventions supported by the Demonstration. Past utilization is not endogenous because it cannot be impacted by future treatment. The outcome of interest is future (that is, post treatment entry) utilization, not past utilization. Future utilization is never appropriate for inclusion in the matching process, while past utilization patterns can be essential to control for when interventions are targeted specifically based on prior risk or service utilization patterns, as will likely be the case in many care coordination, care transition, and diversion projects. Controlling for past utilization is one of the key ways to ensure that treatment and comparison groups do not have embedded within them differential expected levels of regression to the mean in utilization and cost metrics.

Data gap identification for each component of evaluation. Evaluation activities will ensure that data will be collected for all Demonstration projects as needed to facilitate the dissemination and comparison of valid quantitative data. Gaps in the extant data sources available to complete proposed evaluation activities will be identified and addressed. Currently known gaps, and the strategies to collect the necessary data, are summarized below:

- Qualitative data necessary for formative evaluation and support of the interpretation of quantitative findings will be collected using methods such as focus groups, key informant interviews, and surveys of beneficiaries and providers.
- New survey data will mitigate the impact on the evaluation of the absence of comparable health service utilization data for non-Medicaid clients, and lack of LTSS-related functional assessment data for Medicaid clients not receiving LTSS services, in the evaluation of the MAC and TSOA programs.
- Qualitative data related to health IT adoption and use by providers, who are and are not eligible for the Medicaid EHR Incentive Program, workforce supports needed to support adoption and use, and barriers to use.
- ACHs may be required to regularly report patient and/or provider rosters associated with specific projects, if that information cannot be obtained through regularly collected claims or encounter data. Reporting of this information may be considered as a potential component of "pay for reporting" criteria of the ACH performance payment formula.

Assessment of data limitations and threats to internal validity and generalizability outside of the Washington State environment. Evaluation products will include an assessment of threats to validity and generalizability. From the perspective of internal validity, a key potential threat is the presence of selection bias in the engagement of beneficiaries in specific projects, in the absence of randomized trial designs for project implementation. Although the propensity matching approach is recognized as a valid evaluation design, frequently accepted in the peer-reviewed program evaluation literature, the approach may not fully mitigate the threat of selection bias. In implementing this design, it will remain critical to understand the process that "selects" clients into projects and to use this knowledge to define a credible "matching frame" for each project.

In particular, we note that the specification of the structure of the matching model can have a large effect on the estimated program impact. For example, if selection into a project is tied to a specific pattern of service delivery (e.g., release from a hospital), or due to extreme baseline utilization, then ensuring that the matched comparison group has a similar "trajectory" of service use into the boundary of the pre/post periods will be critical. The richness of the administrative data available to the evaluation team will help reduce the selection bias threat, by moving more client characteristics from the "unobservable variable" column to the "observable variable" column, including the trajectory of prior health service utilization in the baseline period used for matching.[12] The recent evaluation of the State's "Money Follows the Person" program (Roads to Community Living) illustrates the criticality of matching on pre-period utilization trends in the context of interventions that target clients with specific pre-period utilization patterns. In the context of the RCL evaluation, the intervention requires a pattern of prior nursing facility utilization and client interest in community re-integration. The target population would tend to show significant regression to the mean (future reductions) in LTSS expenditures in the absence of any intervention. Comparing the intervention group against the experience of the broader nursing facility population would vastly overstate RCL program treatment effects. The chart on page 5 of the report referenced below illustrates this phenomenon, and the importance of matching on prior service utilization trends leading into the pre/post time boundary.[13]

Another threat to the internal validity of evaluation findings will be the challenge of controlling for all potential confounding interventions and policy changes – in particular the potential for beneficiaries to experience multiple overlapping treatment effects, both from other Demonstration projects and from other initiatives occurring simultaneously to the Demonstration. This risk will be mitigated through the development and maintenance of the statewide beneficiary project attribution model, as described above. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs.

The threats to the generalizability of project impact findings include the following considerations. First, conditions may be different in Washington State than in other states to which Demonstration-supported interventions might be extended. For example, Washington State has a highly rebalanced Medicaid LTSS delivery system, which has already achieved significant rebalancing of care from institutions to home and community settings. Second, variation in local conditions across Washington State may make it more challenging to generalize the effect of ACH-specific initiatives to other regions of the state. Required evaluation deliverables will speak to the potential to generalize findings outside of the Washington State environment.

[12] For a recently published example of an impact analysis using propensity matching and leveraging detailed information on the trajectory of prior health service utilization, see: https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-8-33.pdf.

[13] See: https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-8-33.pdf.

Section 4. Process to Select an Outside Contractor

Required qualifications. Washington will select an independent external evaluator that has the expertise, experience, and impartiality to conduct a sophisticated program evaluation that meets all requirements specified in the Special Terms and Conditions including specified reporting timeframes. Required qualifications and experience include multi-disciplinary health services research skills and experience; an understanding of and experience with the Medicaid program; familiarity with Washington State Medicaid programs and populations; experience assessing the ability of health IT ecosystems to support delivery system and payment reforms, including issues related to governance, financing, policy/legal issues and business operations; and experience conducting complex, multi-faceted evaluations of large, multi-site health and/or social services programs.

Potential evaluation entities will be assessed on their relevant work experience, staff expertise, data management and analytic capacity, experience working with state agency program and research staff, proposed resource levels and availability of key staff, track record of related publications in peer-reviewed journals, and the overall quality of their proposal. Proposed deliverables must meet all standards of leading academic institutions and academic journal peer review. In the process of identifying, selecting, and contracting with an independent external evaluator, the State will act appropriately to prevent a conflict of interest with the independent external evaluator. The independent external evaluator will have no affiliation with ACHs or their providers.

Cooperation with potential federal evaluator. Should CMS undertake an independent evaluation of any component of the demonstration, the state shall cooperate fully, to the greatest extent possible, with CMS or the evaluator selected by CMS. To promote efficiency, consistency, and best practices, the State independent external evaluator and any CMS evaluator will share data sources and methodology. There may be cases where the State and CMS evaluator choose to focus in different areas or pursue different modeling and statistical techniques. This will lead to a fuller and more nuanced understanding of the success and challenges of the Demonstration, as long as, both approaches fully consider the unique systems and experience in Washington State.

Collaboration with state agency program and research staff. The core evaluation, to be completed by the independent external evaluator, will include all elements required in the STCs. The state plans to fully leverage the independent evaluation to inform and support implementation, to develop internal reporting capability, to share lessons learned across projects and geography. To ensure that the evaluation work can be fully leveraged by the State; the independent external evaluator will be expected to consult extensively with State research staff to ensure agreement on scope, approach, and interpretation of the Washington context. Careful consultation will be essential to develop an evaluation that is responsive to the Washington experience, while identifying generalizable results.

The independent external evaluator will lead the evaluation and ultimately be responsible for the validity, reproducibility, and interpretation of the results. The State's role is to provide extensive guidance on unique aspects of the State's health system; health system participants; data availability, content, and interpretation; information flows; history and context of service provision, etc. The State will provide guidance on its needs and use cases for materials and results produced for the evaluation. The State will use its expertise and experience to provide the independent external evaluator with model identification and application within the Washington context. While all aspects of the evaluation plan outlined here will be the responsibility of the independent external evaluator, the State will participate in and conduct its own ongoing analysis and evaluation to support success across the Domains of the Demonstration.

The state plans to provide extensive consultation and data support for the independent external evaluator. The independent external evaluator will receive reports described in the STC under section 37 including bi-annual milestone and metric reports submitted by ACHs, quarterly DSRIP operational report protocols

submitted by the state, and additional progress milestones for at risk projects. The independent external evaluator will conduct ongoing analyses of these data to inform both the interim and final evaluation reports.

Budget for the independent external evaluator evaluation activities. The total budget for the independent external evaluator is estimated to be over $4 Million for four years (Jan 1, 2018 through Dec 31, 2021). The estimated budget amount will cover all evaluation expenses, including salary, fringe, administrative costs, other direct costs such as travel for data collection, conference calls, etc., as well as, all costs related to quantitative and qualitative data collection and analysis, and report development. More detail and justification for proposed costs will be provided through the independent external evaluator selection process.

The state will also budget for sufficient state agency staff, at both HCA and DSHS, to efficiently and effectively support the independent external evaluator. State support will be similar to the level needed to undertake evaluation on its own. That is, state data, analytic, and research staff will have to undertake data gathering, prepping, and submitting in line with the research goals and objectives. State researchers will provide technical assistance, will create intermediate data products, will share their in-depth knowledge of existing state programs; state populations; Medicaid operations; and will leverage existing relationships with partner organizations. They will also provide information on state IT, local and provider information technology systems as well; data structures, collections, definitions; and compliance with state policies such as privacy and security.

The state will select and enter into a contract with an independent entity to conduct the evaluation of the Demonstration to meet the following timeframes and deliverables.

TABLE 2.
Evaluation Deliverables and Timeline

Deliverable	Responsible Party (from to)	Date
Draft Evaluation Design	State	May 9th, 2017
– Comments from CMS	CMS	60 days from receipt
– Final evaluation design	State	60 days from receipt
DSRIP Deliverables		DY 2, 3, 4, and 5
Quarterly progress reports from independent external evaluator to include quarterly activities, data analysis, reflections and insight on the implementation of projects drawing on key informant interviews, document review, meetings attended, and activity review.	Independent External Evaluator (IE) to State	One month prior to State quarterly and annual reports.
State progress reports will include information on submittals from IE and progress of evaluation.	State to CMS	Include in Quarterly and Annual reports
Semi-annual milestone and metric reports submitted by ACHs, including any additional milestones reported for at-risk projects	ACHs to State/State to IE	Twice a year or according to established schedule
Quarterly DSRIP operational report protocols	State to IE	All available and then quarterly starting with IE contract initiation.
Health IT (STC39)	State to CMS	Quarterly

Deliverable	Responsible Party (from to)	Date
Specification for data required from state including a timeline, data gap analysis, and plan to address data gaps.	IE to State	DY2, Q3
Quarterly, semi-annual, and annual metric updates (depending on metric frequency) for P4P measures	State to IE	Quarterly starting DY 2, Q3
Receipt of annual data submissions from state to support baseline analysis	State to CMS	Annually starting DY 2, Q4
Focus groups and key informant interviews to create baseline information for qualitative analysis	IE to State	90 days after submittal of detailed project plans
Analysis of (2017) baseline state metrics and data	IE	DY 3, Q1
Analysis of VBP materials including existing survey results, data, key informant interviews, and focus groups to create a baseline line assessment of VBP readiness and use in contracting both at the plan and provider level.	IE to State	DY 3, Q1 90 days after receiving focus group data
Review and synthesize documents, data, focus groups, and key informant interviews on baseline workforce capacity	IE to State	DY 3, Q1 90 days after receiving focus group data
Review and synthesize documents, data, focus groups, and key informant interviews on baseline ability and readiness of state HIT/HIE to support health system transformation	IE to State	DY 3, Q1 90 days after receiving focus group data
Qualitative analysis of other aspects of program implementation and operations	IE to State	DY 3, Q1 90 days after receiving focus group data
Identification and baseline analysis of high risk populations expected to be significantly impacted by Demonstration initiatives.	IE to State	DY 3, Q1
Quantitative baseline analysis of overall target populations at the state and ACH levels.	IE to State	DY 3, Q2
Quantitative analysis of project target populations both within and across ACHs.	IE to State	DY 3, Q2
Rapid cycle implementation reports	Joint IE/State products	To be included in quarterly reports to start 90 days after implementation. Quarterly starting DY 3, Q1
Evaluation of specific projects implemented under all three initiatives. Both ACH specific results and Statewide implementation.	IE to State	DY 4, Q1 preliminary results DY 5, Q4 final results
Focus groups and key informant interviews to assess impact of Demonstration on all initiatives	IE to State	DY4, Q2
Focus groups and key informant interviews to assess impact of Demonstration on all initiatives	IE to State	DY 5, Q2

Deliverable	Responsible Party (from to)	Date
Analysis of VBP materials including provider survey results, key informant interviews, and focus groups to assess impact of Demonstration activities on VBP readiness, adoption, and use in contracting both at the plan and provider level.	IE to State	90 days after receiving focus group data (target date DY 5 Q4)
Analyze documents, data, focus groups, and key information interviews to assess Demonstration impact on healthcare workforce capacity	IE to State	90 days after receiving focus group data (target date DY 5 Q4)
Analyze documents, data, focus groups, and key information interviews to assess impact of Demonstration on HIT/HIE investments, use, and impact on health system transformation	IE to State	90 days after receiving focus group data (target date DY 5 Q4)
Qualitative analysis of other aspects of program implementation and operations	IE to State	90 days after receiving focus group data (target date DY 5 Q4)
Draft Interim Evaluation Report	State	April 3rd, 2021
– CMS comments	CMS	TBD
– Final interim evaluation report	State	60 days from receipt of CMS comments
Draft Final Evaluation Report	State	January 30th, 2022
– CMS comments	CMS	TBD
– Final evaluation report	State	60 days from receipt of CMS comments

The independent external evaluator will provide additional analyses and reporting to enable Washington to fully leverage the work of evaluation to inform and improve the implementation of the initiatives under the Demonstration. For this reason, the evaluation will need to be undertaken in stages, with reports and information being produced for internal stakeholders at each stage. Early work will focus on qualitative data gathered from focus groups, key informant interviews, and surveys. As the implementation progresses, analysis and reports will move towards impact and outcomes. Washington will also be interested in an evaluation of the effectiveness of our measurement process and incentive payments in promoting effective project selection and implementation, and the extent to which measure selection promoted a positive impact on the targeted populations.

Washington is undertaking an ambitious set of Medicaid innovation initiatives to continue and build upon current success in transforming the way health services are provided. Washington seeks an independent external evaluator who has the capacity and vision to pursue publication of results in peer reviewed journals. Washington is committed to the value of sharing both positive and negative experiences with innovation in order to inform the broader health care transformation effort.

Project 2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation (Required)

Component	Description
Goals and objectives	Through a whole-person approach to care, address physical and behavioral health (BH) needs through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need.
Target populations	All Medicaid beneficiaries (children and adults) particularly those with or at-risk for behavioral health conditions, including mental illness and/or substance use disorder (SUD).
Evaluation questions and testable hypotheses	Evaluation questions pertain to understanding whether projects undertaken to better integrate the delivery of physical and behavioral health services: • Increase screening and identification of need for behavioral and physical health care services • Increase access to and engagement in treatment for BH conditions • Improve quality of care for behavioral and physical health conditions • Improve patient behavioral and physical health outcomes • Reduce disparities in health and social outcomes for persons with behavioral health risk factors • Reduce inpatient, psychiatric inpatient, and ED utilization Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will use MMIS-derived physical, behavioral health, and LTSS service utilization data, LTSS assessment data, and linked "social determinant" outcome data. Data are routinely collected through the operation of existing data interfaces, and is generally linked (collected into) into the State's integrated client data environment on a quarterly basis. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.

Component	Description
Measures	Measures derived from administrative data sources in the State's integrated client data environment will include: • Measures of health service utilization and cost, including ED visits, inpatient admissions, LTSS utilization and overall Medicaid expenditures • Access to mental health and substance use disorder treatment • Other health care quality measures (e.g., psychotropic medication adherence, comprehensive diabetes care) Specific examples of potential measures include (but are not limited to): • Outpatient Emergency Department Visits per 1000 Member Months • Inpatient Admissions per 1,000 Member Months • Plan All-Cause 30-Day Readmission Rate • Psychiatric Hospital 30-Day Readmission Rate • Antidepressant Medication Management • Child and Adolescents' Access to Primary Care Practitioners • Comprehensive Diabetes Care: Eye Exam (Retinal) Performed • Comprehensive Diabetes Care: Medical Attention for Nephropathy • Medication Management for People with Asthma (5 to 64 Years) • Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence • Follow-up After Hospitalization for Mental Illness • Mental Health Treatment Penetration (Broad Version) • Substance Use Disorder Treatment Penetration Analyses may also consider impacts on social outcomes including measures of homelessness and housing stability; employment, hours worked, and earnings levels; and criminal justice involvement (arrests). Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for many of the state-developed outcome measures are provided in Appendix 2.
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care contracts. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will

Component	Description
	draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Provider capacity to effectively deliver integrated care • Implementation fidelity to adopted models of integration (e.g., Bree Collaborative recommendations, Collaborative Care Model principles) • The adoption of EHRs and other systems that support bi-directional data sharing • The extent of clinical-community linkages • Communication flows among care team members • Adoption of care coordination and management processes • Supply of mental health providers, substance use disorder providers, social workers, nurse practitioners, primary care providers • Opportunities for use of telehealth • Workflow changes to support integration of new screening and care processes, care integration, communication • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatments
Subgroup analyses to assess disparities and differences	Analyses will be conducted to assess variation in outcome measures across groups with a history of significant differences and disparities in beneficiary experience. For example, the underlying rationale for prioritizing projects addressing bi-directional integration of physical and behavioral health care includes the observation that there are extreme rates of inpatient and ED utilization for Medicaid beneficiaries with serious mental illness and/or substance use disorders. Adult Medicaid beneficiaries with co-occurring mental illness and SUD experience inpatient hospitalizations and ED utilization at about 3 times the rate observed in the general medical population, and experience similar disparities in rates of arrest and homelessness. Other notable disparities include differences in measures of access and/or quality of care across racial and ethnic groups, between urban and rural/frontier regions of the state, and between persons with significant functional impairments receiving LTSS services and other Medicaid beneficiaries. Based on these considerations, we expect subgroup analyses to assess disparities in access to services and outcomes to include analysis of variation in beneficiary outcomes by: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier) • Behavioral health risk characteristics: severity of mental illness, SUD, co-occurring mental illness and SUD • Presence of physical comorbidities or need for functional supports

Project 2B: Community-Based Care Coordination (optional).

Component	Description
Goals and objectives	Promote care coordination across the continuum of health services for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.
Target populations	Medicaid beneficiaries (adults and children) with one or more chronic disease or condition, or mental illness, or substance use disorder and at least one risk factor (e.g., unstable housing, food insecurity, high EMS utilization).
Evaluation questions and testable hypotheses	General hypothesis—Care coordination is essential for ensuring that children and adults with complex health needs are connected to evidence-based interventions and services that will improve their outcomes. A hub-based (or similar) model provides a platform for communication among multiple care providers, so that each is able to work in a more coordinated fashion. Specific hypotheses - Implementation of a hub-based coordination model is expected to: • Increase access to and engagement in treatment for those with complex and/or co-occurring conditions • Improve quality of care for behavioral and physical health conditions • Improve patient behavioral and physical health outcomes • Reduce disparities in health and social outcomes for persons with behavioral health risk factors and persons needing functional supports • Reduce inpatient, psychiatric inpatient, and ED utilization • Improve access to Home and Community-based LTSS services Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will use MMIS-derived physical, behavioral health, and LTSS service utilization data, LTSS assessment data, and linked “social determinant” outcome data. Data are routinely collected through the operation of existing data interfaces, and is generally linked into the state’s integrated client data environment on a quarterly basis. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.

Component	Description
Measures	Measures derived from administrative data sources in the state's integrated client data environment will include: • Measures of health service utilization and cost, including ED visits, inpatient admissions, LTSS utilization and overall Medicaid expenditures • Access to mental health and substance use disorder treatment • Other health care quality measures (e.g., psychotropic medication adherence, comprehensive diabetes care) Specific examples of potential measures include (but are not limited to): • Outpatient Emergency Department Visits per 1000 Member Months • Inpatient Admissions per 1,000 Member Months • Plan All-Cause 30-Day Readmission Rate • Psychiatric Hospital 30-Day Readmission Rate • Antidepressant Medication Management • Child and Adolescents' Access to Primary Care Practitioners • Comprehensive Diabetes Care: Eye Exam (Retinal) Performed • Comprehensive Diabetes Care: Medical Attention for Nephropathy • Medication Management for People with Asthma (5 to 64 Years) • Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence • Follow-up After Hospitalization for Mental Illness • Mental Health Treatment Penetration (Broad Version) • Substance Use Disorder Treatment Penetration • Percent Homeless (Narrow Definition) • Percent Employed (Medicaid) • Home and Community-based Long Term Services and Supports Use • Skilled Nursing and Rehabilitation Facility Use Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for state-developed outcome measures are provided in Appendix 2.
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes.

Component	Description
	Qualitative analysis. A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address issues such as: • Implementation fidelity to the adopted evidence-based care coordination approach (e.g., Pathways Community HUB) • Adequacy of procedures used to identify risk factors • Identification of evidence-based and best practice interventions • Capability of EHRs and other technologies used for identifying high-risk populations, linking to services, tracking beneficiaries, and documenting outcomes • Capacity and shortages for workforce to implement the selected care coordination focus areas • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery
Subgroup analyses to assess disparities and differences	Analyses will be conducted to assess variation in outcome measures across groups with a history of significant differences and disparities in beneficiary experience. Understanding variation in the ability of care coordination interventions to engage and impact outcomes for different populations is an important consideration in assessing the success and extensibility of ACH interventions. Subgroup analyses to assess disparities in outcomes may include: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier) • Type of risk factors, physical health conditions, behavioral health conditions, need for LTSS supports

Project 2C: Transitional Care (optional).

Component	Description
Goals and objectives	Improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.
Target populations	Medicaid beneficiaries in transition from intensive settings of care or institutional settings, including beneficiaries discharged from acute care to home or to supportive housing, and beneficiaries with SMI discharged from inpatient care, or clients returning to the community from prison or jail.
Evaluation questions and testable hypotheses	General hypothesis—Points of transition out of intensive services/settings and into the community are critical intervention points in the care continuum. Individuals discharged from intensive settings may not have a stable environment to return to or may lack access to reliable care. More intensive transitional care and care management can improve access to care for these individuals and reduce avoidable hospital utilization. Specific hypotheses—Implementation of enhanced transitional care is expected to: • Increase access to and engagement in community-based treatment for physical and behavioral health conditions

	• Reduce inpatient admissions, psychiatric inpatient admissions, ED utilization, and institutional stays • Improve access to Home and Community-based Long Term Services and Supports Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will use MMIS-derived physical, behavioral health, and LTSS service utilization data, LTSS assessment data, and linked "social determinant" outcome data. Data are routinely collected through the operation of existing data interfaces, and are generally linked into the state's integrated client data environment on a quarterly basis. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Measures	Measures derived from administrative data sources in the state's integrated client data environment will include: • Measures of health service utilization and cost, including ED visits, inpatient admissions, LTSS utilization and overall Medicaid expenditures • Access to mental health and substance use disorder treatment • Other health care quality measures (e.g., psychotropic medication adherence, comprehensive diabetes care) Specific examples of potential measures include (but are not limited to): • Outpatient Emergency Department Visits per 1000 Member Months • Inpatient Admissions per 1,000 Member Months • Plan All-Cause 30-Day Readmission Rate • Psychiatric Hospital 30-Day Readmission Rate • Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence • Follow-up After Hospitalization for Mental Illness • Percent Homeless (Narrow Definition) • Home and Community-based Long Term Services and Supports Use Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for many of the state-developed outcome measures are provided in Appendix 2.

Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Implementation fidelity to the adopted evidence-based or evidence-informed approaches to transitional care (e.g., INTERACT, TCM, CTI, APIC Model) • Capacity of population health management/HIT systems to effectively deliver care transition services • Workforce capacity and shortages • Workflow changes to support integration of care transition processes and communications • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery
Subgroup analyses to assess disparities and differences	Subgroup analyses to assess disparities in access to services and outcomes may include, depending on the specific populations targeted by the selected transitional care initiatives: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier) • Delivery system affiliation (e.g., transfers from Acute inpatient care, SNF, inpatient psychiatric care, prison, or jail • Chronicity of housing instability • Extent of prior criminal justice involvement

Project 2D: Diversion Interventions (optional).

Component	Description
Goals and objectives	Implement diversion strategies to: (1) promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, and (2) redirect low-level offenders engaged in drug or prostitution activity to community-based services, instead of jail and prosecution.

Component	Description
Target populations	Medicaid beneficiaries presenting at the ED for non-acute conditions, Medicaid beneficiaries who access the EMS system for a non-emergent condition, and Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement.
Evaluation questions and testable hypotheses	General hypothesis—Diversion strategies provide opportunities to re-direct individuals away from high-cost medical and legal avenues and into community based health care and social services that can offer comprehensive assessment, care/case planning and management to lead to more positive outcomes. Specific hypotheses—Implementation of these diversion strategies is expected to: • Reduce ED utilization • Improve access to primary care • Improve access to behavioral health services • Reduce homeless rates • Reduce arrest rates Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will use MMIS-derived physical, behavioral health, and LTSS service utilization data, LTSS assessment data, and linked "social determinant" outcome data. Data are routinely collected through the operation of existing data interfaces, and is generally linked into the State's integrated client data environment on a quarterly basis. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Measures	Measures derived from administrative data sources in the State's integrated client data environment will include: • Measures of health service utilization and cost, including ED visits, inpatient admissions, and overall Medicaid expenditures • Access to mental health and substance use disorder treatment • Social outcomes including homelessness and criminal justice involvement Specific examples of potential measures include (but are not limited to): • Percent Homeless (Narrow Definition)

Component	Description
	• Percent Arrested • Outpatient Emergency Department Visits per 1000 Member Months • Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence • Adult Access to Preventive/Ambulatory Care • Mental Health Treatment Penetration (Broad Version) • Substance Use Disorder Treatment Penetration Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for many of the state-developed outcome measures are provided in Appendix 2.
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Implementation fidelity to evidence-supported diversion strategies • Willingness and readiness of stakeholders to participate • Potential shortages of community health workers, social workers, mental health providers, substance abuse disorder providers. • Ability to use electronic health records (EHRs) and Health Information Exchange (HIE) systems to facilitate communication between emergency departments, community paramedics and other health care providers • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery
Subgroup analyses to assess disparities and differences	Subgroup analyses to assess disparities in access to services and outcomes may include, depending on the specific populations targeted by the selected diversion initiatives: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier)

Component	Description
	• Functional risk factors (presence of behavioral risks, severity of physical comorbidities) • Extent of prior criminal justice involvement • Chronicity of housing instability

Project 3A: Addressing the Opioid Use Public Health Crisis (required).

Component	Description
Goals and objectives	Reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, overdose prevention, and recovery supports. Selected specific objectives include: • Reducing opioid use through prevention measures (e.g., adherence to opioid prescribing guidelines, Prescription Drug Monitoring Program promotion) • Increasing opioid use disorder treatment capacity (e.g., numbers of providers certified to prescribe medication-assisted therapies, innovative use of telehealth in rural areas) • Identifying and treating opioid use disorder among pregnant women • Increasing treatment engagement (e.g., promoting projects that offer low barrier access to buprenorphine in emergency departments, correctional facilities, syringe exchange programs, SUD and mental health programs) • Preventing overdoses (e.g. increased availability of naloxone)
Target populations	Medicaid beneficiaries, including youth, who use, misuse, or abuse, prescription opioids and/or heroin.
Evaluation questions and testable hypotheses	Implementation of strategies to reduce opioid-related morbidity and mortality is expected to: • Reduce opioid-related deaths • Reduce non-fatal overdose involving prescription opioids • Increase substance use disorder treatment penetration among opioid users • Reduce the number of patients on high-dose chronic opioid therapy • Increase the numbers receiving Medication Assisted Therapy (MAT) with Buprenorphine and Methadone Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will use MMIS-derived physical, behavioral health, and LTSS service utilization data, LTSS assessment data, and linked “social determinant” outcome data. Data are routinely collected through the operation of existing data interfaces, and is generally linked into the State’s integrated client data environment on a quarterly basis. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data

	collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Measures	Measures derived from administrative data sources in the State's integrated client data environment will include: • Opioid Related Deaths (Medicaid Enrollees and Total Population) per 100,000 covered lives • Non-fatal overdose involving prescription opioids per 100,000 covered lives • Substance Use Disorder Treatment Penetration, by type of treatment, for persons with opiate use disorder • Outpatient Emergency Department Visits per 1000 Member Months • Inpatient Admissions per 1,000 Member Months Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for many of the state-developed outcome measures are provided in Appendix 2.
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Enhancements in EHRs and other systems to support clinical decisions in accordance with guidelines • Efforts to increase use of the Prescription Drug Monitoring Program (PDMP) • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery • Results of integrating telehealth approaches

	• Effectiveness of structural supports (e.g. case management capacity, nurse care managers, integration with substance use disorder providers) to support medical providers to implement and sustain medication assisted treatment
Subgroup analyses to assess disparities and differences	Subgroup analyses to assess disparities in access to services and outcomes may include: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier) • Nature of opioid use (heroin injection, prescription opioids) • Presence of co-occurring mental illness, physical comorbidities and functional support needs • Extent of homelessness • Extent of prior criminal justice involvement In response to feedback on the initial evaluation design submission, we note that persons with opiate use disorders (and, more generally, persons with substance use disorders) have extremely high rates of homelessness and criminal justice involvement, relative to the general Medicaid population. As such, understanding the impact of opioid-related initiatives on populations with a history of prior homelessness or criminal justice involvement is of particular concern, as these beneficiaries are at high risk of experiencing adverse future outcomes.

Project 3B: Reproductive and Maternal/Child Health (optional).

Component	Description
Goals and objectives	Broad objective—Ensure that women have access to high quality reproductive health care throughout their lives and promote the health and safety of Washington's children. Specific objectives include: • Ensuring that families have intended and healthy pregnancies that lead to healthy children by promoting utilization of effective reproductive health strategies, healthy behaviors and risk reduction, effective contraceptive use, safe and quality prenatal and perinatal care, and general preventive care • Promoting healthy pregnancy and parenting through evidence-based home visiting models for pregnant high-risk mothers. • Improving child health through improving regional well-child visit rates and childhood immunization rates.
Target populations	Medicaid beneficiaries who are women of reproductive age, pregnant women, mothers of children ages 0-3, and children ages 0-17.
Evaluation questions and testable hypotheses	Implementation of strategies related to reproductive health and maternal/child health are expected to: • Reduce rates of teen pregnancy • Reduce the number of unintended pregnancies • Reduce the rate of low-birth weight deliveries • Increase substance use disorder treatment penetration among pregnant women • Increase Well-Child Visit rates among infants and young children

Component	Description
	• Increase rates of Chlamydia Screening • Improve access to effective contraceptive care (including LARC) • Increase childhood immunization rates Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will primarily use MMIS-derived physical and behavioral health data, and vital records (birth certificates from the Department of Health Center for Health Statistics individually linked to Medicaid clients in the First Steps Database, a component of the ICDB). Data are routinely collected through the operation of existing data interfaces, and is generally linked into the State's integrated client data environment on a quarterly basis. Measures related to unintended pregnancy and immunization rates will use Department of Health's the Pregnancy Risk Assessment Monitoring System (PRAMS) survey and immunization registry data, respectively. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Measures	Measures derived from administrative and PRAMS survey data sources in the State's integrated client data environment will include: • Rate of Teen Pregnancy (15 – 19) • Rate of Unintended Pregnancies (PRAMS survey) • Rate of Low Birth Weight Births • Prenatal care in the first trimester of pregnancy • Mental Health Treatment Penetration (Broad Version) • Substance Use Disorder Treatment Penetration • Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life • Well-Child Visits in the First 15 Months of Life • Chlamydia Screening in Women Ages 16 to 24 • Contraceptive Care – Most & Moderately Effective Methods • Contraceptive Care – Access to LARC • Contraceptive Care – Postpartum • Childhood Immunization Status

Component	Description
	Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for many of the state-developed outcome measures are provided in Appendix 2.
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Fidelity to evidence-based models (e.g., Nurse Family Partnership, Bright Futures) • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery • Barriers to increasing immunization rates • Adoption of evidence-based interventions to reduce substance abuse during pregnancy
Subgroup analyses to assess disparities and differences	Subgroup analyses to assess disparities in access to services and outcomes may include, depending on the specific projects designed in this domain: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier) • Behavioral health risk factors (e.g., maternal depression, other maternal mental illness conditions, substance use during pregnancy)

Project 3C: Access to Oral Health Services (optional).

Component	Description
Goals and objectives	Increase access to oral health services to prevent or control the progression of oral disease and ensure that oral health is recognized as a fundamental component of whole-person care.

Component	Description
Target populations	All Medicaid beneficiaries, especially adults.
Evaluation questions and testable hypotheses	The project focuses on providing oral health screening and assessment, intervention, and referral in the primary care setting, or through the deployment of mobile clinics and/or portable equipment. This is expected to increase access to oral health services for adults, improve prevention and control the progression of oral disease, and reduce reliance on emergency departments for oral pain and related conditions. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will use MMIS-derived physical, behavioral health, and dental service data. Data are routinely collected through the operation of existing data interfaces, and are generally linked into the State's integrated client data environment on a quarterly basis. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Measures	Measures derived from administrative data sources in the State's integrated client data environment will include: • Oral health services utilization among Medicaid beneficiaries • Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers • Outpatient Emergency Department Visits per 1000 Member Months • Ongoing Care in Adults with Chronic Periodontitis • Periodontal Evaluation in Adults with Chronic Periodontitis • Caries at Recall (Adults and Children) • Adult Treatment Plan Completed • Sealants - % Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk • Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for many of the state-developed outcome measures are provided in Appendix 2.

Component	Description
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Ability to elicit dental service provider participation • Shortages of dentist, hygienist, and other dental care providers, and primary care providers • Alignment between payment structures and the integration of oral health services • Referral relationships with dentists and other specialists, such as ENTs and periodontists • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery
Subgroup analyses to assess disparities and differences	Subgroup analyses to assess disparities in access to services and outcomes may include, depending on the specific projects designed in this domain: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier), including an assessment of regional variation in the supply of oral health providers • Factors such as behavioral health conditions and functional support needs that might affect ability to access dental services

Project 3D: Chronic Disease Prevention and Control (optional).

Component	Description
Goals and objectives	Integrate health system and community approaches to improve chronic disease management and control.
Target populations	Medicaid beneficiaries (children and adults) with, or at risk for, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity and stroke,

Component	Description
	with a focus on those populations experiencing the greatest burden of chronic disease(s) in the region.
Evaluation questions and testable hypotheses	The project focuses on integrating health system and community approaches to improve chronic disease management and control. Implementation of evidence-based guidelines and best practices for chronic disease care and management using the Chronic Care Model is expected to: • Improve the quality of care for chronic conditions • Improve patient outcomes • Reduce utilization of inpatient and emergency department services • Increase patient activation/confidence to self-manage chronic conditions Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will use MMIS-derived physical, behavioral health, and LTSS service utilization data, and LTSS assessment data. Data are routinely collected through the operation of existing data interfaces, and are generally linked into the State's integrated client data environment on a quarterly basis. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Measures	Measures derived from administrative data sources in the State's integrated client data environment may include (depending on region-specific target populations): • Outpatient Emergency Department Visits per 1000 Member Months • Inpatient Admissions per 1000 Medicaid Member Months • Child and Adolescents' Access to Primary Care Practitioners • Adult Access to Preventive/Ambulatory Care • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Medical attention for nephropathy • Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life • Well-Child Visits in the First 15 Months of Life • Medication Management for People with Asthma (5 – 64 Years)

Component	Description
	• Influenza Immunizations 6 months of age and older • Statin Therapy for Patients with Cardiovascular Disease • Adult Body Mass Index Assessment Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for many of the state-developed outcome measures are provided in Appendix 2.
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Fidelity to Chronic Care Model (CCM) guidelines • Ability of Health Information Technology systems to support data sharing, clinical-community linkages, timely communication among care team members, and care coordination and management processes • Shortages of Community Health Workers, Certified Asthma Educators, Certified Diabetes Educators, Home Health care Providers • Required workflow changes to support Registered Nurses and other clinical staff to be working to the top of professional licensure • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery
Subgroup analyses to assess disparities and differences	Subgroup analyses to assess disparities in access to services and outcomes may include, depending on the specific projects designed in this domain: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier) • Differences in selected target populations and chronic conditions

PROJECT-LEVEL DETAIL

Long Term Services and Supports (LTSS) - Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)

<table>
<tr><th>Component</th><th>Description</th></tr>
<tr><td>Goals and objectives</td><td>Providing limited-scope LTSS to individuals “at risk” for Medicaid – and to Medicaid beneficiaries who are not currently receiving Medicaid-funded LTSS – to avoid or delay eligibility for and use of full Medicaid LTSS benefits, while preserving quality of life for beneficiaries and reducing costs for the state and federal government.</td></tr>
<tr><td>Target populations</td><td>MAC. Eligible individuals for the MAC program include current Medicaid beneficiaries who are functionally eligible for LTSS, but have chosen to receive limited-scope services supporting an unpaid caregiver rather than traditional Medicaid-funded LTSS. Further eligibility criteria include:

Age 55 or older;
Eligible for Categorically Needy (CN) or Alternative Benefit Plan (ABP) services; and
Meet functional eligibility criteria for Nursing Facility Level of Care (NFLOC) as determined through an eligibility assessment.

TSOA. The demonstration establishes a new eligibility category for persons “at risk” of becoming eligible for Medicaid in order to access LTSS. This “At Risk” or “Tailored Supports for Older Adults” (TSOA) eligibility group is comprised of individuals who could receive Medicaid State Plan benefits under 42 CFR §435.236 and §435.217.Under the Demonstration, these persons may access a new LTSS benefit package designed to preserve quality of life while delaying increases in support needs (and the financial impoverishment) required for full Medicaid benefits. The individuals must:

Be age 55 or older;
Be a U.S. citizen or in eligible immigration status;
Not be currently eligible for CN or ABP Medicaid;
Meet functional eligibility criteria for NFLOC as determined through an eligibility assessment;
Be cared for by an unpaid caregiver in need of support services, or be an individual without a caregiver;
Have income up to 300% of the SSI Federal Benefit Rate.

To determine eligibility for TSOA services, the state will consider the income of the applicant, not their spouse/dependents, when determining if gross income is at or below the 300% SSI Federal Benefit Rate limit; and
To determine income, Washington will use the Social Security Income (SSI)-related income methodologies currently in use for determining eligibility for Medicaid LTSS. No post-eligibility treatment of income will apply and eligibility will be determined using only the applicant’s income. Like the MAC population, Washington will not apply post-eligibility treatment of income to the TSOA populations.

</td></tr>
</table>

Component	Description
	• Resource Limits -- Have countable resources below $53,100 for a single applicant and below $53,100 plus the state spousal resource standard for a married couple. • To determine resources, the State will us the Social Security Income (SSI)-related resource rules currently in use for determining eligibility for Medicaid LTSS with the following exceptions: a. Transfer of asset penalties do not apply b. Excess home equity provisions do not apply
Evaluation questions and testable hypotheses	Demonstration hypotheses (STC 108) associated with this initiative pertain to understanding the effects of modifying eligibility criteria and benefit packages for long-term services and supports, and assessing whether providing limited scope LTSS to individuals "at risk" for Medicaid – and to Medicaid beneficiaries who are not currently receiving Medicaid-funded LTSS – will avoid or delay eligibility for and use of full Medicaid LTSS benefits, while preserving quality of life for beneficiaries and reducing costs for the state and federal government. The domains of focus and associated research questions specified in STC 109 are: "What are the effects of modifying eligibility criteria and benefit packages for long-term services and supports?" Detailed project-level mapping of Initiative 2 research questions, testable hypotheses, data sources, and outcome metrics are provided in this section, and are not reproduced in Appendix 1. Specific testable hypotheses will include: • Do caregivers show change from baseline to 6-month follow-up in survey/self-report measures of: • Caregiving burden • Physical/mental health status • Quality of life • Do care receivers, including TSOA individuals without unpaid caregivers, show change from baseline to 6-month follow-up in survey/self-report measures of: • Physical/mental health status • Quality of life • Are caregivers and care receivers satisfied with their experience with the program? • Do MAC program participants show similar health outcomes to comparable recipients of traditional Medicaid LTSS services? • Following implementation of the MAC and TSOA programs, are Medicaid-paid LTSS cost trends lower than expected based on forecasts derived from baseline Medicaid-paid LTSS utilization rates and the observed changes in per cap costs and the composition of the Washington State population? Detailed mapping of research questions, outcome metrics, and data sources are provided in the sections below, and are not reproduced in Appendix 1.

Component	Description
Data strategy, sources and collection frequency	**Participant Self-Report Data.** Self-report data from Caregivers (CG) and care receivers (CR) to support evaluation of the MAC and TSOA programs will be collected from participants through two sources: (1) assessments (Tailored Caregiver Assessment and Referral (TCARE®) for caregivers and GetCare for persons without caregivers) and related administrative data and (2) surveys. These two data collection methods are complementary, as some data is best collected in the course of screening, establishing eligibility, service planning and periodic re-screening and re-assessment. Other data elements are best collected through survey methods. Self-report data to be collected are expected to include: • Opportunities and challenges encountered in program implementation (supporting formative evaluation); • Satisfaction with program participation; • Caregiver characteristics, perceived burdens, stressors, relationship with care receiver, quality of life, and physical/mental health issues; • Care receiver living situation, assistance needs, problematic behaviors, cognitive status, quality of life, and physical/mental health; • Values/preferences related to decision-making around these programs; • LTSS placement intentions; and • Qualitative descriptions of caregiver and care receiver experiences, in their own words. Self-report data will mitigate the impact on the evaluation of the absence of comparable health service utilization data for non-Medicaid clients, and lack of LTSS-related functional assessment data for Medicaid clients not receiving LTSS services. ***Self-Reported Administrative Assessment Data.*** IT systems used to administer the MAC and TSOA programs (e.g., TCARE and GetCare) are expected to collect information on a number of domains of interest for evaluation. These data are expected to be gathered by the program in the course of application, planning, and initial and ongoing screenings and assessments. Program IT systems will capture information for the universe of persons served, and are likely to be relied upon to support the range of potential subgroup analyses. In some cases, information captured by administrative data systems are collected at a time that best reflects the circumstances of caregivers and care receivers at the time of decision-making. Data will be collected initially at the time of initial application, screening and assessment. For those receiving ongoing services, re-screening will occur every 6 months and reassessment annually, allowing longitudinal analysis. The following measurement domains may be particularly informed by data gathered using program IT systems: • Caregiver characteristics, perceived burdens, relationship with care receiver, issues with caregiving, mental health indicators, and overall health status; • Care receiver living situation, assistance needs, problematic behaviors, cognitive status, and items related to physical/mental health; • LTSS placement intentions ***Survey Data.*** The primary purpose of the surveys will be to describe the experiences, outcomes, and conditions/circumstances of caregivers and care

Component	Description
	receivers participating in the programs. Survey instruments will be designed to complement the information available in administrative data, and collect additional key data and more in-depth information. Surveys can address questions beyond those involved in screening, establishing eligibility, and assessment. They allow more detailed answers, less opportunity for bias, and precise identification of respondent. The surveys will also collect early feedback on program implementation to support formative evaluation. Survey data are expected to be collected by the survey unit of the DSHS Research and Data Analysis Division (RDA), with the independent external evaluator having primary responsibility for analyzing the collected data. Data to be collected with these surveys are expected to include: • Opportunities and challenges encountered in program implementation (supporting formative evaluation); • Satisfaction with program participation; • Care receiver quality of life; • Values/preferences related to decision-making around these programs; • Qualitative descriptions of caregiver and care receiver experiences, in their own words; and • In-depth data regarding issues addressed in self-report data from assessments and related data (e.g., caregiver quality of life and LTSS placement intentions). **Survey 1.** In the winter of 2018 (at least 4 months after program implementation), RDA will conduct a survey to identify emerging issues from the perspective of caregivers and care receivers. This survey will also serve as a pilot test to refine procedures, survey questions, and data collection cost estimates for subsequent survey waves. Because the primary goal of this survey wave is rapid collection of qualitative data to support program implementation through formative evaluation, the sample size will be relatively small. RDA will complete at least 50 telephone interviews with enrolled CGs and 50 with CRs who have completed full intake assessments of each of the two programs (MAC and TSOA), with a planned total of 232 interviews (accounting for pretesting and expected differences in response rates). **Survey 2.** Between April 2018 and December 2018, RDA will survey a random sample of CG-CR dyads soon after they first receive services/benefits through MAC or TSOA. The time required for reliable identification of all beneficiaries is still unknown, but we anticipate contact attempts starting approximately 30 days after first receipt of benefits. Survey 2 will serve as a "baseline" for comparisons of measures representing the domains listed above. **Survey 3**. Between March 2019 and September 2019, RDA will conduct another survey targeting participants interviewed in Survey 2. Contact attempts will begin approximately 12 months after the Survey 2 interview date. Survey 3 will provide a second measurement point that will enable description of how CGs and CRs experience the effects of participation in the MAC and TSOA programs. **Survey design and sampling.** The study population for all three surveys will be caregiver/care receiver dyads enrolled in MAC and TSOA, or TSOA individuals who have a completed care plan to receive first-time stage 3 services. All survey samples will utilize random sampling, and will be stratified by program. If indicated

Component	Description
	by the pilot results and enrollee characteristics, additional stratification factors may be chosen for surveys 2 and 3. A primary purpose of Survey 1 is to obtain early feedback about implementation. For this reason, selection for survey 1 will focus on early enrollees who are new to LTSS. The specific selection criteria will depend on the pace of enrollment, characteristics and geographic dispersion of early enrollees, and availability of the sampling frame. In general, all members of a group with slowest enrollment will be selected sequentially until a target proportional to that population is reached. Other groups will be sampled systematically from a random start point, with every kth dyad selected according to an interval determined by the expected enrollment of each group over the time period required to complete the slowest group. Surveys 2 and 3 are planned as two longitudinal waves in which respondents to survey 2 will be re-interviewed for survey 3. Depending on pilot results, resources, project needs, we expect to augment survey 3 with a cross-sectional random sample. All participants interviewed in Survey 2 will be eligible to complete survey 3, including those who are no longer receiving services. Based on experience conducting surveys of similar populations, we estimate that 70% of CG/CR dyads can be contacted and will consent to take the survey in the first year, but 25% of CRs will be unable to complete an interview due to cognitive or physical limitations. We estimate 1-year attrition of up to 56%, based on a 2014 RDA analysis of TCARE assessment results for the Family Caregiver Support Program (FCSP). The final plan for survey 2 sample selection will be determined after evaluation of survey 1 results and enrollment patterns in Demonstration Year 1. Sample size estimates are based on paired t-test requirements for 90% power to detect differences of 1 SD ($p < .05$) in a population with $M = 0$ and $SD = 1$, plus a contingency adjustment of 1.25 (minimum $n = 30$ pairs for each combination of program (MAC or TSOA) and role (CG or CR). In the event of high attrition, augmenting the survey 3 sample with up to 170 additional participants with similar length of participation (85 CG-CR dyads) will allow equivalent power for cross-sectional (two-sample) t-test comparisons. Data will be weighted to reflect selection probabilities and (if needed) adjusted for nonresponse. **Assessment and mitigation of potential biasing factors.** In any longitudinal survey there is potential for bias if nonresponse is correlated with the measurements of interest. The abundance of administrative and program data will allow us to assess this potential in surveys 2 and 3 by analyzing the relationships between survey response and variables from the NFLOC prescreening and TCARE assessments, including but not limited to LTSS placement intentions, caregiver ratings of care receiver health and quality of life, caregiver health status and burdens experienced, and demographic characteristics. If these analyses indicate the potential for nonresponse bias, post-stratification weights will be constructed using the factors that are most strongly related to nonresponse. Weighted survey data will be analyzed using routines that adjust for complex designs using the Taylor series method or resampling methods for variance adjustment, such as SAS PROC SURVEYREG. **LTSS utilization and cost impact estimates.** These estimates will use Medicaid-paid LTSS cost and utilization data derived from ProviderOne and related service payment data, linked to Medicare Part A, B and D data for persons dually eligible

Component	Description
	for Medicare and Medicaid. As described in detail in Section 3, Medicaid data are routinely collected through the operation of existing payment processes, and is generally linked into the State's ICDB environment on a quarterly basis. Washington State is a national leader in the integration of Medicare data to support analytical and care management uses for dual eligibles. Medicaid-paid LTSS cost and utilization data will be combined with Washington State population data derived from US Census Bureau data products (e.g., the American Community Survey), as reflected in the County Population Estimation Model (CPEM) maintained by the OFM Forecasting and Research Division. The CPEM is expected to be updated by the end of CY 2017 with projections through at least 2025, with updates on an approximately annual basis as new American Community Survey data are released.
Measures	**Survey and administrative self-report measures.** As detailed above, administrative assessment data is expected to capture measures related to caregiver characteristics and issues; caregiver condition/circumstances, and LTSS placement intentions. Many of these measures are part of the evidence-based, validated TCARE® screening and assessment system, which has been a component of numerous recognized evidence-based assessments. Survey instruments will be designed to complement the information available in administrative data, and collect additional key data and more in-depth data. As detailed above, the first survey wave is designed to inform program implementation and operation, rather than to measure program impacts on caregiver and care receiver experiences and outcomes. Measures of participant experiences and potential impacts on quality of life, caregiver burdens and health, and participant satisfaction with program participation will be derived from data captured in the second and third survey waves, described above. The precise specifications of wave 2 and wave 3 survey instruments are expected to be determined in consultation with the independent external evaluator. **Comparisons between MAC clients and recipients of traditional Medicaid LTSS services.** This component of the evaluation will focus on health service utilization and related outcomes, including: • Outpatient Emergency Department Visits per 1000 Member Months (NCQA HEDIS® EDU or similar state-defined alternative) • Inpatient Admissions per 1,000 Member Months (NCQA HEDIS® IHU or similar state-defined alternative) • Plan All-Cause 30-Day Readmission Rate (NCQA HEDIS® PCR) • Nursing facility entry rate (state-defined measure derived from nursing home claim data currently integrated into the State's ICDB) • Mortality rates (state-defined measure derived from death certificate records currently integrated into the State's ICDB **Overall LTSS utilization and cost impact estimates.** Estimates of impacts on Medicaid-paid LTSS utilization and costs will be derived using the "synthetic estimation projection" approach described in the next section. This analysis will rely on measures of Medicaid-paid LTSS service costs and utilization derived from state agency administrative data, combined with Washington State population data derived from US Census Bureau data products (e.g., the American Community

Component	Description
	Survey), as reflected in the County Population Estimation Model maintained by the OFM Forecasting and Research Division.
Statistical framework for measuring impacts	**Survey and administrative assessment measures.** Due to the lack of data necessary to create a “comparison sampling frame” for persons meeting comparable eligibility criteria who do not engage in MAC or TSOA services, analysis of survey and assessment data will focus on levels and changes in measures for the intervention group between the second (baseline) and third survey waves described above. This is essentially a pre-test/post-test design, where we recognize that the pre-test survey wave will occur very early in the “treatment period” (e.g., approximately 30 days after first receipt of benefits). Analysis of administrative data from TCARE assessments and related sources will take a similar approach, with changes in caregiver and care receiver circumstances measured from their initial assessment through subsequent assessments. In the absence of comparison groups of similar caregiver and care receiver dyads not receiving MAC or TSOA services, analysis of administrative assessment data is likely to be used primarily to understand participant experiences and differences in experiences across populations. **Comparisons between MAC clients and recipients of traditional Medicaid LTSS services.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. An assessment of the difference between MAC clients and recipients of traditional Medicaid LTSS services will be conducted using difference-of-difference designs where appropriate, wherein the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. The matching process will leverage the available baseline assessment data for MAC clients and recipients of traditional Medicaid LTSS services. The pre-post boundary for each treatment group (MAC and traditional LTSS) will be based on the point at which they first engage in the intervention, with the imposition of a minimum prior period with no LTSS service receipt. The PS matching process will proceed through the following steps: • Examination of key baseline predictors of treatment entry within the pooled intervention and comparison matching frame to ensure inclusion of appropriate measurement dimensions in the PS model. This includes creating an extensive set of predictors that are determined, ex ante, to be potentially relevant to the matching process. This set of predictors is generally expected to span a wide range of the measurement domains contained with the State’s ICDB, which may include: • Service utilization data across Medicare and Medicaid funded delivery systems (physical, mental health, substance use disorder, long-term services and support, and developmental disability services);

Component	Description
	• Expenditure data at the "major modality" (e.g., IP hospitalization, OP ED visits, etc.) per-member per-month level; • Risk factors associated with chronic disease conditions, including mental illness and substance use disorders, derived from the CDPS and Medicaid-Rx risk models; • Data on functional support needs, cognitive impairment, and behavioral challenges from the client's initial LTSS assessment at the point of intake into the MAC or traditional LTSS service; • Client demographics (age, gender, race/ethnicity); • Medicaid enrollment by detailed coverage category; and • Urban/rural/frontier characteristics of the beneficiary's residential location. • Application of machine learning techniques (e.g., stepwise logistic or lasso regression) to determine the final propensity score model. • Propensity score matching using procedures in the R programming language (e.g., the Matchit procedure). Exact matching may be required for key variables (e.g., age and gender). As with all Demonstration initiatives, target populations are expected to partially overlap across projects and programs. The statewide project attribution data infrastructure will be leveraged to identify project participation longitudinally at the beneficiary level. Analyses may be limited to subpopulations of clients with "common support" across baseline matching criteria, and subpopulations not engaged in other Demonstration projects or other initiatives. This restriction has parallels to study enrollment restrictions commonly imposed in the randomized clinical trial context. The baseline period for construction of matching variables will typically be the prior 12 months, but may be of longer duration if information from prior periods is determined to be predictive of engagement in MAC or traditional LTSS services. Outcome periods will typically be periods comprised of one or more 12-month segments or intervals, depending on the length of available follow-up time. Impact will generally be estimated in a regression framework using SAS regression procedures and models including controls for baseline characteristics, notably including those characteristics on which exact matching is not imposed. The ICDB will be the data source all measurement within this component of the evaluation. As was discussed in more detail in Section 3, the ICDB is designed to support quasi-experimental evaluation of health and social service interventions in Washington State, has been widely used in evaluation studies published in peer-reviewed journals, and contains data from the administrative data systems, including Medicare Parts A, B, and D data and the State's ProviderOne MMIS data system, necessary to implement this component of the quantitative evaluation design. **Overall LTSS utilization and state and federal cost impact estimates.** Estimates of impacts on Medicaid-paid LTSS utilization and costs will be done using a "synthetic estimation projection" approach. This approach involves: • Measuring baseline SFY 2017 (pre-Demonstration) Medicaid-paid LTSS utilization in Washington State, by detailed demographic cells defined by age,

Component	Description
	gender, race/ethnicity, and income level as derived from ACS data for Washington State; • Applying these utilization rates to (1) observed changes in per cap (per service user per month)[14] costs by LTSS service modality and (2) the forecast demographic composition of the Washington State population based on a process maintained by the Governor's Office of Financial Management which leverages ACS data for Washington State; and • Comparing the actual levels of Medicaid-paid LTSS utilization and costs under the Demonstration, including the MAC and TSOA program costs, to the levels of utilization and costs projected from the synthetic estimation model derived from baseline utilization, the observed evolution of per cap LTSS costs, and forecast changes to the composition of the Washington State population.
Subgroup analyses to assess disparities and differences	The dimensions to be considered for analysis of disparities and differences in access to services and outcomes, to the extent feasible using available survey and administrative data, may include: • Age and gender • Race/ethnicity • Geography (urban/rural/frontier) • Functional risk factors (presence of cognitive impairment or dementia, behavioral risks, severity of physical comorbidities) • Care receiver relationship to caregiver • For the TSOA program, clients with caregivers relative to clients without caregivers

PROJECT-LEVEL DETAIL
Foundational Community Supports Program

Component	Description
Goals and objectives	Provide targeted community transition services, community support services, and supported employment services to help at-risk clients reside in stable community settings and gain and maintain stable employment, helping to improve beneficiary housing stability, employment outcomes, health outcomes, quality of life, and reduce Medicaid program costs.[15]
Target populations	Potential changes to the FCS protocol are currently being reviewed with CMS. This table references FCS program descriptions reflected in the originally approved STCs, for purposes of illustrating the proposed evaluation approach. The final evaluation approach will reflect the actual design of the implemented FCS program.

[14] These are per user per month costs by major LTSS service modality (nursing facility, in-home personal care, and community residential care) that are used as key components of the State's LTSS budget forecast, along with monthly caseload data. In other words, we expect to use the observed evolution of these LTSS cost parameters in this analysis.

[15] Potential changes to the FCS protocol are currently being reviewed with CMS. This document references FCS program descriptions reflected in the originally approved STCs, for purposes of illustrating the proposed evaluation approach. The final evaluation approach will reflect the actual design of the implemented FCS program.

Component	Description

	As with all Demonstration initiatives, target populations are expected to partially overlap across projects and programs. The statewide project attribution data infrastructure will be leveraged to identify project participation longitudinally at the beneficiary level. Analyses based on the propensity score matching approach may be limited to subpopulations of FCS clients with “common support” across baseline matching criteria, and subpopulations not engaged in other Demonstration projects or other initiatives. This restriction has parallels to study enrollment restrictions commonly imposed in the randomized clinical trial context.
	
	Eligible individuals include those who would be eligible under a section 1915(c) waiver program or a section 1915(i) state plan amendment and are determined to be require FCS services in order to obtain and maintain stable housing and/or employment.
	
	FCS is comprised of:
	• **Community Transition Services (CTS).** One-time supports designed to assist eligible clients transitioning out of institutional settings, or prevent eligible clients from entering institutional settings. Supports cover expenses necessary to enable an eligible client to obtain an independent, community-based living setting.
	• **Community Support Services (CSS).** Ongoing supportive services designed to support placement in an independent, community-based setting, as established in the eligible client’s needs assessment and individualized treatment plan.
	• **Supported Employment - Individual Placement and Support (IPS).** Ongoing supports to participants who, because of their disabilities, need intensive support to obtain and maintain employment in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.
	
	CTS eligibility criteria include Medicaid clients age 18 and older, who meet the following criteria:
	• But for the provision of such services, the client would require admission into an institutional setting, or,
	• Is transitioning out of an institutional setting and, but for the provision of such services, would not be able to access and maintain a community-based setting; and
	• Exhibits one or more of the following characteristics:
	  ◦ Chronically homeless, as defined by the US Department of Housing and Urban Development,
	  ◦ Frequent or lengthy institutional or residential care stays,
	  ◦ Frequent turnover of in-home caregivers, or
	  ◦ Has a Predictive Risk Intelligence System (PRISM) score of 1.5 or above
	
	PRISM integrates medical, behavioral health and long-term care data to assess an individual’s projected service needs. For the purposes of CTS, institutional settings include settings requiring a nursing facility level of care, inpatient medical hospitals, or inpatient behavioral health facilities.

Component	Description
	CSS eligibility criteria include Medicaid clients age 18 or older who are in need of Community Support Services, as determined by a functional needs assessment. The assessment must determine that one or more of the following characteristics are present: • Chronically homeless as defined by the US Department of Housing and Urban Development, • Frequent or lengthy institutional contacts as defined in the functional needs assessment, • Frequent or lengthy adult residential care stays as defined in the functional needs assessment, • Frequent turnover of in-home caregivers as defined in the functional needs assessment, or • Have a Predictive Risk Intelligence System (PRISM) Risk Score of 1.5 or above. IPS eligibility includes Medicaid clients age 16 or older who are in need of IPS, as determined by a functional needs assessment. The assessment must determine that one or more of the following characteristics are present: • Enrolled in the state Housing and Essential Needs (HEN) or Aged, Blind or Disabled (ABD) program • A diagnosed Serious and Persistent Mental Illness (SPMI) • Multiple instances of inpatient substance use treatment • Co-occurring mental and substance-use disorders • Working age youth, age 16 and older, with a behavioral health diagnosis • Receiving long-term services and supports
Evaluation questions and testable hypotheses	Demonstration hypotheses (STC 108) associated with this initiative pertain to understanding whether the provision of foundational community supports - supportive housing and supported employment - will improve health outcomes and reduce costs for a targeted subset of the Medicaid population. The domains of focus and associated research questions specified in STC 109 include assessing the effectiveness of the providing foundational community supports in terms of health, quality of life, and other benefits to the Medicaid program. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. The term “targeted subset” used in the STC refers to the targeted eligibility criteria associated with the FCS program, as indicated in the “target population” section immediately above. Again, we note that as with all Demonstration initiatives, target populations are expected to partially overlap across projects and programs. The statewide project attribution data infrastructure will be leveraged to identify project participation longitudinally at the beneficiary level. Analyses based on the propensity score matching approach may be limited to subpopulations of FCS clients with “common support” across baseline matching criteria, and subpopulations not engaged in other Demonstration projects or other initiatives. This restriction has parallels to study enrollment restrictions commonly imposed in the randomized clinical trial context. Evaluation questions pertain to understanding whether the provision of foundational community supports will improve health outcomes and reduce costs

Component	Description
	for a targeted subset of the Medicaid population. Specific testable hypotheses, as described in more detail in Appendix 1, will include: • Do CTS or CSS services reduce homelessness and increase housing stability? • Do IPS services increase employment rates and earnings levels? • Do CTS, CSS or IPS services reduce the risk of criminal justice involvement? • Do CTS, CSS or IPS services reduce health service utilization and costs, including ED visits, inpatient admissions, or institutional LTSS utilization and overall Medicaid expenditures? • Is receipt of CTS, CSS or IPS services associated with increased engagement in other supportive preventative care, mental health or substance use treatment services (with increased engagement in such services considered to be a positive outcome)? • Is receipt of CTS, CSS or IPS services associated with increased measures of health care quality, consistent with positive effects on the beneficiary's ability to manage physical and behavioral health conditions? • Is Health IT used to support service delivery on behalf of persons for whom CTS, CSS, or IPS services are provided. For example, does health technology support the exchange of information between programs (such as criminal justice, Homeless Management Information System, Vocational Rehabilitation, and Medicaid) or providers (such as Emergency medical Response, EDs, acute care hospitals, and MH/SUD providers))? If so, how? If not, why not?
Data strategy, sources and collection frequency	Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Impact analyses will use MMIS-derived physical and behavioral health service utilization data, LTSS assessment data, and linked "social determinant" outcome data. Data is routinely collected through the operation of existing data interfaces, and is generally linked into the State's integrated client data environment on a quarterly basis. To address a request for clarification from feedback received on the prior draft, we note that LTSS data is one of multiple sources of health risk factor information (e.g., ICD-10 diagnoses, cognitive performance scale scores, ADL functional need scores) integrated into the State's ICDB. Propensity-score models will generally match treatment group members to comparison group members with comparable baseline levels of LTSS utilization. In this context, use of LTSS assessment data ensures balance on assessment-derived risk factors for subpopulations with comparable balance in their exposure to LTSS assessment processes. This is an example of our use of the vast dimensionality of risk information in the ICDB to reduce (i.e., mitigate) the magnitude of selection bias that could occur if the proposed analytical approaches were undertaken in a less information-rich environment.
Measures	Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for many of the state-developed outcome measures are provided in

Component	Description
	Appendix 2. Measures derived from administrative data sources in the State's integrated client data environment will include: • Measures of homelessness and housing stability • Measures of employment, hours worked and earnings • Measures of criminal justice involvement • Measures of health service utilization and cost, including ED visits, inpatient admissions, nursing facility utilization and overall Medicaid expenditures • Access to mental health and substance use disorder treatment • Other health care quality measures (e.g., psychotropic medication adherence, comprehensive diabetes care)

Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products.
	The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. An assessment of the difference between FCS program participants and non-participants with comparable baseline attributes will be conducted using difference-of-difference designs where appropriate, wherein the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. The matching process will leverage the richness of baseline demographic, risk, and utilization data contained in the State's ICDB. The pre-post boundary for each treatment group will be based on the point at which they first engage in the intervention. The PS matching process will proceed through the following steps:
	• Examination of key baseline predictors of treatment entry within the pooled intervention and comparison matching frame to ensure inclusion of appropriate measurement dimensions in the PS model. This includes creating an extensive set of predictors that are determined, ex ante, to be potentially relevant to the matching process. This set of predictors is generally expected to span a wide range of the measurement domains contained with the State's ICDB, which may include:
	  ● Service utilization data across Medicaid funded delivery systems (physical, mental health, substance use disorder, long-term services and support, and developmental disability services);
	  ● Expenditure data at the "major modality" (e.g., IP hospitalization, OP ED visits, etc.) per-member per-month level;
	  ● Risk factors associated with chronic disease conditions, including mental illness and substance use disorders, derived from the CDPS and Medicaid-Rx risk models;

Component	Description
	• Data on functional (ADL) support needs, cognitive impairment, and behavioral challenges from the client's current LTSS assessment, if applicable; • Prior patterns of housing instability or homelessness; • Prior rates of employment and earnings levels; • Prior arrest experiences; • Client demographics (age, gender, race/ethnicity); • Medicaid enrollment by detailed coverage category; and • Urban/rural/frontier characteristics of the beneficiary's residential location. • Application of machine learning techniques (e.g., stepwise logistic or lasso regression) to determine the final propensity score model. • Propensity score matching using procedures in the R programming language (e.g., the Matchit procedure). Exact matching may be required for key variables (e.g., age and gender). As with all Demonstration initiatives, target populations are expected to partially overlap across projects and programs. The statewide project attribution data infrastructure will be leveraged to identify project participation longitudinally at the beneficiary level. Analyses may be limited to subpopulations of clients with "common support" across baseline matching criteria, and subpopulations not engaged in other Demonstration projects or other initiatives. This restriction has parallels to study enrollment restrictions commonly imposed in the randomized clinical trial context. The baseline period for construction of matching variables will typically be the prior 12 months, but may be of longer duration if information from prior periods is determined to be predictive of engagement in FCS services. Outcome periods will typically be periods comprised of one or more 12-month segments or intervals, depending on the length of available follow-up time. Impact will generally be estimated in a regression framework using SAS regression procedures and models including controls for baseline characteristics, notably including those baseline characteristics on which exact matching is not imposed. The ICDB will be the data source all measurement within this component of the evaluation. As was discussed in more detail in Section 3, the ICDB is designed to support quasi-experimental evaluation of health and social service interventions in Washington State, has been widely used in evaluation studies published in peer-reviewed journals, and contains data from the administrative data systems, including Medicare Parts A, B, and D data and the State's ProviderOne MMIS data system, necessary to implement this component of the quantitative evaluation design. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as:

Component	Description
	• Provider capacity to effectively deliver CTS, CSS and supported employment services • Implementation fidelity to CTS, CSS and supported employment service models • Use of HIT to support delivery of CTS, CSS and supported employment services • The extent of linkages between CTS, CSS and supported employment service providers and other health care providers • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery
Subgroup analyses to assess disparities and differences	Among the dimensions that will be considered for analysis of disparities and differences in access to services and outcomes include: • Race/ethnicity, age and gender • Geography (urban/rural/frontier) • Delivery system affiliation (e.g., physical health, mental health, SUD, LTSS and/or Tribal) • Chronicity of housing instability • Extent of prior employment history • Functional risk factors (presence of cognitive impairment or TBI, behavioral health risk factors, severity of physical comorbidities) • Extent of prior criminal justice involvement • Previously institutionalized populations

Section 6. Substance Use Disorder Demonstration Amendment Evaluation Design

Washington State Medicaid Transformation Project Section 1115(a) Medicaid Demonstration SUD Amendment
Revisions Submitted: June 28, 2019

SECTION A: General Background Information. Opioid misuse and addiction is a public health crisis in Washington State and across the country. In communities across the state, this epidemic is devastating families and overwhelming law enforcement and social services. In 2016, there were 694 opioid related deaths in Washington State. Of these deaths, 382 individuals died from a prescription opioid overdose, 278 died from a heroin overdose, and 90 died from a fentanyl overdose. This high mortality is due to the increase in heroin overdose deaths even though prescription opioid overdose deaths have decreased.

The State of Washington applied for and received an amendment to the state's section 1115(a) demonstration titled, "Medicaid Transformation Project" (MTP) (Project Number 11-W-00030/1) from the U.S. Centers for Medicaid and Medicare (CMS) to maintain and expand access to inpatient and residential treatment for substance use disorder (SUD)[16]. Specifically, the amendment "authorizes Washington to receive federal financial participation (FFP) for the provision of all Medicaid state plan services-including a continuum of services to treat addictions to opioids and other substances-for Medicaid enrollees primarily diagnosed with opiate use disorder (OUD) and/or other substance use disorders (SUD) who are short-term

[16] The Section 1115 Waiver SUD Amendment request is available at: https://www.hca.wa.gov/assets/program/hw-mtp-waiver-amendment-request.pdf

residents in residential and inpatient treatment facilities that meet the definition of an Institution for Mental Diseases (IMD)."[17]

The original section 1115(a) waiver is effective January 9, 2017 through December 31, 2021. The SUD amendment is effective July 17, 2018 through December 31, 2021.

The SUD amendment has the following goals:

(1) Increased rates of identification, initiation and engagement in treatment for OUD and other SUDs;
(2) Increased adherence to and retention in treatment for OUD and other SUDs;
(3) Reductions in overdose deaths, particularly those due to opioids;
(4) Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
(5) Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUD; and
(6) Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs.

To achieve these goals, Washington's implementation plan[18] outlines the selected path to provide a full continuum of care for all Medicaid beneficiaries with OUD and other SUDs, regardless of age. This includes expanding access and improving outcomes in the most cost-effective manner possible. Six key milestones, as identified by CMS, will be used to guide Washington's SUD amendment:

(1) Access to critical levels of care for OUD and other SUDs;
(2) Widespread use of evidence-based, SUD-specific patient placement criteria;
(3) Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;
(4) Sufficient provider capacity at each level of care, including Medication Assisted Treatment (MAT);
(5) Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
(6) Improved care coordination and transitions between levels of care.

Prior to 2016, Washington State was able to utilize FFP for services in IMD facilities in lieu of providing those services in non-IMD settings. This authority was included in the state's 1915(b) waiver, and deemed a cost effective alternative to Medicaid State Plan services. However, this arrangement was altered with the 2016 Managed Care Final Rule, which prohibited the use of FFP for IMD stays greater than 15 days (See Figure 1). As a result, the state and the managed care entities it contracts with were constrained to using limited state dollars to pay for treatment in IMDs beyond 15 days. These changes may have reduced the state's ability to focus funding on other services. They may have also restricted supply of IMD beds, if some facilities responded to the Final Rule by reducing their capacity to 16 beds (which would have removed them from IMD status), or if other groups delayed plans to expand capacity. As of July 2018, Washington had 1,643 beds across 17 SUD facilities providing services for adults that met the definition of an IMD. It is anticipated that the number of available beds will increase with the expanded expenditure authority under the 1115 waiver.

FIGURE 1.

Policy Changes Related to FFP for IMD Stays

2014	2015	2016	2017	2018	2019	2020	2021
Under 1915(b) waiver, WA able to use FFP for IMD stays up to 30 days		***Final Rule prohibits FFP for IMD says beyond 15 days***		***WA receives waiver amendment to use FFP for IMD stays for up to 30 days***			

[17] The updated STCs are available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wa/wa-medicaid-transformation-ca.pdf.

[18] Washington's full implementation plan can be found in Appendix K of the updated STCs (see above).

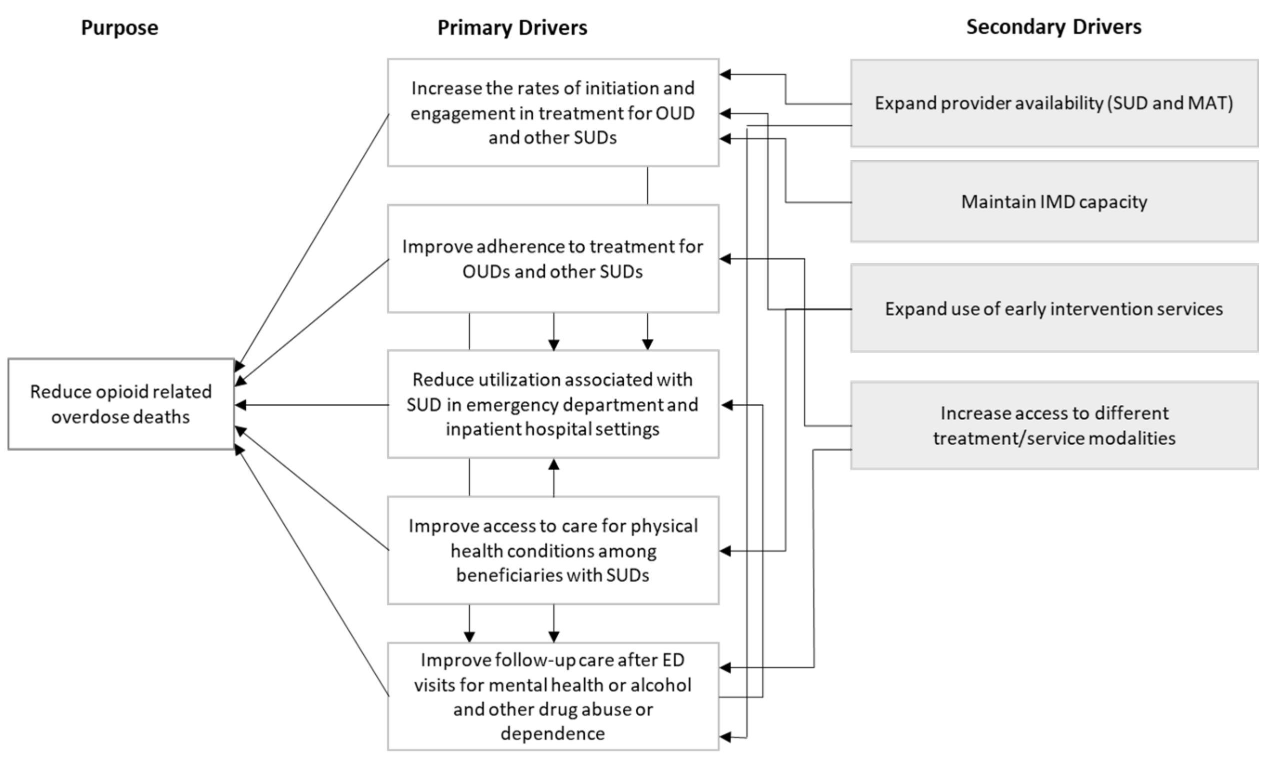
Under this amendment to Washington's Medicaid 1115 waiver, this expenditure authority applies to all Medicaid beneficiaries who receive inpatient SUD services in an IMD that would otherwise be subject to the 15 day IMD rule. While there are existing exemptions to the IMD rule for the <21 and 65+ age ranges, there are facility type restrictions that the WA SUD IMDs do not meet. Therefore, this amendment also allows SUD IMD facilities to receive FFP for individuals who are younger than 21 and 65 and older as well.

SECTION B: Evaluation Questions and Hypotheses

Driver Diagram. Figure 2 below depicts the relationship between the amendment's overall purpose of reducing opioid related overdose deaths and the primary and secondary drivers that are necessary to achieve this overall goal. Five primary drivers contribute directly towards achieving the SUD amendment's purpose, with five secondary drivers that are necessary to support the primary drivers. As noted in the diagram, several of the primary drivers also affect other primary drivers. For example, improving access to care for co-morbid physical health conditions among beneficiaries with SUDs may help achieve a reduction in utilization of emergency department and inpatient hospital settings for SUD treatment and may help increase use of the most appropriate service modality.

Secondary drivers also contribute to multiple primary drivers. Expanding use of early intervention services, such as increasing the use of the Screening, Brief Intervention, and referral to Treatment (SBIRT) tool, can increase the rates of initiating and engaging in treatment for OUD and other SUDS, as well as improving access to care for co-morbid physical health conditions among beneficiaries with SUDs.

FIGURE 2.
Driver Diagram



Questions and Hypotheses

This evaluation is designed to test the hypothesis specified in Special Terms and Conditions (STC) 111. Broadly, we will test whether authorizing expenditure authority for services in IMDs will increase Medicaid beneficiary access to inpatient and residential SUD treatment services as part of an effort to provide the full continuum of treatment services, and increase the likelihood that Medicaid beneficiaries receive SUD treatment in the setting most appropriate for their needs.

The emphasis of the evaluation will be quantitative, using administrative data to answer questions about the effect of expanded FFP for IMD services on measures of access, quality, health outcomes, and expenditures. We will focus on these key questions:

(1) Does the demonstration increase access to and utilization of SUD treatment services?
(2) Does the receipt of SUD services improve appropriate physical health care use?
(3) Are rates of opioid-related overdose deaths impacted by the demonstration?
(4) What was the impact on total expenditures and expenditures for SUD-related services?

Table 1 below connects the evaluation questions to the primary and secondary drivers specified in Figure 2. This table also indicates which metrics will be used to evaluate each demonstration goal. Key outcome metrics were selected based on inclusion in the SUD Monitoring Protocol Metric Workbook and availability of timely data. Details about the metric specifications are dependent on acceptance of the SUD Monitoring Protocol Metric Workbook by CMS, which will occur after this evaluation design is submitted for CMS review. Thus, the final list of metrics may vary slightly from the list below.

TABLE 3.

Crosswalk of Evaluation Questions, Demonstration Goals, Evaluation Hypotheses, and Metrics

<table>
<tr><th colspan="7">Evaluation Question: Does the demonstration increase access to and utilization of SUD treatment services?</th></tr>
<tr><th colspan="7">Demonstration Goal: Increase rates of identification, initiation, and engagement in treatment for OUD and other SUDs.</th></tr>
<tr><th colspan="7">Evaluation Hypothesis: The demonstration will increase the percentage of beneficiaries who are referred and engage in treatment for OUD and other SUDs.</th></tr>
<tr><th>Driver</th><th>Metric Description</th><th>Steward</th><th>Numerator</th><th>Denominator</th><th>Source</th><th>Analytic Approach</th></tr>
<tr><td rowspan="2">Primary Driver: Increase the rates of initiation and engagement in treatment for OUD and other SUDs.</td><td rowspan="2">Initiation and engagement of alcohol and other drug dependence treatment*</td><td rowspan="2">NQF #0004</td><td>Initiation: number of Medicaid beneficiaries who began initiation of treatment through an inpatient admission or outpatient visit within 14 days of the index episode start date</td><td rowspan="2">Number of Medicaid beneficiaries who were diagnosed with a new episode of alcohol or drug dependency during the first 10 and 1/2 months of the measurement year</td><td>Claims data</td><td>Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.</td></tr>
<tr><td>Engagement: initiation of treatment and two or more inpatient admissions or outpatient visits with any alcohol or drug diagnosis within 30 days after the date of the initiation encounter</td><td>Claims data</td><td>Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.</td></tr>
</table>

Secondary Driver: Expand use of early intervention services	Early intervention*	SUD Monitoring Protocol	Number of Medicaid beneficiaries who received SBIRT during the measurement period	Number of Medicaid beneficiaries in the measurement period	Claims data	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.
Secondary Driver: Expand provider availability	SUD provider availability*	SUD Monitoring Protocol	The number of providers who billed Medicaid for an SUD service during the measurement period		Claims data	Descriptive statistics; Analysis of trend data to examine provider availability post-implementation relative to pre-implementation baseline.
	SUD provider availability - MAT*	SUD Monitoring Protocol	The number of providers who billed Medicaid for MAT during the measurement period		Claims data	Descriptive statistics; Analysis of trend data to examine provider availability post-implementation relative to pre-implementation baseline.
Secondary Driver: Maintain IMD capacity	Number of IMDs providing treatment for SUD	WA State	The number of IMD facilities providing SUD treatment during the measurement period		State IMD data	Descriptive statistics; Analysis of trend data to examine the number of IMD/IMD beds available post-implementation relative to pre-implementation baseline.
	Number of beds in IMDs providing treatment for SUD	WA State	The number of beds in IMD facilities providing SUD treatment during the measurement period		State IMD data	Descriptive statistics; Analysis of trend data to examine the number of IMD/IMD beds available post-implementation relative to pre-implementation baseline.

Demonstration Goal: Increase adherence to and retention in treatment for OUD and other SUDs.						
Evaluation Hypothesis: The demonstration will increase the percentage of beneficiaries who adhere to treatment of OUD and SUDs.						
Driver	**Metric Description**	**Steward**	**Numerator**	**Denominator**	**Source**	**Analytic Approach**
Primary Driver: Improve adherence to treatment for OUDs and other SUDs	Continuation of pharma-cotherapy for OUD*	NQF #3175	Number of adult Medicaid beneficiaries with at least 180 days of continuous pharmacotherapy treatment for OUD	Adult Medicaid beneficiaries with OUD	Claims data	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.
	Any SUD Treatment*	SUD Monitoring Protocol	Number of Medicaid beneficiaries who used any SUD treatment service, facility claim, or pharmacy claim during the measurement period	Number of Medicaid beneficiaries with SUD in the measurement period	Claims data	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.
Secondary Driver: Increase access to different treatment/ service modalities	Outpatient services*	SUD Monitoring Protocol	Number of Medicaid beneficiaries who used outpatient services for SUD during the measurement period	Number of Medicaid beneficiaries with SUD in the measurement period	Claims data	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.
	Residential and inpatient services*	SUD Monitoring Protocol	Number of Medicaid beneficiaries who used residential and/or inpatient services for SUD during the measurement period	Number of Medicaid beneficiaries with SUD in the measurement period	Claims data	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.
	Withdrawal management *	SUD Monitoring Protocol	Number of Medicaid beneficiaries who used withdrawal management services during the measurement period	Number of Medicaid beneficiaries with SUD in the measurement period	Claims data	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.

	Medication assisted treatment*	SUD Monitoring Protocol	Number of Medicaid beneficiaries who have a claim for MAT for SUD during the measurement period	Number of Medicaid beneficiaries with SUD in the measurement period	Claims data	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.
	Medicaid beneficiaries treated in an IMD for SUD*	SUD Monitoring Protocol	Number of Medicaid beneficiaries with a claim for residential treatment for SUD in an IMD during the measurement period	Number of Medicaid beneficiaries with SUD in the measurement period	Claims data	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.
	Average length of stay in IMDs*	SUD Monitoring Protocol	The average length of stay for beneficiaries discharged from IMD residential treatment for SUD		Claims data	Descriptive statistics; Analysis of trend data to examine the average length of stay post-implementation relative to pre-implementation baseline.

Demonstration Goal: Reduce utilization of emergency department and inpatient hospital settings where the utilization is preventable or medically inappropriate through improved access to other continuum of care services

Evaluation Hypothesis: The demonstration will decrease the rate of emergency department and inpatient visits within the beneficiary population for SUD.

Driver	Metric Description	Steward	Numerator	Denominator	Source	Analytic Approach
Primary Driver: Reduce utilization associated with SUD in emergency department and inpatient hospital settings	Emergency department utilization for SUD per 1,000 Medicaid beneficiaries*	SUD Monitoring Protocol	Total number of emergency department visits for SUD in the measurement period	Per 1,000 Medicaid beneficiaries	Claims data	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.
	Inpatient admissions for SUD per 1,000 Medicaid beneficiaries*	SUD Monitoring Protocol	Total number of inpatient stays for SUD in the measurement period	Per 1,000 Medicaid beneficiaries	Claims data	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.

Secondary Driver: Improver follow-up care after emergency department visits for mental health or alcohol and other drug dependence	Follow-up after emergency department visit for mental illness (7 days, 30 days)*	NQF #2605	Number of ED visits for mental illness for which the Medicaid beneficiary received follow-up within 7 days of the ED visit	Number of Medicaid beneficiary ED visits for mental illness	Claims data	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.
		NQF #2605	Number of ED visits for mental illness for which the Medicaid beneficiary received follow-up within 30 days of the ED visit	Number of Medicaid beneficiary ED visits for mental illness	Claims data	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.
	Follow-up after emergency department visit for alcohol and other drug abuse or dependence (7 days, 30 days)*	NQF #2605	Number of ED visits for AOD for which the Medicaid beneficiary received follow-up within 7 days of the ED visit	Number of Medicaid beneficiary ED visits for AOD	Claims data	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.
		NQF #2605	Number of ED visits for AOD for which the Medicaid beneficiary received follow-up within 30 days of the ED visit	Number of Medicaid beneficiary ED visits for AOD	Claims data	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.

Evaluation Question: Does the receipt of SUD services improve appropriate physical health care use?						
Demonstration Goal: Improved access to physical health care among beneficiaries with OUD or other SUDs.						
Evaluation Hypothesis: The demonstration will increase the percentage of beneficiaries with OUD or other SUDs who access physical health care.						
Driver	**Metric Description**	**Steward**	**Numerator**	**Denominator**	**Source**	**Analytic Approach**
Primary Driver: Improve access to care for physical health conditions among beneficiaries with SUDs	Access to preventive/ambulatory health services for adult Medicaid beneficiaries with SUD*	Modified HEDIS®	Medicaid beneficiaries who had an ambulatory or preventive care visit during the measurement period	Number of Medicaid beneficiaries with SUD in the measurement period	Claims data	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.
Secondary Driver: Expand use of early intervention services	Early intervention *	SUD Monitoring Protocol	Number of Medicaid beneficiaries who received SBIRT during the measurement period	Number of Medicaid beneficiaries in the measurement period	Claims data	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.

Demonstration Goal: Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.						
Evaluation Hypothesis: Among beneficiaries receiving care for SUD, the demonstration will reduce readmissions to the same or higher level of care.						
Driver	**Metric Description**	**Steward**	**Numerator**	**Denominator**	**Source**	**Analytic Approach**
Primary Driver: Improver follow-up care after emergency department visits for mental health or alcohol and other drug dependence	Follow-up after emergency department visit for mental illness (7 days, 30 days)*	NQF #2605	Number of ED visits for mental illness for which the Medicaid beneficiary received follow-up within 7 days of the ED visit	Number of Medicaid beneficiary ED visits for mental illness	Claims data	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.
		NQF #2605	Number of ED visits for mental illness for	Number of Medicaid	Claims data	Descriptive statistics; Modified pre-post

			which the Medicaid beneficiary received follow-up within 30 days of the ED visit	beneficiary ED visits for mental illness		regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.
	Follow-up after emergency department visit for alcohol and other drug abuse or dependence (7 days, 30 days)*	NQF #2605	Number of ED visits for AOD for which the Medicaid beneficiary received follow-up within 7 days of the ED visit	Number of Medicaid beneficiary ED visits for AOD	Claims data	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.
		NQF #2605	Number of ED visits for AOD for which the Medicaid beneficiary received follow-up within 30 days of the ED visit	Number of Medicaid beneficiary ED visits for AOD	Claims data	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.
	Readmission for SUD (30 Days)*	SUD Monitoring Protocol	The number of acute inpatient stays among beneficiaries with SUD during the measurement period followed by an acute readmission within 30 days	The number of acute inpatient stays among beneficiaries with SUD during the measurement period	Claims data	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.

Evaluation Question: Are rates of opioid-related overdose deaths impacted by the demonstration?						
Demonstration Goal: Reduce overdose deaths, particularly those due to opioids.						
Evaluation Hypothesis: The demonstration will decrease the rate of overdose deaths due to opioids.						
Driver	**Metric Description**	**Steward**	**Numerator**	**Denominator**	**Source**	**Analytic Approach**
Primary Driver: Reduce opioid-related overdose deaths	Use of opioids at high dosage in persons without cancer*	Bree Collaborative (See SUD Monitoring Protocol)	Number of Medicaid beneficiaries with ≥90mg morphine equivalent dosage in the quarter	Number of Medicaid beneficiaries with a ≥60 days supply of opioids in the calendar quarter	Claims data	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.
	Concurrent use of opioids and benzodiazepines*	Bree Collaborative (See SUD Monitoring Protocol)	Number of Medicaid beneficiaries with ≥60 days supply of opioids and prescribed ≥60 days supply of sedatives in the quarter	Number of Medicaid beneficiaries with a ≥60 days supply of opioids in the calendar quarter	Claims data	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.
	Count of overdose deaths due to any opioid*	SUD Monitoring Protocol	Number of Medicaid beneficiary overdose deaths during the measurement period.		Vital Statistics	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.
	Rate of overdose deaths due to any opioid*	SUD Monitoring Protocol	Number of Medicaid beneficiary overdose deaths during the measurement period.	Number of Medicaid beneficiaries in the measurement period	Vital Statistics	Descriptive statistics; Modified pre-post regression analysis comparing person-quarter outcomes post-implementation relative to pre-implementation baseline.

In addition to the above questions, this evaluation will also examine the impact of the SUD amendment on total expenditures and expenditures for SUD-related services. See Analytic Methods section for more details.

**Denotes metric reported in the SUD Monitoring Protocol*

SECTION C: Methodology

Evaluation Methodology. The focus of the SUD amendment evaluation will be quantitative, relying primarily on administrative data from the State's Integrated Client Data Bases (ICDB). We will use claims data to conduct pre-post analyses, with potential sensitivity analyses and supplemental analyses to assess pre-policy trends and the utility of interrupted-time series analyses. Analysis of cost trends will consider a comparison group approach, contrasting PMPM cost trends for persons with SUD relative to Medicaid beneficiaries without SUD, as described more fully below.[19] Where possible, we will leverage ongoing contextual information gathered by the research team as part of the overall MTP evaluation. We provide more detail in the "Analytic Methods" section below.

Target and Comparison Populations. The primary focus of our evaluation is adults enrolled in Medicaid with a substance use disorder (SUD). We will also conduct subanalyses on the subpopulation of adults presenting primarily with opioid use disorder (OUD). Analyses of these populations will provide an assessment of how utilization of specific treatment services has changed with expanded access to IMD facilities. In addition to this primary analysis, we will also assess changes in the prevalence of SUD and OUD in the broader population. These analyses will provide a more nuanced understanding of trends in the state. For example, if the prevalence of SUD was increasing during the study period, increased access to treatment might be observed in the broader population (with more people in the state receiving treatment), even if treatment rates among individuals with SUD did not increase. This finding would demonstrate, for example, that increased access might have allowed the state to keep pace with increasing SUD prevalence, but greater capacity or changes to the delivery system might be warranted to insure that a greater proportion of individuals with SUD received recommended treatment.

Evaluation Period. The IMD provisions in the final rule were for rates effective on or after July 5, 2016 (though later extended to rates on or after October 1, 2016 through a CMS-issued addendum). Because WA Behavioral Health Organization rates operated on a State Fiscal Year (July – June) basis, implementation of the rule started with rates effective 7/1/17 (see Figure 1). The final evaluation will include data from April 2016 through December 2020, allowing for 9 quarters of "pre-policy" analysis, including 15 months of data prior to the implementation of the Managed Care Final Rule and up to 10 quarters of post-policy analysis, with July 1, 2018 serving as the pre-post boundary. The final number of quarters post-policy analysis is dependent on the availability of fully mature data.

Data Sources. As noted in Table 1, three types of data/data sources will be used in the SUD evaluation: claims data, State IMD data, and Vital Statistics. Each data type and source are described below.

Claims Data. The evaluation will leverage the integrated administrative data maintained in the Department of Social and Health Services Integrated Client Databases (ICDB). The ICDB was explicitly designed to support quasi-experimental evaluation of health and social service interventions in Washington State, and has been widely used in evaluation studies published in peer-reviewed journals.[20]

The ICDB contains nearly 20 years of individual-level, massively dimensional data for nearly 6 million persons residing in Washington State over that time span. It contains data from approximately 20 administrative data systems, including the State's ProviderOne MMIS data system and all other data sources necessary to implement the quantitative evaluation design described in this document.

More specifically, the ICDB contains:

[19] As an illustration of this type of approach, see "Bending the Health Care Cost Curve by Expanding Alcohol/Drug Treatment" at https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-4-81.pdf.

[20] For a recent example, see Jingping Xing, Candace Goehring and David Mancuso. Care Coordination Program For Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs Care Coordination Program For Washington State. Health Affairs, 34, no.4 (2015):653-661.

- Service event level utilization data across all Medicaid funded delivery systems (physical, mental health, substance use disorder, long-term services and support, and developmental disability services);
- Billing and servicing provider information for Medicaid paid claims;
- Expenditure data at the service event and per-member per-month level of aggregation by major service modality, for all Medicaid beneficiaries over the time period relevant to this evaluation (with a few caveats related to issues like the methods for applying pharmacy rebates);
- Risk factors associated with chronic and acute disease conditions, including mental illness and substance use disorders, derived from the CDPS and Medicaid-Rx risk models and related tools;[21]
- Data on "social outcomes" including arrests, employment and earnings, and homelessness and housing stability;
- Client demographics (age, gender, race/ethnicity);
- Medicaid enrollment by detailed coverage category;
- MCO enrollment or fee-for-service Medicaid coverage status;
- Medicare Parts A, B, and D integration for persons dually enrolled in Medicaid and Medicare; and
- Geographic residential location spans.

The ICDB is updated on a quarterly basis. The ICDB analytical data infrastructure is complemented by a suite of HEDIS and related metric measurement algorithms that currently regularly produce quantitative outcome metrics (listed in Section 5 and Appendix 1 in the original Evaluation Design) on at least a semi-annual basis for all Medicaid beneficiaries in Washington State meeting measure specification requirements.

State IMD Data. The Washington State Department of Health (DOH) oversees the licensing of behavioral health facilities. When a new behavioral health facility opens or changes the number of beds it operates, the Washington Health Care Authority (HCA) assesses the facility to determine if it meets the criteria for IMD designation. This assessment is based on federal IMD rules. Information about new IMD facilities or changes in IMD certification are communicated between DOH, HCA, and DSHS-RDA. This ensures that the number of facilities and beds that are SUD IMD certified is regularly updated in the State IMD dataset to reflect SUD IMD availability in the state.

Vital Statistics. Information on deaths with a primary cause of drug overdose is available through the Department of Health, Center for Health Statistics. Overdose deaths will also be reported via the SUD monitoring protocol.

Analytic Methods

Most analyses will focus on changes over time. Before describing this model in detail, we note that we are aware of the conceptual advantages of modeling changes in the affected Washington population relative to an appropriate comparison group. However, we do not believe that there is an applicable comparison population that would be feasible and suitable for most aspects of this evaluation. An ideal comparison group would be a population with the same characteristics as those who were potentially affected by the SUD amendment, but who were not themselves affected by the amendment. We note, for example, that IMDs are not present in all Washington counties, suggesting that the populations of these counties would not be affected by expanded FFP for IMD stays, and that these populations could be used as a comparison group. However, IMDs are typically accessed by patients from other regions, and in some cases, providers may support the idea of sending clients to a separate region in order to isolate them from their home environment. This means populations in counties without IMDs may nevertheless be affected by expanded FFP for IMD stays and would not constitute a suitable comparison group.

[21] For more information about the CDPS and Medicaid-Rx, visit http://cdps.ucsd.edu/.

Given these constraints, in most analyses we propose to assess changes in the 9 quarters leading up to the amendment approval (April 2016 through June 2018) and the up to 10 quarters following the amendment approval (July 2018 through December 2020). Our unit of analysis will be the person-quarter. We use the following specification:

$$Y_{it} = \beta_0 + \sum_{t=1}^{10} \beta_t I_t + \tau_Q + \theta X_{it} + e_{it}$$

where Y_{it} is the outcome of interest for individual *i* in quarter *t*; I_t represents 1 of 10 dummy variables that occur in the post-IMD period (July 2018 through December 2020); τ_Q represents dummy variables for year-quarters (e.g., Q2, Q3, Q4, with Q1 as a reference); $\boldsymbol{X_{it}}$ is a vector of demographic covariates and risk adjusters; and e_{it} is a random error term associated with the unmeasured variation in the outcome of interest. The coefficients of interest, β_1,…, β_{10} capture the change from baseline to each of the 10 quarters following the expansion of IMD services, net of other observable factors.

This model provides an assessment of changes relative to the April 2016 through June 2018 baseline.

This model can be seen as modification of a "pre-post" study. An alternative approach could be to impose linear trends using an "Interrupted Time Series" (ITS) analysis. The ITS method can be helpful in estimating treatment effects in the presence of a stable, long-term trend. However, we anticipate that SUD measures may have been fluctuating prior to the July 2018 policy change. In this case, results from the ITS method could be highly sensitive to the length of the pre-policy window. Thus, our primary assessment will not impose this restriction. However, we will test the sensitivity of our results through several different assessments. First, we will run alternatives to the model specified above, but allowing for different definitions of the baseline, including an analysis where we define the pre-period as 2017 only. This approach restricts our baseline to the cleanest 12 months prior to the intervention, and allows for a "wash-out" period prior to 2018. Second, we will test our primary results against an ITS model. Third, we will assess all outcomes visually in order to insure that our primary findings are not driven by unusual fluctuations or outlier events.

We will choose the regression model – e.g., linear regression, logistic regression, generalized linear model – that is most suitable for the distribution of the outcome variable *Y*. In general, we have a preference for linear models, which generally outperform other statistical models in estimating population averages for large N studies, and offer the additional advantages of generating coefficients that are straightforward to interpret. We note that the distribution of health expenditures is typically right skewed with a heavy mass at zero (see Cost Analyses section below for detailed description of planned cost analyses). The study team has experience in two-part models and will test the relative performance of these approaches relative to an OLS approach. In our past work, we have found that, in large N studies, OLS has produced estimates that are similar to those produced by two-part models.

Outcome Metrics: The outcome metrics listed in Table 1 were drawn primarily from the CMS required SUD Monitoring Protocol reporting. The final list of metrics may change based on CMS approval of the Monitoring Protocol and may be modified if better performance measurement tools become available in the evaluation window (see Section 3 – "Quantitative analyses leveraging integrated administrative data" of the original Evaluation design for more details).

Key Covariates: At a minimum, we propose to adjust for age, gender, rural residence, and Chronic Illness and Disability Payment System (CDPS) risk indicators. Additional covariates that could be extracted from the Integrated Client Databases (ICDB), such as data on social outcomes, including employment and housing stability will be assessed for feasibility and utility. However, we would be cautious in our deployment of these variables. On the one hand, we anticipate that these social outcome variables are strongly correlated with many outcome variables. On the other hand, some of these variables may be more correctly viewed as outcome variables and could change as a result of MTP. In that event, including them as covariates might tend to bias the estimate of the overall MTP effect toward zero.

System Capacity Outcomes

Three secondary drivers focus on system capacity outcomes: (1) expanding provider availability; (3) maintaining IMD capacity; and (3) increasing access to different treatment/services modalities. The analytic approach to each of these secondary drivers is different from the Medicaid beneficiary focused analyses described above. The overall approach, a pre-post study that compares post-implementation relative to pre-implementation baseline, is the same. However, the analysis will focus on changes in trend information rather than person-quarter outcomes. Each secondary driver is examined below.

Expand Provider Availability. There are two metrics associated with this secondary driver: SUD provider availability broadly and SUD provider availability specific to MAT. In Washington, there is no centralized and regularly updated registry of all SUD providers who are currently accepting Medicaid clients. Thus, this analysis will focus on the providers who are actively providing SUD treatment services to Medicaid clients. These providers will be identified using claim data in the ICDB. Descriptive statistics and an analysis of the number of providers post-implementation relative to pre-implementation baseline will demonstrate how provider availability has changed due to the implementation of the SUD amendment.

Maintain IMD Capacity. There are two metrics associated with this secondary driver: number of IMDs providing treatment for SUD and the number of beds in IMDS providing treatment for SUD. Descriptive statistics and an analysis of trend data to examine the number of IMDs and IMD beds available post-implementation relative to pre-implementation baseline will demonstrate how the use of IMDs have shifted due to the implementation of this amendment. Depending on data availability, the number of SUD inpatient/residential treatment facilities and the number of beds in those facilities may provide a useful comparison group.

Increase Access to Different Treatment/Service Modalities. The metric associated with this secondary driver, average length of stay in IMDs, is crucial to understanding how use of IMDs have changed post-implementation of the SUD amendment. As with the other system capacity outcomes, descriptive statistics and an analysis of trend data will be used to examine the average length of stay post-implementation relative to pre-implementation baseline. These findings will be used in conjunction with information on how other treatment/service modality use have changed post-implementation.

Cost Analyses

A key component of the evaluation will focus on understanding how the change in FFP bends the cost curve and affects utilization trends for the risk pool we expect to be impacted by the amendment – Medicaid beneficiaries with SUD. The intended methodologic approach and potential data issues are detailed below.

Methodological Approach: Following the preferred approach noted by CMS, we expect to use a comparison group design, assessing how costs change over time for Medicaid beneficiaries with a substance use disorder (the treatment group) compared to Medicaid beneficiaries without a substance use disorder (the comparison group). This approach will be the basis for estimating the impact of the SUD IMD waiver on PMPM total costs, SUD costs, non-SUD costs, and sources of treatment cost drivers across the state. We expect to compare the percent deviation from expected costs trends for Medicaid beneficiaries *with* SUD, relative to the percent deviation from expected cost trends for Medicaid beneficiaries *without* SUD. Pre-waiver experience for each group will be used to form post-waiver expected cost trends.[22]

Given that the state's waiver was implemented across the entire state at the same time, there is no geography-based comparison population available. Our proposed approach helps control for common confounding factors affecting changes in expenditures across all Medicaid beneficiaries, such as secular trends in service utilization or changes in reimbursement rates. By examining changes in costs for all clients

[22] A more detailed discussion of this methodological approach can be found at: https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-4-81.pdf

with SUD, we mitigate the risk selection bias poses to measurement designs that limit the treatment group only to those who enter SUD treatment.

The key challenge for our proposed approach is the potential confounding effects of changes in the health care environment disproportionately affecting Medicaid beneficiaries with a substance use disorder. One notable confounding issue is that pre-waiver increases in medication-assisted treatment for opiate addiction – particularly accelerating after HCA policy changes implemented in October 2015 – may have had a disproportional effect on health care cost trends for the SUD population immediately prior to waiver implementation. Another major confounder is the potential impact of the original initiatives of the waiver. We will assess the implications for the cost analyses of pre- and post-waiver SUD-related policy changes and targeted interventions, and may recommend modifications to the measurement approach if there is a scientific basis for change.

Key Covariates: For the cost analysis, we propose to adjust for age, gender, rural residence, and Chronic Illness and Disability Payment System (CDPS) risk indicators. As described above, we will also assess the feasibility and utility of including other covariates (primarily related to social risk, but also potentially including dual eligible status) that could be extracted from the Integrated Client Databases (ICDB).

Sources of Treatment Cost Drivers: We will assess total costs, as well as costs separated out by the following lines of service:

- Emergency Department (ED) visits, defined as visits with CPT codes 99281-99285; UB revenue codes 0450, 0451, 0452, 0456, 0459, or 0981; or a 'place of service code' of 23 combined with a qualifying CPT code (from NCQA HEDIS definition)
- Other Outpatient (non-ED) visits, defined as outpatient visits that do not occur in the ED; includes 'observation visits' defined as same-day discharges from an inpatient facility
- Inpatient admissions, defined as visits with 'type of bill' beginning 11 or 12; 'place of service' codes 21 or 51; or 'claim type' of A (inpatient crossover) or I (inpatient)
- Prescription drug spending, using "allowed amount" from prescription drug claims
- Long-term care costs, including nursing facility, community residential (e.g., adult family home and assisted living), and in-home personal care services

Data Considerations: Most Medicaid beneficiaries are enrolled in managed care. While integrated managed care (IMC) plans and traditional medical managed care organizations submit priced encounter data into the State's MMIS data warehouse, Behavioral Health Organizations (BHO) do not submit priced encounters. Although they are being phased out as Washington transitions to the IMC model statewide, BHOs will continue to operate in three of the nine regions of the state until 2020.

In addition to the implications of unpriced BHO encounter data, there are other areas where information available on health service encounters does not reflect the full cost of service provision. Examples include (but are not limited to):

- FQHC and RHC enhancement payments;
- Non-emergency transportation and interpreter services provided via contracted brokers;
- Certified public expenditure (CPE) payments to hospitals; and
- Pharmacy rebate adjustments that are made outside of the context of the State's MMIS system.

Although we plan to shadow price BHO encounters and account for CPE program impacts on reported inpatient hospital expenditures, we do not anticipate adjusting for FQHC/RHC enhancements or pharmacy rebates or accounting for transportation and interpreter services provided via contracted brokers. As suggested in CMS evaluation design guidance, we will consider conducting utilization analyses without ascribing prices if shadow pricing BHO encounter data proves problematic.

We will also monitor the timeliness and completeness of claims data from IMDs. The ICDB currently applies a global six-month data lag on all claims data to mitigate completeness concerns. However, if there are additional completeness issues specific to IMDs, we will review the additional strategies provided by CMS to adjust our approach as necessary.

SECTION D: Methodological Limitations

Our evaluation will face a variety of limitations. This study provides analyses of changes over time and does not include a comparison or "counterfactual" group that would provide an indication for how access and related measures might have evolved in the absence of the SUD waiver. Thus, our analyses and estimates will be limited by assumptions about what we believe might have happened in the absence of the waiver. However, even simple descriptive analyses can provide valuable policy-relevant information. In particular, this assessment will provide information on entry and new beds from IMDs and the extent to which these are used by Medicaid patients.

A second and important limitation is the extent to which effects of ongoing efforts to address the opioid crisis, such as part of Project 3A, Initiative 1, in the larger Medicaid Transformation Project (MTP), may make it difficult to isolate or disentangle the effects of the SUD waiver. Fortunately, the larger evaluation includes plans to understand the effect of Project 3A. Findings for this work will inform our understanding of the impacts of the SUD waiver.

SECTION E: Additional Information/Attachments

Independent Evaluator Selection Process – No Attachment. For the broader 1115 Waiver evaluation, Washington selected an independent external evaluator that has the expertise, experience, and impartiality to conduct a sophisticated program evaluation that meets all requirements specified in the Special Terms and Conditions including specified reporting timeframes. Oregon Health Sciences University (OHSU) was selected after an RFP process. Required qualifications and experience included:

- Multi-disciplinary health services research skills and experience;
- An understanding of and experience with the Medicaid program;
- Familiarity with Washington State Medicaid programs and populations;
- Experience assessing the ability of health IT ecosystems to support delivery system and payment reforms, including issues related to governance, financing, policy/legal issues and business operations;
- And experience conducting complex, multi-faceted evaluations of large, multi-site health and/or social services programs.

Potential evaluation entities were assessed on their relevant work experience, staff expertise, data management and analytic capacity, experience working with state agency program and research staff, proposed resource levels and availability of key staff, track record of related publications in peer-reviewed journals, and the overall quality of their proposal. Proposed deliverables must meet all standards of leading academic institutions and academic journal peer review. In the process of identifying, selecting, and contracting with an independent external evaluator, the State acted appropriately to prevent a conflict of interest with the independent external evaluator. The independent external evaluator has no affiliation with ACHs or their providers.

After discussion with CMS, Washington received approval to use OHSU as the Independent Evaluator for the SUD amendment evaluation.

Evaluation Budget – No Attachment. At the time the original evaluation design was submitted to CMS, the evaluation budget was projected to be $4 million dollars. However, given the complexity of evaluation required, an addition $1.5 million dollars was added after the original evaluation design was submitted. OHSU is under contract to conduct the evaluation for the original 1115 Waiver. They have agreed to

incorporate the SUD amendment activities under the existing contract that has a total maximum contract amount of $5.5 million dollars. An estimate of the SUD evaluation budget is below:

Task	Estimated Cost
Total Staff	$302,100
Staff – Analytic Work	*$225,100*
Staff – Draft Interim Evaluation Report	*$25,900*
Staff – Final Interim Evaluation Report	*$12,600*
Staff – Draft Final Evaluation Report	*$25,900*
Staff – Final Evaluation Report	*$12,600*
Administrative Costs	$25,000
Other Costs	$1,000
TOTAL COSTS	**$328,100**

Timeline and Major Milestones

Due Date	Milestone / Deliverable
January 13, 2019	SUD Evaluation Draft Design
April 26, 2019	SUD Evaluation Design Revisions
June 28, 2019	SUD Evaluation Design Revisions
July 31, 2020	Obtain data from period Jan 2016 - Oct 2019
December 31, 2020	Conduct preliminary analyses
December 31, 2020	Draft Interim Evaluation Report to CMS
60 days from receipt of CMS comments	Final Interim Evaluation Report to CMS
July 31, 2021	Obtain new/refreshed data up through Oct 2020
June 30, 2023	Draft Final Evaluation Report to CMS
60 days from receipt of CMS comments	Final Evaluation Report to CMS

Section 7. SMI/SED Amendment Evaluation Design

Washington State Medicaid Transformation Project Section 1115(a) Medicaid Demonstration SMI/SED Amendment

Revisions Submitted: September 25, 2021

SECTION A: General Background Information.

For the past decade Washington State has focused on integrating physical and behavioral health purchasing as it continues to grapple with a severe lack of psychiatric inpatient bed capacity and health systems that have come to rely on state hospitals as the ultimate safety net for individuals with psychiatric needs. Western State Hospital, the larger of Washington's two state hospital, was decertified by CMS in 2018 having failed to meet conditions of participation. The legislature has determined the best course is to reposition state hospitals as forensic treatment centers and focus on developing more capacity in community settings.

Washington has also pursued several IMD related initiatives including, participation in the Affordable Care Act section 2707 Medicaid Emergency Demonstration Project from 2012-2014, negotiating with CMS to permit up to 30 days stay in community psychiatric hospital IMDs via prior "in lieu of" service rules from July 2014 through July 2017, until the revisions to 42 CFR §438.6(e) established a 15-calendar day length of stay limitation for managed care enrollees affected by IMD exclusion rules.

The original section 1115(a) waiver is effective January 9, 2017 through December 31, 2021. The SUD amendment is effective July 17, 2018 through December 31, 2021. The SMI/SED amendment is effective December 23, 2020 through December 31, 2021. In late 2020, Washington State requested a modification to its waiver timeline to extend the end date by one year. If approved, this amendment would extend the end date for Initiative 5 (and the 1115 waiver as a whole) to December 31, 2022. A determination has not been made about this request at the time this document was submitted for CMS review.

The Initiative 5 amendment is intended to ensure beneficiaries have access to a full range of evidence-based SMI treatment services including short-term acute care in inpatient settings as well as ongoing care for chronic conditions in community-based settings. A November 13, 2018 letter from CMS to State Medicaid Directors defined five goals of all state SMI waivers that applies to Washington's Initiative 5:

1) Reducing utilization and length of stay (LOS) in emergency departments among beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings;
2) Reducing preventable readmissions to acute care hospitals and residential settings;
3) Improving availability of crisis stabilization services, including call centers and mobile crisis units, intensive outpatient services, as well as acute short-term stays in residential stabilization programs, psychiatric hospitals and residential treatment settings;
4) Addressing chronic mental health care needs for beneficiaries with SMI or SED by improving access to community-based services through increased integration of primary and behavioral health care;
5) Improving care coordination and continuity of care following episodes of acute care in hospitals and residential treatment facilities.

The Initiative 5 amendment authorizes Washington State to receive Federal Financial Participation (FFP) for services provided to beneficiaries in IMDs for up to 60 days, on the condition that the average length of stay in IMDs is 30 days or less at the time of a mid-point assessment due September 30, 2023. Services provided in IMDs are not eligible for FFP for stays exceeding 60 days.

At present Washington State currently has 11 mental health Institution for Mental Diseases facilities providing acute inpatient care. Washington State's Medicaid inpatient psychiatric care network includes two distinct levels of care:

1) Psychiatric hospitals
2) Residential treatment facilities licensed as evaluation and treatment centers

At this time, all of the state's inpatient psychiatric Institution for Mental Diseases facilities are Medicare participating, nationally accredited, state licensed hospitals.

Under Washington State Law, RCW 71.24.510, an integrated comprehensive screening and assessment process for substance use and mental disorders is required for any provider offering treatment under the community behavioral health services act which would include all psychiatric hospitals and residential settings. WAC 246-341-0610 also requires facilities to provide a clinical assessment (including an assessment for suicidal ideation and SUD). WAC 246-341-0610 also includes the requirement to refer for provision of emergency/crisis services.

SECTION B: Evaluation Questions and Hypotheses

Logic Models

Figure 1. Goal #1: Reducing utilization and length of stay (LOS) in emergency departments among beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings

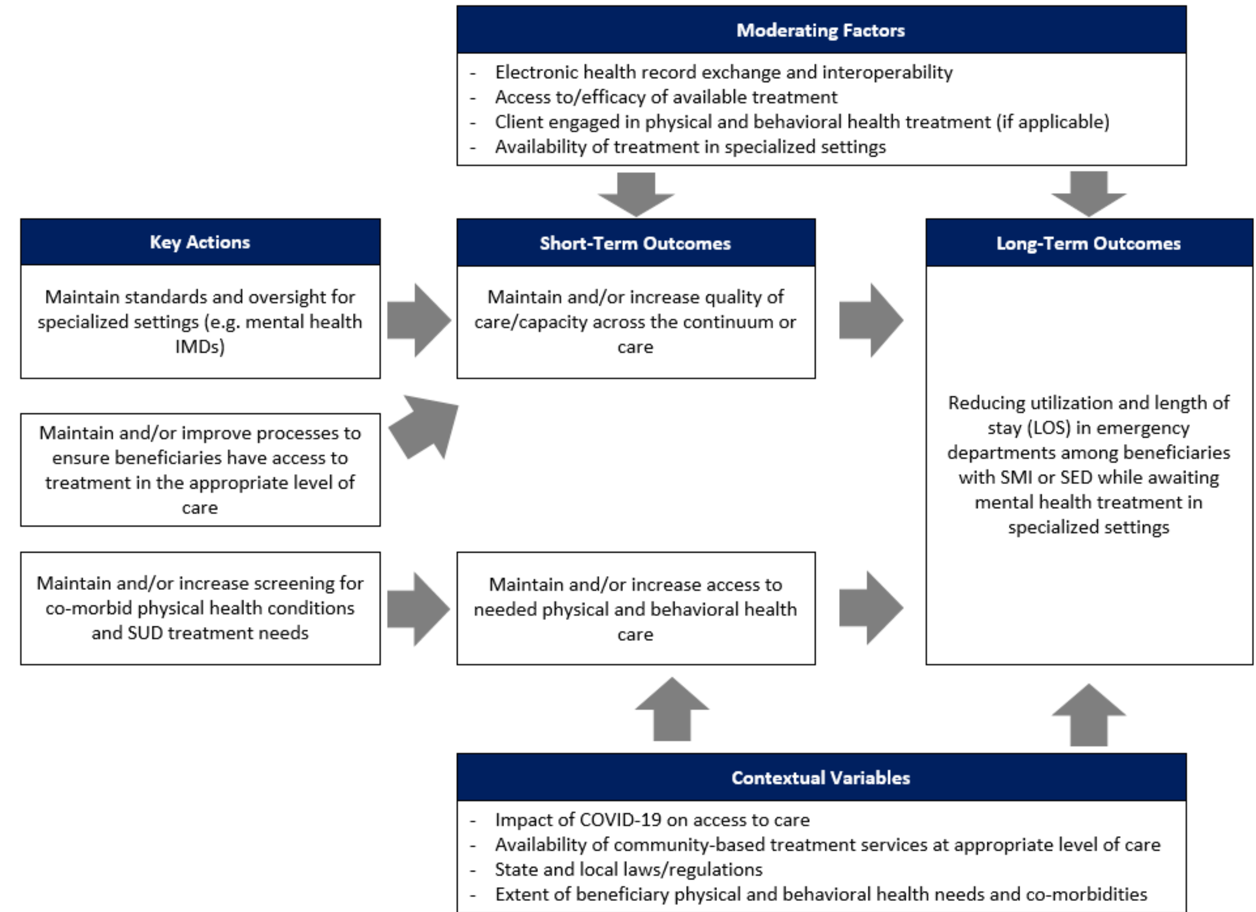


Figure 2. Goal #2: Reducing preventable readmissions to acute care hospitals and residential settings

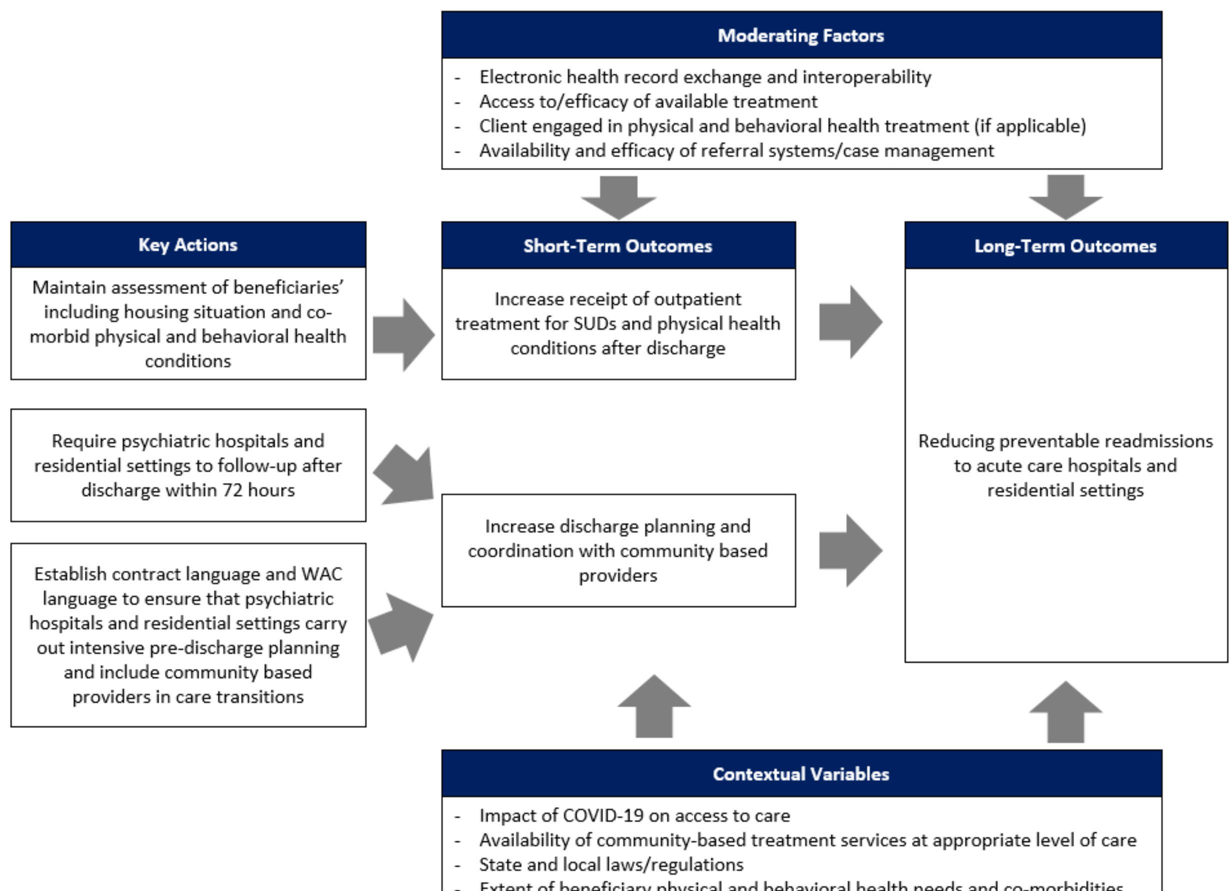


Figure 3. Goal #3: Improving availability of crisis stabilization services, including call centers and mobile crisis units, intensive outpatient services, as well as acute short-term stays in residential stabilization programs, psychiatric hospitals and residential treatment settings

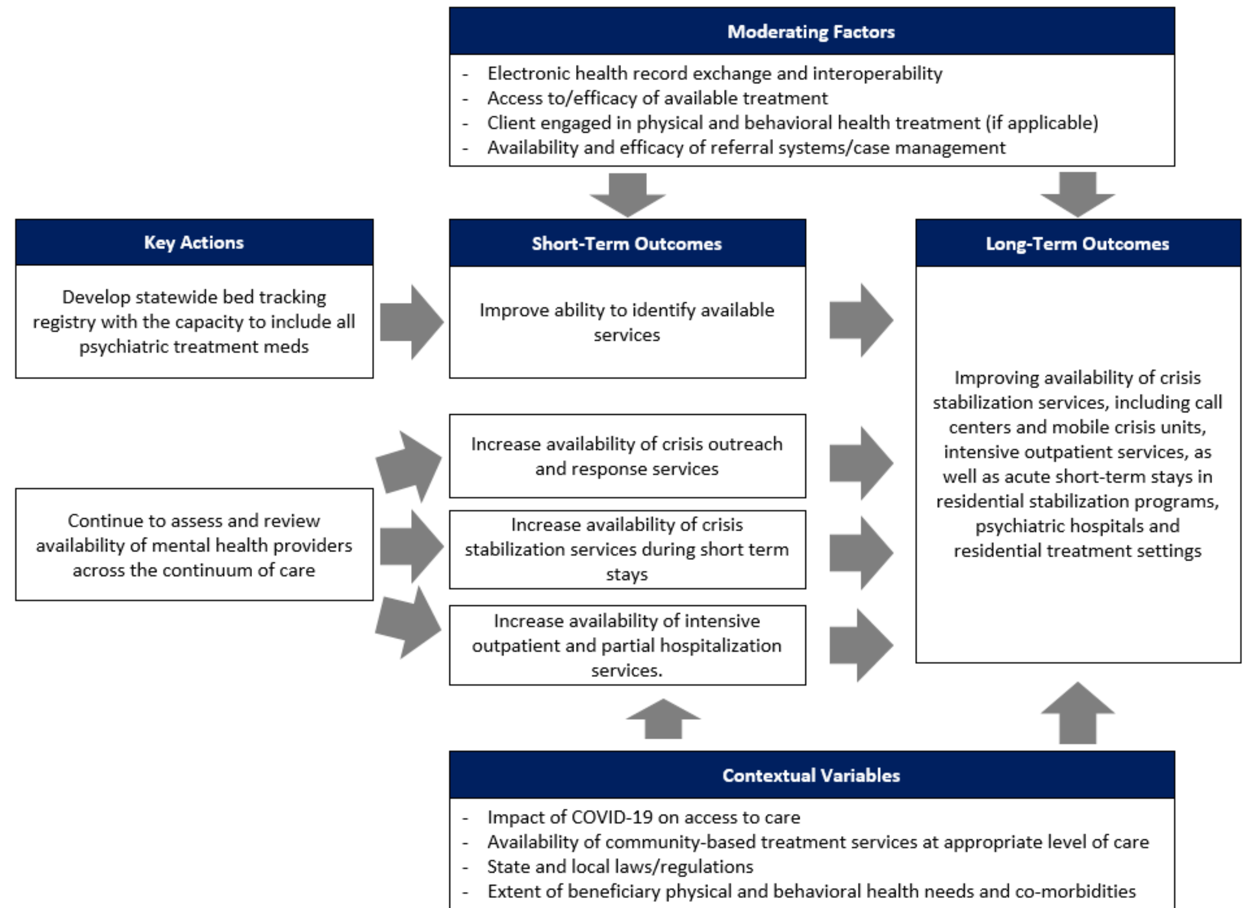


Figure 4. Goal #4: Addressing chronic mental health care needs for beneficiaries with SMI or SED by improving access to community-based services through increased integration of primary and behavioral health care

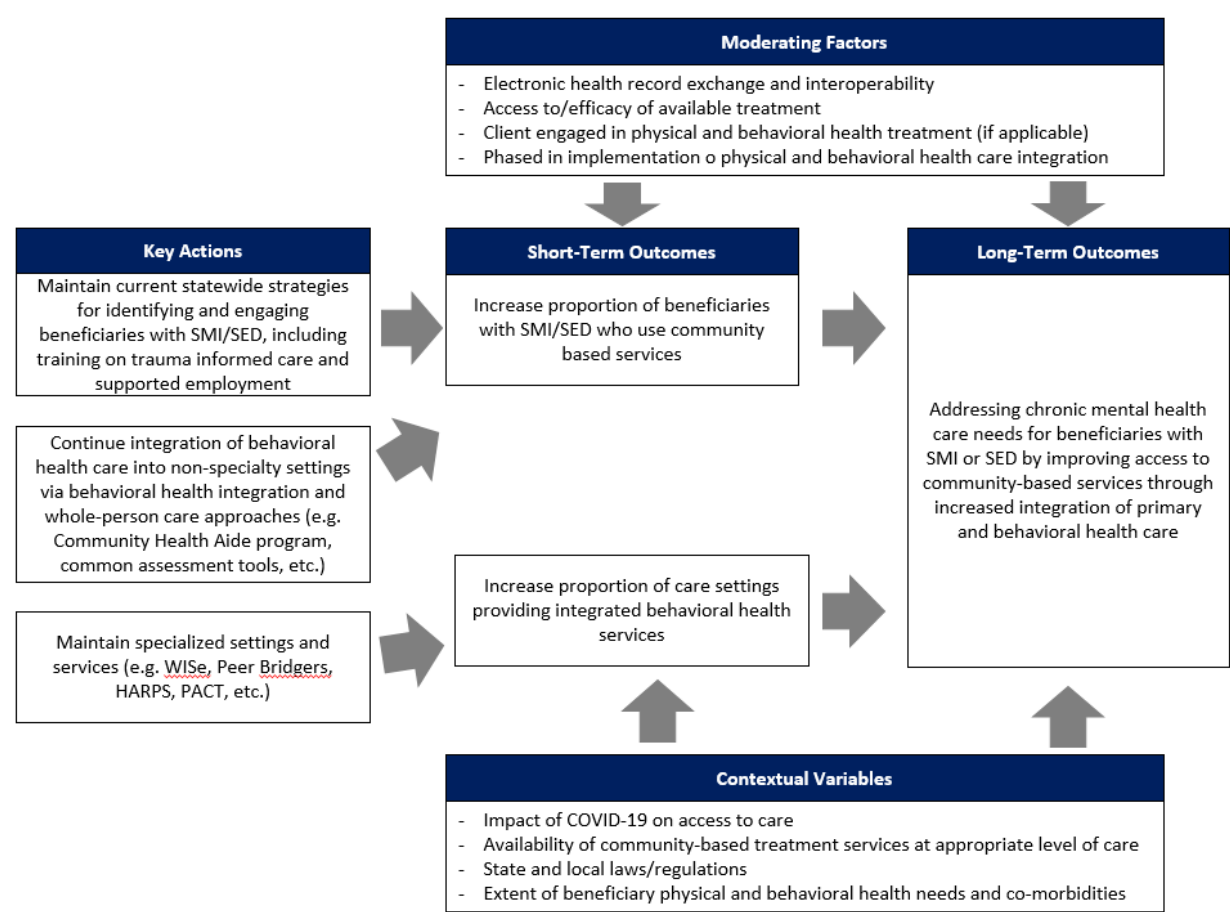
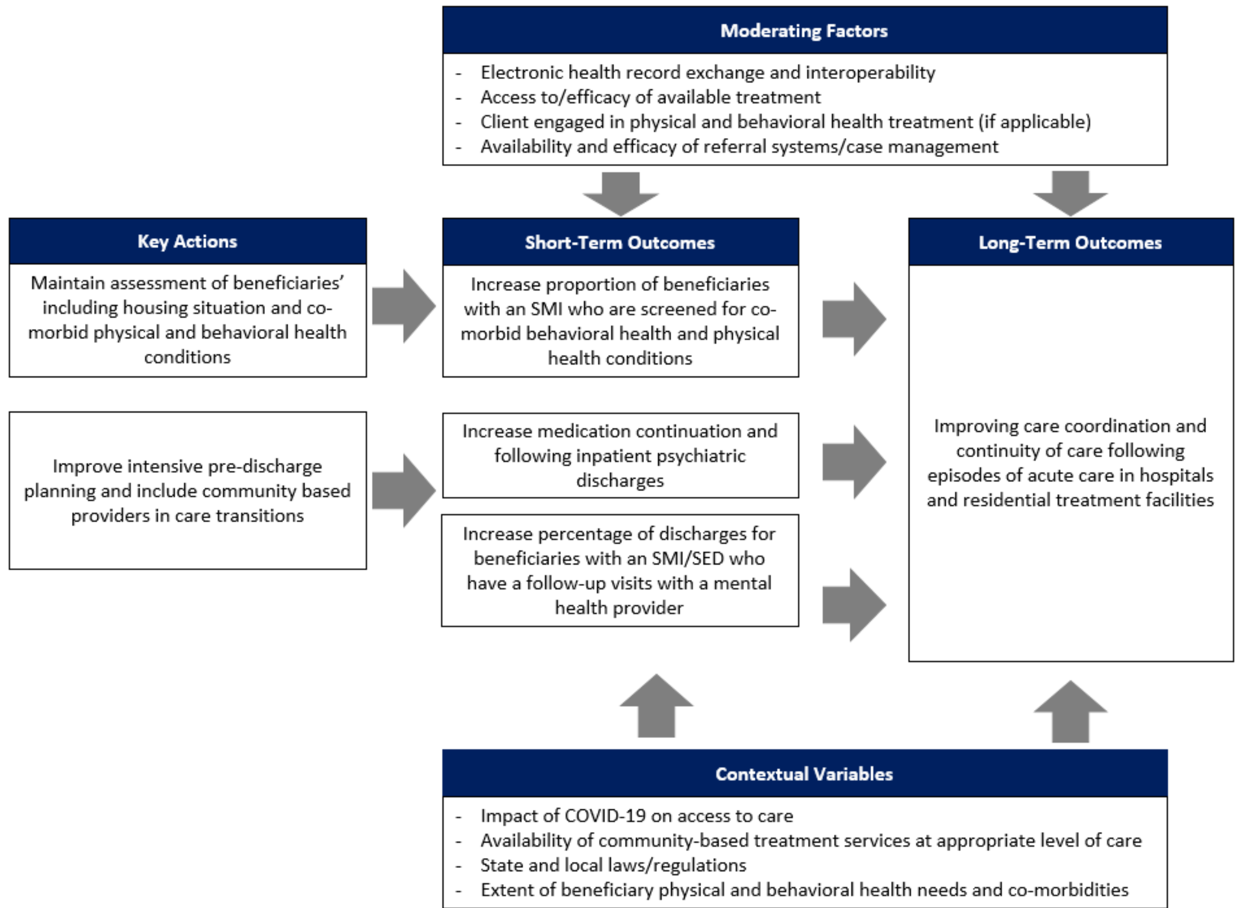


Figure 5. Goal #5: Improving care coordination and continuity of care following episodes of acute care in hospitals and residential treatment facilities



Questions and Hypotheses. The evaluation will test the five hypotheses presented in Exhibit A below which correspond to the five policy goals of Washington's Initiative 5. To test these five hypotheses, the evaluator will address a series of primary and subsidiary research questions that correspond to the recommended research questions presented in CMS' *Evaluation Design Guidance for Section 1115 Demonstrations for Beneficiaries with Serious Mental Illness/Serious Emotional Disturbance and Substance Use Disorders* (nd).

Hypothesis 1: The SMI/SED demonstrations will result in reductions in utilization and length of stay in EDs among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment. (Goal 1)

Research Question	Analytic Approach	Data Source	Population	Measures
RQ 1.0. Does the SMI/SED demonstration result in reductions in utilization and length of stay in EDs among Medicaid beneficiaries with	Modified difference-in-differences*	claims	members	Number of all-cause ED visits per 1,000 beneficiary-months among adult Medicaid beneficiaries age 18 and older who met the eligibility criteria of beneficiaries with SMI

SMI/SED while awaiting mental health treatment?	Modified difference -in- difference s*	claims	members	Number of beneficiaries with SMI/SED who use ED services for mental health during the measurement period
RQ 1.1. How do the SMI/SED demonstration effects on reducing utilization and length of stay in EDs among Medicaid beneficiaries with SMI/SED vary by geographic area or beneficiary characteristics?	Modified difference -in- difference s*	claims	Members, including subgroups by MCO region, race/ethnicit y, chronic disease, SUD diagnosis, and age (0-17, 18-64, 65+), CBS users	Number of all-cause ED visits per 1,000 beneficiary-months among adult Medicaid beneficiaries age 18 and older who met the eligibility criteria of beneficiaries with SMI
RQ 1.2. How do SMI/SED demonstration activities contribute to reductions in utilization and length of stay in EDs among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment in specialized settings?	qualitativ e	KI interviews	ED and state demonstrati on staff	• Demonstration activities or their components or characteristics that stakeholders identify as most effective in reducing utilization and lengths of stays in EDs among Medicaid beneficiaries with SMI or SED • Obstacles that stakeholders identify as hindering the effectiveness of the demonstration in reducing utilization and lengths of stays in EDs
	qualitativ e	KI interviews	ED and/or state demonstrati on staff	• Changes made through the demonstration to systems, processes, or policies related to tracking inpatient psychiatric bed availability in real time Demonstration activities that ED and/or state demonstration staff identify as most effective for improving the ability to track inpatient psychiatric bed availability in real time • Obstacles that ED and/or state demonstration staff identify as hindering the effectiveness of demonstration activities aimed at improving systems or processes for tracking inpatient psychiatric bed availability in real time

* Modified difference-in-differences. We will explore the potential to compare changes in outcomes of individuals with SMI/SED to those without SMI/SED. This approach departs from traditional difference-in-differences approaches where the comparison group is similar in demographics and differentiated by absence of treatment. We will assess the viability of this approach by reviewing the data and comparability of trends among different groups. A default

approach (including for measures that are limited by definition to people with behavioral health risk factors) is to assess pre-post changes over time, as planned for some analyses below, where a comparison group is not available.

Hypothesis 2: The SMI/SED demonstration will result in reductions in preventable readmissions to acute care hospitals and residential settings. (Goal 2)

Research Question	Analytic Approach	Data Source	Population and subgroups	Measures
RQ 2.0. Does the SMI/SED demonstration result in reductions in preventable readmissions to acute care hospitals and residential settings (including, short-term inpatient and residential admissions to both IMDs and non-IMD acute care hospitals, critical access hospitals, and residential settings)?	pre-post	claims	members	Thirty-day, all-cause unplanned readmissions following psychiatric hospitalization
RQ 2.1. How do the SMI/SED demonstration effects on reducing preventable readmissions to acute care hospitals and residential settings vary by geographic area or beneficiary characteristics?	pre-post	claims	Members, including subgroups by MCO region, race/ethnicity, chronic disease, SUD diagnosis, and age (0-17, 18-64, 65+), CBS users	Thirty-day, all-cause unplanned readmissions following psychiatric hospitalization
RQ 2.2. How do demonstration activities contribute to reductions in preventable readmissions to acute care hospitals and residential settings?	qualitative	KI interviews	hospital/residential staff and community-based service providers	• Demonstration activities or their components or characteristics that stakeholders identify as most effective in reducing preventable readmissions to acute care hospitals and residential settings • Obstacles that stakeholders identify as hindering the effectiveness of the demonstration in reducing preventable readmissions to acute care hospitals and residential settings

	pre-post	claims	members	Qualifying discharges with 30-day, all-cause unplanned readmissions following psychiatric hospitalization who receive community-based treatment services in the 7 and 30 days prior to readmission
RQ 2.3. Does the SMI/SED demonstration result in increased screening and intervention for comorbid SUD and physical health conditions during acute care psychiatric hospital and residential setting stays and increased treatment for such conditions after discharge?	pre-post	claims	members	• Proportion of beneficiaries who receive outpatient treatment for SUDs and physical health conditions within 30 days after discharge from a psychiatric inpatient or residential treatment facility • Proportion of beneficiaries who receive inpatient/residential treatment for SUDs and physical health conditions within 30 days after discharge from a psychiatric inpatient facility

Hypothesis 3: The SMI/SED demonstration will result in improved availability of crisis stabilization services throughout the state. (Goal 3)

Research Question	Analytic Approac h	Data Source	Population	Measure
RQ 3.1. To what extent does the SMI/SED demonstration result in improved availability of crisis outreach and response services (including, crisis call centers, mobile crisis units, crisis observation/assessment centers, and coordinated community crisis response teams) throughout the state?	pre-post	annual availability assessment	facilities	Number of crisis call centers Number of mobile crisis units Number of crisis observation/assessment centers Number of coordinated community crisis response teams
	pre-post	annual availability assessment	Facilities, including by MCO region	The ratio of Medicaid beneficiaries with SMI/SED to the number of: •Crisis call centers •Mobile crisis units •Crisis observation/assessment centers •Coordinated community crisis response teams
RQ 3.2. To what extent does the SMI/SED demonstration result in improved availability of intensive outpatient services and partial hospitalization?	pre-post	annual availability assessment	Members, including by MCO region	Number of Medicaid-enrolled intensive outpatient and partial hospitalization providers
	pre-post	annual availability assessment	Providers, including by MCO region	Ratio of Medicaid beneficiaries with SMI/SED to Medicaid-enrolled intensive outpatient/partial hospitalization providers

RQ 3.3. To what extent does the SMI/SED demonstration improve the availability of crisis stabilization services provided during acute short-term stays in each of the following: public and private psychiatric hospitals; residential treatment facilities; general hospital psychiatric units; and community-based settings (such as residential crisis stabilization programs, small inpatient units in community mental health centers, peer-run crisis respite programs, and so on)?	pre-post	annual availability assessment	facilities	Number of psychiatric hospitals Total number of residential mental health treatment facilities and beds (adult) Number of Medicaid-enrolled psychiatric residential treatment facilities and beds (child) Number of Medicaid-enrolled psychiatric units in acute care and critical access hospitals Number of licensed psychiatric hospital and psychiatric unit beds Number of crisis stabilization units
	pre-post	annual availability assessment	Facilities, including by MCO region	The ratio of the number of Medicaid beneficiaries with SMI/SED to the number of: •Psychiatric hospitals •Medicaid-enrolled psychiatric units in acute care and critical access hospitals •Licensed psychiatric hospital and psychiatric unit beds •Crisis stabilization units
	pre-post	annual availability assessment	Facilities, including by MCO region	The ratio of Medicaid beneficiaries with SMI to the total number of residential mental health treatment facilities and beds (adult)
	pre-post	annual availability assessment	Facilities, including by MCO region	The ratio of Medicaid beneficiaries with SED to the number of Medicaid-enrolled psychiatric residential mental health treatment facilities and beds (child)

Hypothesis 4: Access of beneficiaries with SMI/SED to community-based services to address their chronic mental health care needs will improve under the demonstration, including through increased integration of primary and behavioral health care. (Goal 4)

Research Question	**Approach**	**Data source**	**Unit or Pop**	**Measure**
RQ 4.1. Does the demonstration result in improved access of beneficiaries with SMI/SED to community-based services to address their chronic mental health care needs?	Modified difference-in-differences*	claims	members	• Proportion of beneficiaries with SMI/SED who use mental health–related (1) outpatient, rehabilitation, and targeted case management services and (2) home and community-based services. • Proportion of beneficiaries with SMI/SED who use mental health-related (1) outpatient, rehabilitation, and targeted case

				management services; and (2) long-term services and supports.
	Modified difference-in-differences*	claims	services	Amount of mental health–related (1) outpatient, rehabilitation, and targeted case management services; (2) home and community-based services; and (3) long-term services and supports used by beneficiaries with SMI/SED
	pre-post	claims	members	Ratio of non-inpatient/nonresidential costs associated with mental health services to inpatient or residential costs, for beneficiaries with SMI/SED**
RQ 4.1a.To what extent does the demonstration result in improved availability of specific types of community-based services needed to comprehensively address the chronic needs of beneficiaries with SMI/SED?	pre-post	annual availability assessment	providers	Number of Medicaid-enrolled: •Community mental health centers •Psychiatrists and other mental health practitioners authorized to prescribe •Mental health practitioners (other than psychiatrists) who are certified and licensed by the state to independently treat mental illness
RQ 4.1b. To what extent does the demonstration result in improved access of SMI/SED beneficiaries to the specific types of community-based services that they need?	pre-post	claims	members	The percentage of children and adolescents ages 1 to 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment
	pre-post	claims	members	Percentage of new antipsychotic prescriptions for Medicaid beneficiaries age 18 and older who have completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication
RQ 4.1c. How do the SMI/SED demonstration effects on access to community-based services vary by geographic area or beneficiary characteristics?	pre-post	annual availability assessment	Providers, including by MCO region	The ratio of Medicaid beneficiaries with SMI/SED to Medicaid-enrolled: •Community mental health centers •Psychiatrists and other mental health practitioners authorized to prescribe •Mental health practitioners (other than psychiatrists) who are certified and licensed by the state to independently treat mental illness

RQ 4.2. Does the integration of primary and behavioral health care to address the chronic mental health care needs of beneficiaries with SMI/SED increase under the demonstration?	pre-post	annual availability assessment	facilities	Number of FQHCs that offer behavioral health services
	pre-post	claims	Providers	Number and percentage of Medicare FFS or Medicaid providers providing behavioral health integration services
**Beginning in 2018, Washington State started the transition from reliance on state hospitals to local facilities for civil commitments. Inpatient stays resulting from civil commitments that would have previously referred to a Washington state psychiatric hospital will be excluded from this calculation to attempt to isolate changes associated with the SMI/SED demonstration.				

Hypothesis 5: The SMI/SED demonstrations will result in improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities. (Goal 5)

Research Question	Approach	Data Source	Population	Measure
RQ 5.1. Does the SMI/SED demonstration result in improved care coordination for beneficiaries with SMI/SED?	Modified difference -in-differences*	claims	members	Percentage of patients age 18 and older with an SMI who were screened for unhealthy alcohol use with a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user
	pre-post	claims	members	Percentage of discharges for patients age 18 and older who had a visit to the ED with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7 and 30 days of discharge
	qualitative	KI interviews	state demonstration and/or inpatient/residential and outpatient provider staff	• Changes made through the demonstration to data sharing systems, processes, or policies *Demonstration activities regarding data sharing systems, processes, or policies that staff identify as most effective for improving care coordination • Obstacles that staff identify as hindering the effectiveness of demonstration activities regarding data sharing systems, processes, or policies aimed at improving care coordination

RQ 5.2. Does the SMI/SED demonstration result in improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities?	pre-post	claims	services	Medication continuation following inpatient psychiatric discharge
	pre-post	claims	members	The percentage of discharges for patients age 6 to 17 who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner
	pre-post	claims	members	The percentage of discharges for patients age 18 and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner
	pre-post	claims	Members, including subgroups by MCO region, race/ethnicity, chronic disease, SUD diagnosis, and age (0-17, 18-64, 65+), CBS users	Amount of mental health–related (1) outpatient, rehabilitation, and targeted case management services; (2) home and community-based services; and (3) long-term services and supports used by beneficiaries within 30 days after discharge from a psychiatric inpatient or residential treatment facility
RQ 5.2a. Does the SMI/SED demonstration result in improved discharge planning and outcomes regarding housing for beneficiaries who are transitioning out of acute psychiatric care in hospitals and residential treatment facilities?	pre-post	claims	members	Percentage of members who receive acute psychiatric care in a hospital or residential treatment facility who experience homelessness within 12 months of discharge
RQ 5.2b. How do demonstration activities contribute to improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities?	qualitative	KI interviews	state demonstration and/or inpatient/residential and outpatient provider staff	• Demonstration activities or their components or characteristics that stakeholders identify as most effective in improving continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities • Obstacles that stakeholders identify as hindering the effectiveness of the demonstration in improving continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities

Hypothesis 6: The SMI/SED demonstration will result in changes in health care spending.

Research Question	Approach	Data Source	Population	Measure
RQ 6.1: Does the SMI/SED demonstration result in higher or lower total costs per member per month (PMPM) inclusive of spending on inpatient, outpatient, pharmacy and long-term care?	pre-post	claims	members	• Sum of inpatient, outpatient, prescription, long term care and IMD costs (see cost analysis section for more detail). • Total federal costs (total Medicaid costs * federal medical assistance percentage (FMAP))
RQ 6.2: Does the SMI/SED demonstration result in higher, neutral or lower cost related to diagnosis and treatment of SMI/SED?	pre-post	claims	members	• IMD costs reported by the state with primary SMI/SED diagnosis and/or procedure codes • Other (non-IMD) costs with SMI/SED diagnosis and/or procedure code
	pre-post	claims	members	• IMD costs reported by the state with primary SUD diagnosis or procedure code • Other (non-IMD) costs with SUD diagnosis and/or procedure code
RQ 6.3: What are the drivers of SMI/SED treatment costs?	pre-post	claims	members	• Inpatient costs • Emergency department costs • Behavioral health outpatient costs

				• Non-behavioral health outpatient costs • Prescription drug costs • Long-term care costs

SECTION C: Methodology

Evaluation Methodology. The focus of the SMI amendment evaluation will be quantitative, relying primarily on administrative data from the State's Integrated Client Data Bases (ICDB). We will use claims data to conduct pre-post analyses, with potential sensitivity analyses and supplemental analyses to assess pre-policy trends and the utility of interrupted-time series analyses. Analysis of cost trends will consider a comparison group approach, contrasting PMPM cost trends for persons with SMI relative to Medicaid beneficiaries without SMI, as described more fully below.[23] Where possible, we will leverage ongoing contextual information gathered by the research team as part of the overall MTP evaluation. We provide more detail in the "Analytic Methods" section below.

Target and Comparison Populations. As noted above, the waiver is intended to improve outcomes for these specific populations:

- Adult beneficiaries with a diagnosed serious mental illness (SMI)
- Child beneficiaries with a diagnosed serious emotional disturbance (SED)

To identify members with SMI we will use the definition of SMI that has been used for the larger MTP waiver evaluation. Our definition of SMI includes at least one inpatient or psychiatric residential claim or at least two outpatient claims on separate dates with a primary diagnosis of schizophrenia (F20, F25), bipolar I (F30, F31.0-F31.78), major depressive disorder (F32.2, F32.3, F33.2, F33.3), or other schizophrenia spectrum or psychotic disorder (F28).

For SED, we propose a definition that builds on a definition from a 1993 *Federal Register* and advice from a 2014 expert panel convened by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Center for Behavioral Health Statistics and Quality (CBHSQ). [CITE: Serious Emotional Disturbance (SED) Expert Panel Meetings' Substance Abuse and Mental Health Services Administration (SAMHSA) & Center for Behavioral Health Statistics and Quality (CBHSQ); September 8 and November 12, 2014]

We include the following categories, derived from ICD-10 groupings as part of the Agency for Healthcare Research and Quality's Clinical Classification Software Refined (CCSR) [CITE https://www.hcup-us.ahrq.gov/toolssoftware/ccsr/ccs_refined.jsp]:

- RNVS016, Sleep wake disorders
- MBD001, Schizophrenia spectrum and other psychotic disorders
- MBD002, Depressive disorders
- MBD003, Bipolar and related disorders
- MBD004, Other specified and unspecified mood disorders
- MBD005, Anxiety and fear-related disorders
- MBD006, Obsessive-compulsive and related disorders
- MBD007, Trauma- and stressor-related disorders

[23] As an illustration of this type of approach, see "Bending the Health Care Cost Curve by Expanding Alcohol/Drug Treatment" at https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-4-81.pdf.

- MBD008, Disruptive, impulse-control and conduct disorders
- MBD009, Personality disorders
- MBD010, Feeding and eating disorders
- MBD011, Somatic disorders
- MBD013, Miscellaneous mental and behavioral disorders/conditions
- MBD012, Suicidal ideation/attempt/intentional self-harm
- MBD027, Suicide attempt/intentional self-harm; subsequent encounter
- EXT021 External cause codes: intent of injury, self-harm

We also include ICD10 codes R455-R457, R4583, R45850, R4587, R462, R466, and R4681 to capture psychotic symptoms/experiences, mania/hypomania, suicidality, regulatory behaviors, and codes F900-902 and F908-F909 to capture attention-deficit hyperactivity disorders. Following federal guidance, we further exclude any codes that include substance use disorders.

Study Populations. We will identify the first population, adult beneficiaries with a diagnosed serious mental illness, from the larger population of people age 18 years or older in Washington State who are enrolled in Medicaid during the study period, using claims and enrollment data obtained from Washington State. We will further stratify this population into age bands including 1) members age 18-64, and 2) members 65 years and older.

We will identify the second population, child beneficiaries with a diagnosed serious emotional disturbance, from the population of people age 0-17 years of age in Washington State who are enrolled in Medicaid during the study period, also using claims and enrollment files.

Subgroups. We will obtain demographic data from Washington State as necessary to further stratify our study populations by:

- Managed Care Organization (MCO) region.
- Race and ethnicity.
- Presence or absence of a chronic disease (as defined through a standardized approach such as the Chronic Conditions Warehouse (CCW) that will be selected by the evaluator).
- Substance use disorder diagnosis (as defined in Washington's SUD waiver evaluation).
- Use of Community Based Services (using an approach we will develop in collaboration with the state).
- Medicaid Eligibility Groups.

Due to the volume of sub-analyses and measures, the IEE will work with Washington State to identify particular sub-analyses for inclusion in the evaluation report, and will report other results of sub-analyses in a supplemental data appendix to the final report.

Comparison groups. Washington's SMI/SED waiver affects individuals across the state and occurs during a time of widespread transformation. An ideal evaluation design might include a comparison state that would allow us to net out secular trends. However, we do not believe a comparison state is feasible for the current evaluation. States geographically close to Washington – including Oregon and Idaho – are undertaking their own reforms addressing mental health, and thus are not a good "business as usual" comparison for Washington State. Washington's implementation plan for its SMI/SED waiver will address all regions of the

state on a single timeline, which will not allow us to exploit differences in regional implementation timing to construct within-state comparison groups.

In the absence of a strong comparison group outside the state or within the state, we believe that our analysis of a long-time series of longitudinal Washington data – beginning in 2016 and running through 2021 or 2022, will allow us to describe how access and quality may change following the implementation of the SMI/SED waiver. We anticipate that this approach will allow for a thorough assessment of Washington's performance, particularly when the findings are placed in the appropriate context of a dynamic policy and payment environment.

Evaluation period. The IMD provisions in the final rule were for rates effective on or after July 5, 2016 (though later extended to rates on or after October 1, 2016 through a CMS-issued addendum). Because WA Behavioral Health Organization rates operated on a State Fiscal Year (July – June) basis, implementation of the rule started with rates effective 7/1/17 (see Figure 1). The final evaluation will include data from April 2016 through either September 2020 or December 2020, allowing for 8 or 9 quarters of "pre-policy" analysis, including 15 months of data prior to the implementation of the Managed Care Final Rule and up to 10 quarters of post-policy analysis. The final number of quarters post-policy analysis is dependent on the availability of fully mature data.

The variable number of pre-policy analysis is due to the needed alignment with the state reporting and data structure. The effective date of the Washington SMI demonstration is December 23, 2020. However, to align with existing reporting infrastructure, January 1, 2021 is used as the start date for reporting. This does not change the effective date of the demonstration. For evaluation purposes, the pre-period for the evaluation could either (1) include ~8 days in which the SMI IMD waiver was active in the final quarter of 2020 or (2) be modified to end September 2020 so there is no overlap with the SMI IMD waiver implementation, but two plus months of the final quarter of 2020 will not be included in the pre-period but could potentially be considered a transition quarter. CHSE will examine both approaches and determine the most effective analytic approach.

CHSE proposes a measurement period spanning January 2016 through December 2021 for claims-based measures and June 2022 for qualitative and assessment-based measures (assuming no extension year is granted by CMS for Washington's MTP demonstration).

Because of the relatively short duration of the waiver, which expires December 2021, the evaluator will not prepare an interim report.

A final evaluation report will be prepared and submitted to CMS in June 2023. This report will address all hypotheses and research questions indicated above, and will include:

- Analysis of administrative claims and encounters data inclusive of a baseline period (spanning January 2016 to December 2020) and a post-implementation period (January 2021 to December 2021).
- Findings related to waiver implementation drawing from qualitative data collected through June 2022, the year after implementation of the waiver (or the second demonstration year, if an extension is approved).

Analysis of facility and capacity data spanning a baseline period of July 2018 through June 2022.

Data Sources. The evaluation will rely on four sources of data – Medicaid administrative data, state IMD data, a service availability assessment prepared by state as a reporting requirement under its monitoring protocol, and key informant interviews that will be conducted by the evaluator. Each of these data sources are described in further detail below.

Claims Data. The evaluation will include an analysis of member-level Medicaid data obtained from the State of Washington, inclusive of claims, encounters, enrollment, and member-level demographic variables for the study period (See Section 3 "Quantitative analyses leveraging integrated administrative data" for more information). Under existing agreements with Washington State, the IEE already obtains Medicaid administrative data on a rolling quarterly basis to support the state's 1115 waiver evaluation (with transmissions occurring approximately in February, May, August and November during the evaluation period). These previously scheduled quarterly data transmissions are planned to occur at the same intervals and through the same time period that will be needed to complete the SMI/SED waiver evaluation. The IEE will work with the state to identify all necessary data elements for the analyses described in this document and ensure they are obtained on this schedule.

State IMD Data. The Washington State Department of Health (DOH) oversees the licensing of behavioral health facilities. When a new behavioral health facility opens or changes the number of beds it operates, the Washington Health Care Authority (HCA) assesses the facility to determine if it meets the criteria for IMD designation. This assessment is based on federal IMD rules. Information about new IMD facilities or changes in IMD certification are communicated between DOH, HCA, and DSHS-RDA. This ensures that the number of facilities and beds that are SUD IMD certified is regularly updated in the State IMD dataset to reflect SUD IMD availability in the state.

Service Availability Assessment. The evaluation will rely on a service availability assessment prepared by Washington State in support of its monitoring and reporting requirements to CMS (the "Assessment of the Availability of Mental Health Services"). The workbook for this assessment will capture facility-level and provider level data such as bed-counts and capacity, enrolled providers, etc. The state and evaluator are currently working to determine if individual provider/facility level information will be available or if the aggregate information in the availability assessment will be used. The state will make this workbook available to the evaluator in 2021, 2022 and 2023 following submission of the workbook to CMS.

Key Informant Interviews. The evaluation will incorporate approximately 20-30 key informant interviews with representatives from the following groups to address specific research questions:

Table 2. Key Informant Interviews by Category

Informant Category	Estimated Sample	Research Questions Addressed
1. Emergency Department	3-4	1.2
2. Psychiatric hospitals and inpatient residential facilities	5-7	2.2, 5.1, 5.2b
3. Outpatient psychiatric facilities	3-5	5.1, 5.2b
4. Community-based mental health service providers	5-8	2.2
5. State agency staff	1-2	1.2, 5.1, 5.2b
6. Managed care organizations (MCOs)	2-4	

Total	20-30	

The IEE will develop a purposive sampling frame that maximizes variation in informant geography (at the level of Washington's Accountable Communities of Health regions) and urban/rural representation for the interview sample as a whole, and minimizes duplication of ACH region or urban/rural designation within any of the specific informant categories. The evaluator will consult with Washington State to identify additional organizational characteristics of interest such as organizational ownership, payer mix, size or service types, to be prioritized within the sampling frame for each informant category.

For categories 1-4 above, prospective interview participants will be identified from a list of all Medicaid provider organizations the IEE previously obtained from Washington State to support primary data collection at the provider organization level. Prospective participants meeting sampling frame criteria will be further prioritized in consultation with state agency staff identified as subject matter experts. The IEE will make a final determination regarding prospective participants and conduct outreach and recruitment on an iterative basis as needed to achieve the intended sample size and mix.

One or two members of the research team will conduct semi-structured interviews with recruited key informants by video conference from approximately March 2022 (eighteen months after the launch of the SMI waiver amendment) to June 2022. This period also corresponds to the end date of the quantitative measurement period for the evaluation (June 2022). Interview guides will be developed and tailored to each informant's specific organizational setting, addressing topics including:

- Demonstration activities or their components or characteristics that stakeholders identify as effective in achieving goals of the demonstration including (Research Questions 1.2, 2.2, 5.2b):
  - Reducing utilization and lengths of stays in EDs among Medicaid beneficiaries with SMI or SED.
  - Improving the ability to track inpatient psychiatric bed availability.
  - Reducing preventable readmissions to acute care hospitals and residential settings.
  - Improving care coordination through data sharing systems, processes, or policies.
  - Improving continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.
- Obstacles that stakeholders identify as hindering the effectiveness of the demonstration in achieving its goals. (Research questions 1.2, 2.2, 5.1, 5.2b).
- Changes made through the demonstration to data sharing systems, processes, or policies, including tracking inpatient psychiatric bed availability. (Research questions 1.2, 5.1, 5.2b).

All interviews will be recorded and transcribed for subsequent analysis (as detailed in the analytic methods section below).

The IEE will request and obtain approval from the Washington State Institutional Review Board for the sampling strategy and materials to be used in key informant interviews prior to any key informant recruitment or engagement. No monetary incentives will be offered to informants in exchange for their participation, as many informants may be prohibited by agency or organizational policy from accepting such payments. The IEE will provide information regarding the potential benefits and risks of participation to informants. All interviews will be conducted confidentially, and informants and their organizations will be de-identified in reported results.

Analytic Methods – Quantitative Methodology

As a whole, the nature of the waiver design does not point to a clear comparison group that would support a quasi-experimental design across all measures of interest. Where possible, CHSE will use propensity score matching to construct a suitable comparison group of Medicaid enrollees to support a difference-in-differences analysis. Where a comparison group cannot be constructed through this approach, CHSE will measure pre-post changes in measures of interest.

Measure Specifications and Benchmarks. The CMS' *Evaluation Design Guidance for Section 1115 Demonstrations for Beneficiaries with Serious Mental Illness/Serious Emotional Disturbance and Substance Use Disorders* (nd) lists measures we will use for to carry out these analyses (see Appendix E.4 of this document). We will analyze changes over the 2016-2021 time period.

Statistical Models. This demonstration evaluation will allow us to assess outcomes from 2016 through December 2021. This demonstration occurs in the context of the onset of the COVID-19 pandemic in 2020, the effects of which are likely to permeate throughout 2021. We propose to assess the data over the course of 2016-2021 in order to identify the most appropriate baseline or comparison. We note that the 2020 COVID-19 pandemic represents a significant disruption in routine care. We will maintain a flexible approach, aiming to provide the most robust and reliable estimates that still account for this unprecedented event. Our mixed methods approach, which incorporates qualitative and quantitative data, will strengthen our ability to place our findings in the appropriate context.

Covariates. Proposed individual level covariates include age-range (0-2, 3-11, 12-18, 19-35, 36-55, and 55-64, and 65+ (where dually eligible individuals are included)); gender; urban residence based on zip code and the Chronic Illness and Disability Payment System (CDPS) risk adjustment methodology.

Approach to Statistical Analysis. Our analyses will be tailored to the specific questions and hypotheses. In general, we will adhere to this approach for analyses that do not include comparison data (i.e., those focusing on pre- to post-intervention analyses:

- Visual inspection of the data, characterized by unadjusted trends and graphical exploration of the outcomes in question over the relevant time period.
- Statistically adjusted pre-post analyses, allowing for different effects across each of the post-intervention years. These analyses are intended to assess the potential for differential changes across years, and are described below.

Model Specifications Models. Our primary model is a flexible model designed to assess changes over time:

$$Y_{it} = m(b_0 + b_1*Year2017 + b_2*Year2018 + b_3*Year2019 + b_4*Year2020 + b_5*Year2021 + + a*X_{it} + e_{it}) \quad (1)$$

where Y_{it} is the outcome of interest for individual i in year t, Year20XX = 1 if the observation occurs in the Year 20XX and 0 otherwise; X_{it} is a vector of demographic covariates and risk adjusters, and e_{it} is

a random error term associated with the unmeasured variation in the outcome of interest. The coefficients on the Year20XX dummies provide an estimate of how much the outcome variable changed relative to the reference year (2016). Our main interest will be on the value of the coefficient b_5. However, modeling the progression over time will allow us to assess pandemic-related changes.

In this equation, m is a general function indicating the relationship between the outcome Y and the independent variables. For example, some outcomes will be continuous variables; others will be dichotomous (0/1) variables. We will choose the regression model – e.g., linear regression, logistic regression, generalized linear model – that is most suitable for the distribution of the outcome variable Y.

This regression approach offers a flexible model that allows for year-to-year assessments. Some analyses call for explorations of subgroup populations. We will assess these trends visually, as well as compare their outcomes to a reference group, to be determined as described above.

For select analyses, we will also test a "modified difference-in-differences" approach. For some outcomes – e.g., all-cause ED visits – it may be possible to consider adults with SMI as the "treated" group and use adults without SMI as a "comparison" group. In this case, we could test the following model:

$$Y_{it} = m(b_0 + b_1 * post2021 + b_2 * SMI + b_3 * SMI * post2021 + a * X_{it} + e_{it}) \quad (2)$$

Where "post2021" represents observations in 2021, and "SMI" represents individuals with SMI. model would provide an assessment of changes among the SMI population with the demonstration implementation, compared to changes among adults without SMI.

Analytic Methods – Cost Analysis

A key component of the evaluation will focus on understanding how the change in FFP bends the cost curve and affects utilization trends for the risk pool we expect to be impacted by the amendment – Medicaid beneficiaries with SMI. In addition to analyzing changes in service utilization associated with the demonstration, we will also analyze the impact of the 1115 SMI/SED waiver on health care costs. We will analyze cost at three levels:

1. **Total costs.** We will construct measures of expenditures on a per-member-per-month (PMPM) basis. These expenditures will include spending on inpatient [IP], outpatient [OT], pharmacy [RX], and long-term care [LT] services.

2. **Costs related to diagnosis and treatment of SMI/SED or SUD.** We propose to separate costs for SMI/SED and SUD, according to the following rubric:
    a. Identify expenditures associated with IMD use.
        i. Among expenditures associated with IMD use, classify expenditures as SMI/SED if the primary diagnosis is related to SMI/SED (as defined above)
        ii. Among expenditures associated with IMD use, classify expenditures as SUD if the primary diagnosis is related to SUD (ICD-10 codes F10-F19)
    b. For remaining (non-IMD) expenditures

   i. Classify expenditures as SMI/SED if the primary diagnosis is related to SMI/SED (as defined above)
   ii. Classify expenditures as SUD if the primary diagnosis is related to SUD (ICD-10 codes F10-F19)
   iii. The remaining expenditures are classified as non-SMI/SED and non-SUD

3. **Source of treatment cost drivers.** We will analyze spending according to the following categories
   a. Inpatient
   b. Emergency department
   c. Behavioral health outpatient
   d. Non-behavioral health outpatient
   e. Prescription drugs
   f. Long term care

Our analyses of cost data will account for the following considerations.

- Medicaid claims submitted by managed care organizations and behavioral health organizations may not include the “allowed” or “payment” amount, particularly when payments to providers are based on a capitation or sub-capitation arrangement. “Shadow prices”, which approximate the actuarial value of the service can be an appropriate proxy for cost analyses. As available, CHSE will use shadow prices to supplement “allowed” or “payment” amounts that are not available on claims data.
- Federal Medical Assistance Percentage (FMAP) rates for managed care vary by Medicaid member according to certain eligibility characteristics (e.g., pregnancy). To calculate total federal costs (RQ #1.6), we will stratify members by Medicaid Eligibility Group to approximate the federal match rate at the member level.
- Our analyses also exclude administrative costs associated with the demonstration. These data are not collected systematically. Accurate collection would require a prospective approach with an instrument to assess and measure administrative costs. However, we would be unable to collect data before 2022, making estimates of the impact of the waiver demonstration difficult. Given the high research and resource cost of conducting these data and the important limitations of our ability to collect those data, we propose to focus on health care expenditures as measures in claims data.

Statistical Models

We will assess outcomes from 2016 through 2021. As with other analyses described in this document, the cost analyses would include the COVID-19 pandemic in 2020 and 2021. We propose to assess the data over the course of 2016-2022 in order to identify the most appropriate baseline or comparison.

Covariates

Proposed individual level covariates include age-range (0-2, 3-11, 12-18, 19-35, 36-55, and 55-64, and 65+ (where dually eligible individuals are included)); gender; urban residence based on zip code and the Chronic Illness and Disability Payment System (CDPS) risk adjustment methodology.

Approach to Statistical Analysis

As with other analyses, our primary model is a flexible model designed to assess changes over time:

$$Y_{it} = m(b_0 + b_1*Year2017 + b_2*Year2018 + b_3*Year2019 + b_4*Year2020 + b_5*Year2021 + a*X_{it} + e_{it}) \quad (1)$$

where Y_{it} is the outcome of interest for individual i in year t, Year20XX = 1 if the observation occurs in the Year 20XX and 0 otherwise; X_{it} is a vector of demographic covariates and risk adjusters, and e_{it} is a random error term associated with the unmeasured variation in the outcome of interest. The coefficients on the Year20XX dummies provide an estimate of how much the outcome variable changed relative to the reference year (2016). Our main interest will be on the value of the coefficients b_5 and b_6.

In this equation, m is a general function indicating the relationship between the outcome Y and the independent variables. A standard approach in modeling health care expenditures is the two-part model that models the probability of any use with a logistic regression and costs, conditional on use, with a generalized linear model.[1–3] However, for large N, linear models often perform better than more complex functional forms in predicting expenditures and can be more interpretable than logarithmically transformed models.[4–6] The team has extensive experience modeling these types of dependent variables.[7–9] Regardless of the approach, our results will be presented in a manner that is easily interpretable for a lay audience. Standard errors will be clustered at the primary care service area (PCSA). PCSAs were developed by the Dartmouth Atlas of Health Care as groups of zip codes that represent natural markets of primary care.[10,11]

Analytic Methods – Qualitative Methodology

Given the lack of a strong comparison group for some measures, and the potentially confounding effects of COVID-19 on data analyzed for 2020 and 2021, qualitative data will provide additional evidence to ascertain changes in facility processes, outcomes or capacities during the demonstration. Qualitative data will also provide context for quantitative changes observed (or not observed) during the demonstration.

The researchers will prepare and de-identify transcripts of all key informant interviews. Transcripts will be compiled in a qualitative database program such as Atlas.ti and catalogued to support thematic analysis across categories of informants, as well as sub-analyses within categories (e.g., by facility type).

The research team will develop a qualitative coding dictionary corresponding to key constructs of interest for the analysis, including:

- Demonstration activities or their components or characteristics that stakeholders identify as effective in achieving goals of the demonstration (Research Questions 1.2, 2.2, 5.2b).
- Obstacles that stakeholders identify as hindering the effectiveness of the demonstration in achieving its goals. (Research questions 1.2, 2.2, 5.1, 5.2b).
- Changes made through the demonstration to data sharing systems, processes, or policies. (Research questions 1.2, 5.1, 5.2b).

The coding dictionary will be iteratively refined based on literature review as well as preliminary review of a subset of interview transcripts. Two members of the research team will separately code a subset of transcripts, comparing and reconciling the application of codes as needed to ensure consistency in the coding strategy. Following any adjustments to the coding strategy, all transcripts will be coded *a priori* by a single researcher.

The research team will jointly review code reports to develop key themes related to research questions 1.2, 2.2, 5.1 and 5.2b, segmenting code reports to allow analysis of data within specific informant categories as well as across categories. These themes will be further distilled to preliminary findings through discussion among the research team. Preliminary findings will be compared to quantitative results as these become

available, and additional review of qualitative code reports will be conducted as appropriate to provide context for quantitative results.

SECTION D: Methodological Limitations

Our evaluation will face a variety of limitations.

Quantitative Analysis Limitations. We acknowledge that there will be challenges in our evaluation. The most significant is the 2020 COVID-19 pandemic, which will continue through a large part of 2021. Our modeling approach is designed to be flexible. We will assess the data empirically in order to provide robust and reliable estimates.

A second challenge is that significant changes in occurring across Washington that may affect outcomes. In the absence of a comparison group, we are unlikely to be able to isolate the impact of these large national and regional changes. However, the team will place our findings in the appropriate context of a dynamic policy environment.

Our study relies on claims data, which does not capture all clinically relevant information. Furthermore, some of our quality measures do not distinguish important dimensions, such as appointment availability, ease of appointment, wait times, the level of engagement of the provider, or the use of evidence-based practices.

Qualitative Analysis Limitations. There are two limitations to the qualitative analytic approach described above. First, the evaluation team resides outside the State of Washington. Despite the team's extensive history conducting research in Washington State, there is a risk that the research team may misinterpret qualitative data because they lack context for local conditions, customs or histories. To mitigate this risk, the research team will work closely with representatives from Washington State HCA and DSHS staff to develop our baseline understanding of the context and conditions in which initiative 5 will be designed and implemented. If appropriate, the evaluation team will conduct member checking or participant validation of qualitative findings to ensure accurate and appropriate interpretation of data.

Second, establishing rapport with participants is an important element of rigorous qualitative research; lack of rapport between researchers and participants may undermine the willingness of key informants to provide candid or complete responses during data collection activities such as interviews. Participants' fear of disclosure or identification in published results when discussing sensitive subjects can also lead to self-censorship in interviews. To mitigate this limitation, the evaluation team will work with Washington State staff or local Accountable Communities of Health as needed to obtain introductions or conduct outreach to potential key informants for the evaluation. Outreach materials such as an evaluation fact sheet will be developed collaboratively with HCA to explain the role of the evaluation team and the purpose of the evaluation. The evaluation team will take appropriate steps to protect participant confidentiality, including the de-identification of participants in published findings and the protection of raw data (such as recordings or transcripts). The evaluation team will obtain approval from the Washington State Institutional Review Board for all data collection instruments and activities prior to initiation of qualitative data collection. Potential risks and benefits of participation will be discussed with key informants, and informed consent will be obtained prior to participation.

SECTION E: Additional Information/Attachments

Independent Evaluator Selection Process – No Attachment. For the broader 1115 Waiver evaluation, Washington selected an independent external evaluator that has the expertise, experience, and

impartiality to conduct a sophisticated program evaluation that meets all requirements specified in the Special Terms and Conditions including specified reporting timeframes. Oregon Health Sciences University (OHSU) was selected after an RFP process. Required qualifications and experience included:

- Multi-disciplinary health services research skills and experience;
- An understanding of and experience with the Medicaid program;
- Familiarity with Washington State Medicaid programs and populations;
- Experience assessing the ability of health IT ecosystems to support delivery system and payment reforms, including issues related to governance, financing, policy/legal issues and business operations;
- And experience conducting complex, multi-faceted evaluations of large, multi-site health and/or social services programs.

Potential evaluation entities were assessed on their relevant work experience, staff expertise, data management and analytic capacity, experience working with state agency program and research staff, proposed resource levels and availability of key staff, track record of related publications in peer-reviewed journals, and the overall quality of their proposal. Proposed deliverables must meet all standards of leading academic institutions and academic journal peer review. In the process of identifying, selecting, and contracting with an independent external evaluator, the State acted appropriately to prevent a conflict of interest with the independent external evaluator. The independent external evaluator has no affiliation with ACHs or their providers.

After discussion with CMS, Washington received approval to use OHSU as the Independent Evaluator for the SMI/SED amendment evaluation.

Evaluation Budget – No Attachment. At the time the original evaluation design was submitted to CMS, the evaluation budget was projected to be $4 million dollars. However, given the complexity of evaluation required, an addition $1.5 million dollars was added after the original evaluation design was submitted. OHSU is under contract to conduct the evaluation for the original 1115 Waiver and the SUD IMD waiver. OHSU has agreed to conduct the SMI/SED amendment activities under the existing contract with an additional $530,109 dollars added to the budget. An estimate of the SMI evaluation budget is below:

Direct Costs	**Estimated Cost**
Personnel	$521,709
Principal Investigator (416 hours @ $195)	*$81,148*
Data Scientist (169 hours @ $140)	*$23,667*
Project Manager / Policy Analyst (1,562 hours @ $140)	*$218,692*
Quantitative Analyst (838 hours @ $140)	*$117,332*
Qualitative Research Assistant (1,155 hours @ $70)	*$80,870*
Interview travel and transcription ($400 x 21)	$8,400
Total Direct and Indirect Costs	**$530,109**

Timeline and Major Milestones

Milestone / Deliverable	Due Date
SMI/SED Evaluation Draft Design Due	June 21, 2021
Draft Final Evaluation Report to CMS	June 30, 2023
Final Evaluation Report to CMS	60 days from receipt of CMS comments

References

1. Duan N, Manning WG, Morris CN, Newhouse JP. A Comparison of Alternative Models for the Demand for Medical Care. *J Bus Econ Stat*. 1983;1(2):115-126. doi:10.1080/07350015.1983.10509330

2. Manning WG. The logged dependent variable, heteroscedasticity, and the retransformation problem. *J Health Econ*. 1998;17(3):283-295.

3. Manning WG, Mullahy J. Estimating log models: to transform or not to transform? *J Health Econ*. 2001;20(4):461-494. doi:10.1016/S0167-6296(01)00086-8

4. Buntin MB, Zaslavsky AM. Too much ado about two-part models and transformation?: Comparing methods of modeling Medicare expenditures. *J Health Econ*. 2004;23(3):525-542. doi:10.1016/j.jhealeco.2003.10.005

5. Ellis RP, McGuire TG. Predictability and predictiveness in health care spending. *J Health Econ*. 2007;26(1):25-48. doi:10.1016/j.jhealeco.2006.06.004

6. Song Z, Safran DG, Landon BE, et al. Health Care Spending and Quality in Year 1 of the Alternative Quality Contract. *N Engl J Med*. 2011;365(10):909-918. doi:10.1056/NEJMsa1101416

7. McConnell KJ. The Effect of Parity on Individuals with Severe Mental Illness. *Health Serv Res*. 2013;48(5):1634-1652.

8. McConnell KJ, Gast SHN, Ridgely MS, et al. Behavioral Health Insurance Parity: Does Oregon's Experience Presage the National Experience With the Mental Health Parity and Addiction Equity Act? *Am J Psychiatry*. 2012;169(1):31-38. doi:10.1176/appi.ajp.2011.11020320

9. McConnell KJ, Wallace NT, Gallia CA, Smith JA. Effect of Eliminating Behavioral Health Benefits for Selected Medicaid Enrollees. *Health Serv Res*. 2008;43(4):1348-1365. doi:10.1111/j.1475-6773.2008.00844.x

10. Goodman DC, Mick SS, Bott D, et al. Primary care service areas: a new tool for the evaluation of primary care services. *Health Serv Res*. 2003;38(1):287-309. doi:10.1111/1475-6773.00116

11. The Dartmouth Institute - Primary Care Service Area (PCSA). Published 2015. Accessed December 1, 2015. http://tdi.dartmouth.edu/research/evaluating/health-system-focus/primary-care-service-area

APPENDIX 1

Alignment of Demonstration and Project-Specific Testable Hypotheses to Evaluation Metrics and Data Sources

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TABLE 1.

Project 2A: Bi-Directional Integration of Care and Primary Care Transformation

H_1		
Demonstration Hypotheses (STC 108)		**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**
Research Questions Identified in Domains of Focus (STC 109)	**Q**	***Were ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*
Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . increase ***screening*** for physical health conditions, with a focus on eliminating disparities for persons with behavioral health risk factors?
		PERFORMANCE METRICS • NCQA HEDIS® Adults' Access to Preventive/Ambulatory Health Services (AAP) • NCQA HEDIS® Child and Adolescents' Access to Primary Care Practitioners • NCQA HEDIS® Breast Cancer Screening (BCS) • NCQA HEDIS® Cervical Cancer Screening (CCS) • NCQA HEDIS® Colorectal Cancer Screening (COL) • NCQA HEDIS® Chlamydia Screening (CHL) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . increase ***access*** to and ***engagement*** in treatment for mental illness and/or substance use disorders?
		PERFORMANCE METRICS • Mental Health Service Penetration (state-defined, see Appendix 2 for measure specification) • Substance Used Disorder Treatment Penetration (state-defined, see Appendix 2 for measure specification) • NCQA HEDIS® Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.3	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . improve ***quality*** of care for behavioral and physical health conditions?

		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Comprehensive Diabetes Care: Eye Exam (Retinal) Performed • NCQA HEDIS® Comprehensive Diabetes Care: Medical Attention for Nephropathy • NCQA HEDIS® Comprehensive Diabetes Care: Hemoglobin A1c Testing • NCQA HEDIS® Medication Management for People with Asthma (MMA) • NCQA HEDIS® Antidepressant Medication Management (AMM) • NCQA HEDIS® Adherence to Antipsychotics for Persons with Schizophrenia (SAA) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.4	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . improve ***coordination*** of care for persons with co-occurring behavioral and physical health conditions?
		PERFORMANCE METRICS • NCQA HEDIS® Diabetes Screening for People with Schizophrenia/Bipolar Disorder • NCQA HEDIS® Follow-up after Emergency Department Visit for Alcohol or Drug Dependence within 7/30 Days (FUA) • NCQA HEDIS® Follow-up after Emergency Department Visit for Mental Illness within 7/30 Days (FUM) • NCQA HEDIS® Follow-Up After Hospitalization for Mental Illness (FUH) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.5	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . improve beneficiary ***health and social outcomes***?
		PERFORMANCE METRICS • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (see Appendix 2 for measure specification) • Employment Rate (state-defined, see Appendix 2 for measure specification) • Arrest Rate (state-defined, see Appendix 2 for measure specification) • Homelessness Rate (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.6	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . reduce disparities in health and social outcomes for persons with mental illness and/or substance use disorders, relative to Medicaid beneficiaries without behavioral health service needs?

PERFORMANCE METRICS

Stratification of measures listed above related to physical health care, service utilization, and cost into subpopulations based with mental illness and/or substance use disorders.

- Presence of mental illness will be defined using the denominator criteria from the state-defined mental health service penetration rate metric.
- Presence of substance use disorder will be defined using the denominator criteria from the state-defined Substance Use Disorder Treatment penetration rate metric.
- Subpopulations with serious mental illness (SMI) may be defined by use of Chronic Illness and Disability Payment System (CDPS) Psychiatric High, Psychiatric Medium, and Psychiatrics Medium Low risk groups which include persons with schizophrenia, mania/bipolar disorders, major recurrent depression, and conditions of comparable severity.

DATA SOURCES

RDA Integrated Client Databases supplemented by project data if required for attribution.

H2

Demonstration Hypotheses (STC 108)	**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation effective in achieving lower health care costs?***

Project-Specific Testable Hypotheses	2.1	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . reduce potentially avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.2	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . reduce ED utilization?
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . reduce utilization of nursing facility care for persons requiring long-term services and supports?
		PERFORMANCE METRICS • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.4	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . reduce per-member per-month health care expenditures?
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H3

Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***
	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care
		PERFORMANCE METRICS Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation expand health system capacity?*** HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care
		PERFORMANCE METRICS Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation expand health system capacity?*** Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process • Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation accelerate adoption of value-based payment reform?*** This includes: • Adoption of VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatment
		PERFORMANCE METRICS Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

TABLE 2.

Project 2B: Community-Based Care Coordination

H$_1$		
Demonstration Hypotheses (STC 108)	**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**	
Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Community-Based Care Coordination effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*
Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing Community-Based Care Coordination increase access to and engagement in treatment for those with complex and/or co-occurring conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® Adults' Access to Preventive/Ambulatory Health Services (AAP) • NCQA HEDIS® Child and Adolescents' Access to Primary Care Practitioners • NCQA HEDIS® Comprehensive Diabetes Care: Eye Exam (Retinal) Performed • NCQA HEDIS® Comprehensive Diabetes Care: Medical Attention for Nephropathy • NCQA HEDIS® Diabetes Screening for People with Schizophrenia/Bipolar Disorder • Mental Health Service Penetration (state-defined, see Appendix 2 for measure specification) • Substance Used Disorder Treatment Penetration (state-defined, see Appendix 2 for measure specification) • NCQA HEDIS® Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing Community-Based Care Coordination improve quality of care for behavioral and physical health conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Comprehensive Diabetes Care (CDC) • NCQA HEDIS® Medication Management for People with Asthma (MMA) • NCQA HEDIS® Antidepressant Medication Management (AMM) • NCQA HEDIS® Adherence to Antipsychotics for Persons with Schizophrenia (SAA) • NCQA HEDIS® Follow-Up After Hospitalization for Mental Illness (FUH) • NCQA HEDIS® Follow-up after Emergency Department Visit for Alcohol or Drug Dependence within 7/30 Days (FUA) • NCQA HEDIS® Follow-up after Emergency Department Visit for Mental Illness within 7/30 Days (FUM) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.3	***Do ACH projects addressing Community-Based Care Coordination improve patient health and social outcomes?***
		PERFORMANCE METRICS • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative • Employment Rate (state-defined, see Appendix 2 for measure specification) • Arrest Rate (state-defined, see Appendix 2 for measure specification) • Homelessness Rate (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.4	***Do ACH projects addressing Community-Based Care Coordination improve health and social outcomes for persons with behavioral health risk factors and persons needing functional supports (e.g., persons receiving home- and community-based LTSS services)?***
		PERFORMANCE METRICS Stratification of measures listed above related to physical health care, service utilization, and cost into subpopulations with mental illness and/or substance use disorders and use of LTSS services. • Presence of mental illness will be defined using the denominator criteria from the state-defined mental health service penetration rate metric. • Presence of substance use disorder will be defined using the denominator criteria from the state-defined Substance use disorder treatment penetration rate metric. • Subpopulations with serious mental illness (SMI) may be defined by use of Chronic Illness and Disability Payment System (CDPS) Psychiatric High, Psychiatric Medium, and Psychiatrics Medium Low risk groups which include persons with schizophrenia, mania/bipolar disorders, major recurrent depression, and conditions of comparable severity. • LTSS service utilization will be derived from payment data. **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H2

Demonstration Hypotheses (STC 108)		**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**
Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Community-Based Care Coordination effective in achieving lower health care costs?***
	2.1	***Do ACH projects addressing Community-Based Care Coordination reduce inpatient, psychiatric inpatient, and ED utilization?***

Project-Specific Testable Hypotheses		**PERFORMANCE METRICS** • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.2	***Do ACH projects addressing Community-Based Care Coordination reduce potentially avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing Community-Based Care Coordination reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.4	***Do ACH projects addressing Community-Based Care Coordination reduce utilization of nursing facility care for persons requiring long-term services and supports?***
		PERFORMANCE METRICS • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.5	***Do ACH projects addressing Community-Based Care Coordination reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H3

Demonstration Hypotheses (STC 108)	Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***
	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing Community-Based Care Coordination support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing Community-Based Care Coordination expand health system capacity?*** HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing Community-Based Care Coordination expand health system capacity?*** Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process

		• Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing Community-Based Care Coordination accelerate adoption of value-based payment reform?***
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

TABLE 3.

Project 2C: Transitional Care

H_1	
Demonstration Hypotheses (STC 108)	**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Transitional Care effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*

Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing Transitional Care increase access to and engagement in community-based treatment for behavioral health conditions?***
		PERFORMANCE METRICS • Mental Health Service Penetration (state-defined, see Appendix 2 for measure specification) • Substance Used Disorder Treatment Penetration (state-defined, see Appendix 2 for measure specification) • NCQA HEDIS® Follow-Up After Hospitalization for Mental Illness (FUH) • NCQA HEDIS® Follow-up after Emergency Department Visit for Alcohol or Drug Dependence within 7/30 Days (FUA) • NCQA HEDIS® Follow-up after Emergency Department Visit for Mental Illness within 7/30 Days (FUM) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing Transitional Care reduce inpatient admissions, psychiatric inpatient admissions, ED utilization, and institutional stays?***
		PERFORMANCE METRICS • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • Homelessness Rate (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.3	***Do ACH projects addressing Transitional Care improve access to Home and Community-based Long Term Services and Supports?***
		PERFORMANCE METRICS • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.4	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . improve beneficiary ***social outcomes***?
		PERFORMANCE METRICS • Employment Rate (state-defined, see Appendix 2 for measure specification) • Arrest Rate (state-defined, see Appendix 2 for measure specification) • Homelessness Rate (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H2

Demonstration Hypotheses (STC 108)		**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**
Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Transitional Care effective in achieving lower health care costs?***
Project-Specific Testable Hypotheses	2.1	***Do ACH projects addressing Transitional Care reduce potentially avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?***

		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.2	***Do ACH projects addressing Transitional Care reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing Transitional Care reduce utilization of nursing facility care for persons requiring long-term services and supports?***
		PERFORMANCE METRICS • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.4	***Do ACH projects addressing Transitional Care reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H3

Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***

	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing Transitional Care support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing Transitional Care expand health system capacity?*** HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing Transitional Care expand health system capacity?*** • Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process • Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing Transitional Care accelerate adoption of value-based payment reform?*** This includes: • Adoption of VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatment
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

TABLE 4.

Project 2D: Diversion Interventions

H_1

Demonstration Hypotheses (STC 108)		**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**
Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Diversion Interventions effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*
Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing Diversion Interventions reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing Diversion Interventions improve access to primary care?***
		PERFORMANCE METRICS • NCQA HEDIS® Adults' Access to Preventive/Ambulatory Health Services (AAP) • NCQA HEDIS® Child and Adolescents' Access to Primary Care Practitioners **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.3	***Do ACH projects addressing Diversion Interventions improve access to behavioral health services?***
		PERFORMANCE METRICS • Mental Health Service Penetration (state-defined, see Appendix 2 for measure specification)

		• Substance Used Disorder Treatment Penetration (state-defined, see Appendix 2 for measure specification) • NCQA HEDIS® Follow-up after Emergency Department Visit for Alcohol or Drug Dependence within 7/30 Days (FUA) • NCQA HEDIS® Follow-up after Emergency Department Visit for Mental Illness within 7/30 Days (FUM) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.4	***Do ACH projects addressing Diversion Interventions reduce homelessness rates?***
		PERFORMANCE METRICS • Homelessness Rate (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.5	***Do ACH projects addressing Diversion Interventions reduce arrest rates?***
		PERFORMANCE METRICS • Arrest Rate (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H2

Demonstration Hypotheses (STC 108)	**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Diversion Interventions effective in achieving lower health care costs?***

Project-Specific Testable Hypotheses	2.1	***Do ACH projects addressing Diversion Interventions reduce potentially avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

	2.2	***Do ACH projects addressing Diversion Interventions reduce ED utilization?***

Project-Specific Testable Hypotheses		**PERFORMANCE METRICS** • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing Diversion Interventions reduce utilization of nursing facility care for persons requiring long-term services and supports?***
		PERFORMANCE METRICS • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.4	***Do ACH projects addressing Diversion Interventions reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H3

Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***
	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing Diversion Interventions support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care

		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing Diversion Interventions expand health system capacity?*** HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing Diversion Interventions expand health system capacity?*** Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process • Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing Diversion Interventions accelerate adoption of value-based payment reform?*** This includes: • Adoption of VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatment
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator

		DATA SOURCES Data collection strategy to be designed by the independent external evaluator.

TABLE 5.

Project 3A: Addressing the Opioid Use Public Health Crisis

H1		
Demonstration Hypotheses (STC 108)		**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**
Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects "Addressing the Opioid Use Public Health Crisis" effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*
Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing the Opioid Use Public Health Crisis reduce opioid-related deaths?***
		PERFORMANCE METRICS • Opioid Related Deaths (Medicaid Enrollees and Total Population) per 100,000 covered live (CDC standards used to define opioid related deaths) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing the Opioid Use Public Health Crisis reduce non-fatal overdose involving prescription opioids?***
		PERFORMANCE METRICS • Non-fatal overdose involving prescription opioids per 100,000 covered lives **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.3	***Do ACH projects addressing the Opioid Use Public Health Crisis increase substance use disorder treatment penetration among opioid users?***
		PERFORMANCE METRICS • Substance Use Disorder Treatment Penetration, for persons with opiate use disorder (variation of state-defined metric restricted to persons with identified opiate use disorder – see Appendix 2 2) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.4	***Do ACH projects addressing the Opioid Use Public Health Crisis reduce the number of patients on high-dose chronic opioid therapy?***
		PERFORMANCE METRICS • Bree Collaborative: Patients on high-dose chronic opioid therapy by varying thresholds (specification under development)

		• Bree Collaborative: Patients with concurrent sedatives prescriptions (specification under development) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.5	***Do ACH projects addressing the Opioid Use Public Health Crisis increase the numbers receiving Medication Assisted Therapy (MAT) with Buprenorphine and Methadone?***
		PERFORMANCE METRICS • Bree Collaborative: Medication Assisted Therapy (MAT) for Opiate Use Disorder Using Buprenorphine or Methadone (specification under development) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_2

Demonstration Hypotheses (STC 108)	**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects "Addressing the Opioid Use Public Health Crisis" effective in achieving lower health care costs?***

Project-Specific Testable Hypotheses	2.1	***Do ACH projects addressing the Opioid Use Public Health Crisis reduce potentially avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.2	***Do ACH projects addressing the Opioid Use Public Health Crisis reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing the Opioid Use Public Health Crisis reduce utilization of nursing facility care for persons requiring long-term services and supports?***
		PERFORMANCE METRICS • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.4	***Do ACH projects addressing the Opioid Use Public Health Crisis reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H3

Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***
	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing the Opioid Use Public Health Crisis support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing the Opioid Use Public Health Crisis expand health system capacity?*** HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing the Opioid Use Public Health Crisis expand health system capacity?*** Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process • Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing the Opioid Use Public Health Crisis accelerate adoption of value-based payment reform?*** This includes: • Adoption of VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatment
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

TABLE 6.

Project 3B: Reproductive and Maternal Child Health

H$_1$

Demonstration Hypotheses (STC 108)		**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**
Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Reproductive and Maternal/Child Health effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*
Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing Reproductive and Maternal/Child Health reduce rates of teen pregnancy?***
		PERFORMANCE METRICS • State-defined measure rate of teen pregnancy (specification forthcoming) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing Reproductive and Maternal/Child Health reduce the number of unintended pregnancies?***
		PERFORMANCE METRICS • Washington State Department of Health Rate of Unintended Pregnancies (PRAMS survey) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.3	***Do ACH projects addressing Reproductive and Maternal/Child Health reduce the rate of low-birth weight deliveries?***
		PERFORMANCE METRICS • Agency for Healthcare Research and Quality (AHRQ) Rate of Low Birth Weight Births (state-defined, specification forthcoming) • NCQA HEDIS® Prenatal care in the first trimester of pregnancy (PPC) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.4	***Do ACH projects addressing Reproductive and Maternal/Child Health increase engagement in behavioral health treatment penetration among pregnant women?***
		PERFORMANCE METRICS • Substance Used Disorder Treatment Penetration (state-defined, see Appendix 2 for measure specification) • Mental Health Service Penetration (state-defined, see Appendix 2 for measure specification) **DATA SOURCES**

		RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.5	***Do ACH projects addressing Reproductive and Maternal/Child Health increase Well-Child Visit rates among infants and young children?***
		PERFORMANCE METRICS • NCQA HEDIS® Well-Child Visits in the First 15 Months of Life • NCQA HEDIS® Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.6	***Do ACH projects addressing Reproductive and Maternal/Child Health increase rates of Chlamydia screening?***
		PERFORMANCE METRICS • NCQA HEDIS® Chlamydia Screening (CHL) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.7	***Do ACH projects addressing Reproductive and Maternal/Child Health improve access to effective contraceptive care (including LARC)?***
		PERFORMANCE METRICS • U.S. Office of Population Affairs (OPA) Contraceptive Care – Most & Moderately Effective Methods (specification forthcoming) • U.S. Office of Population Affairs (OPA) Contraceptive Care – Access to LARC (specification forthcoming) • U.S. Office of Population Affairs (OPA) Contraceptive Care – Postpartum (specification forthcoming) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.8	***Do ACH projects addressing Reproductive and Maternal/Child Health increase childhood immunization rates?***
		PERFORMANCE METRICS • NCQA HEDIS® Childhood Immunization Status (CIS) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_2

Demonstration Hypotheses (STC 108)	**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Reproductive and Maternal/Child Health effective in achieving lower health care costs?***

Project-Specific Testable Hypotheses	2.1	***Do ACH projects addressing Reproductive and Maternal/Child Health reduce potentially avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.2	***Do ACH projects addressing Reproductive and Maternal/Child Health reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing Reproductive and Maternal/Child Health reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H3

Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***
	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing Reproductive and Maternal/Child Health support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing Reproductive and Maternal/Child Health expand health system capacity?*** HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing Reproductive and Maternal/Child Health expand health system capacity?*** Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process • Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing Reproductive and Maternal/Child Health accelerate adoption of value-based payment reform?*** This includes: • Adoption of VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatment

	PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator DATA SOURCES Data collection strategy to be designed by the independent external evaluator.

TABLE 7.

Project 3C: Access to Oral Health Services

Demonstration Hypotheses (STC 108)		**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**
Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Access to Oral Health Services effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*
Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing Access to Oral Health Services increase access to oral health services for children?***
		PERFORMANCE METRICS • Dental Quality Alliance (DQA) Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers (specification forthcoming) • Dental Quality Alliance (DQA) Caries at Recall (Children) (specification forthcoming) • Dental Quality Alliance (DQA) Sealants - % Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk (specification forthcoming) • Dental Quality Alliance (DQA) Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk (specification forthcoming) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing Access to Oral Health Services increase access to oral health services for adults?***
		PERFORMANCE METRICS • State-defined measure of oral health services utilization among Medicaid beneficiaries (specification forthcoming) • National Network for Oral Health Access (NNOHA) Adult Treatment Plan Completed (specification forthcoming) • National Network for Oral Health Access (NNOHA) Caries at Recall (Adult) (specification forthcoming) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.3	***Do ACH projects addressing Access to Oral Health Services improve prevention and control the progression of oral disease?***
		PERFORMANCE METRICS • Dental Quality Alliance (DQA) Ongoing Care in Adults with Chronic Periodontitis (specification forthcoming) • Dental Quality Alliance (DQA) Periodontal Evaluation in Adults with Chronic Periodontitis (specification forthcoming) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.4	***Do ACH projects addressing Access to Oral Health Services reduce reliance on emergency departments for oral pain and related conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative, with stratification to identify oral pain and related conditions **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H2

Demonstration Hypotheses (STC 108)	**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Access to Oral Health Services effective in achieving lower health care costs?***

Project-Specific Testable Hypotheses	2.1	***Do ACH projects addressing Access to Oral Health Services reduce potentially avoidable utilization of inpatient hospital services?***
		PERFORMANCE METRICS • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.2	***Do ACH projects addressing Access to Oral Health Services reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing Access to Oral Health Services reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H3

Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***
	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing Access to Oral Health Services support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing Access to Oral Health Services expand health system capacity?*** HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care

		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing Access to Oral Health Services expand health system capacity?*** Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process • Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing Access to Oral Health Services accelerate adoption of value-based payment reform?*** This includes: • Adoption of VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatment
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

TABLE 8.

Project 3D: Chronic Disease Prevention and Control

H_1

Demonstration Hypotheses (STC 108)		**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**
Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Chronic Disease Prevention and Control effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*

Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing Chronic Disease Prevention and Control improve the quality of care for chronic conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® Comprehensive Diabetes Care: Eye Exam (Retinal) Performed • NCQA HEDIS® Comprehensive Diabetes Care: Medical Attention for Nephropathy • NCQA HEDIS® Medication Management for People with Asthma (MMA) • Statin Therapy for Patients with Cardiovascular Disease • Adult Body Mass Index Assessment **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing Chronic Disease Prevention and Control reduce utilization of inpatient and emergency department services?***
		PERFORMANCE METRICS • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H2

Demonstration Hypotheses (STC 108)	**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Chronic Disease Prevention and Control effective in achieving lower health care costs?***

Project-Specific Testable Hypotheses	2.1	***Do ACH projects addressing Chronic Disease Prevention and Control reduce potentially avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

	2.2	***Do ACH projects addressing Chronic Disease Prevention and Control reduce ED utilization?***

Project-Specific Testable Hypotheses		**PERFORMANCE METRICS** • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing Chronic Disease Prevention and Control reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H3

Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***
	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing Chronic Disease Prevention and Control support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing Chronic Disease Prevention and Control expand health system capacity?*** HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data

		• Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing Chronic Disease Prevention and Control expand health system capacity?*** Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process • Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing Chronic Disease Prevention and Control accelerate adoption of value-based payment reform?*** This includes: • Adoption of VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatment
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

TABLE 9.

Initiative 3: Foundational Community Supports Program

H_1

Demonstration Hypotheses (STC 108)	**Does the provision of foundational community supports - supportive housing and supported employment - improve health outcomes for a targeted subset of the Medicaid population?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***What impact does the provision of foundational community supports have on beneficiary health and quality of life?***

Initiative-Specific Testable Hypotheses	1.1	***Does participation in the Foundational Community Supports Program increase access to and engagement in treatment for mental illness and/or substance use disorders?***
		PERFORMANCE METRICS • Mental Health Service Penetration (state-defined, see Appendix 2 for measure specification) • Substance Used Disorder Treatment Penetration (state-defined, see Appendix 2 for measure specification) • NCQA HEDIS® Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Initiative-Specific Testable Hypotheses	1.2	***Does participation in the Foundational Community Supports Program improve quality of care for behavioral and physical health conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® Comprehensive Diabetes Care (CDC) • NCQA HEDIS® Medication Management for People with Asthma (MMA) • NCQA HEDIS® Antidepressant Medication Management (AMM) • NCQA HEDIS® Adherence to Antipsychotics for Persons with Schizophrenia (SAA) • NCQA HEDIS® Follow-Up After Hospitalization for Mental Illness (FUH) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Initiative-Specific Testable Hypotheses	1.3	***Does participation in the Foundational Community Supports Program reduce avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Initiative-Specific Testable Hypotheses	1.4	***Does participation in the Foundational Community Supports Program reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

	1.5	***Does participation in the Foundational Community Supports Program reduce utilization of nursing facility care for persons requiring LTSS services?***

Initiative-Specific Testable Hypotheses		**PERFORMANCE METRICS** • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Initiative-Specific Testable Hypotheses	1.6	***Does participation in the Foundational Community Supports Program improve social outcome metrics (reduce homelessness, increase employment, reduce risk of criminal justice involvement)?***
		PERFORMANCE METRICS • Employment Rate (state-defined, see Appendix 2 for measure specification) • Arrest Rate (state-defined, see Appendix 2 for measure specification) • Homelessness Rate (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_2

Demonstration Hypotheses (STC 108)	**Does the provision of foundational community supports - supportive housing and supported employment - reduce costs for a targeted subset of the Medicaid population?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Does the provision of foundational community supports provide other benefits to the Medicaid program?***

Initiative-Specific Testable Hypotheses	2.1	***Does participation in the Foundational Community Supports Program reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Initiative-Specific Testable Hypotheses	2.2	***Do the components of the Foundational Community Supports Program show fidelity to adopted evidence-based models of care?***
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Initiative-Specific Testable Hypotheses	2.3	***Does the Foundational Community Supports Program use HIT to support eligibility determinations and service delivery?***
		PERFORMANCE METRICS

		• Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Initiative-Specific Testable Hypotheses	2.4	***Does the Foundational Community Supports Program use electronic health information exchange (e.g., providers' use (creation and transmission) of employment/housing assessment templates, OneHealthPort (OHP) services (e.g., registration and use of the Clinical Data Repository (CDR))?***
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

APPENDIX 2

State Developed Specification Definitions

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Arrest Rate
Measure Definition (ARREST)

December 27, 2016
Medicaid Version 1.1

Description

The percentage of Medicaid enrollees who were arrested at least once in the measurement year. These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

Eligible Population

Ages	18 – 64
Minimum Medicaid enrollment	A minimum of 7 months of Medicaid enrollment is required in the measurement year.
Anchor date	December 31 of the measurement year for calendar-year reporting
Identification window for Behavioral Health Service Needs	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months) for calendar-year reporting. For quarterly reporting a comparable 24-month period is used, anchored to the end of quarterly reporting period.
Benefit	Medicaid
Service contracting entity attribution	For Behavioral Health Organization (BHO), Area Agency on Aging (AAA) and Managed Care Organization (MCO) reporting, members must meet the additional attribution criteria defined below: • BHO Mental Health populations must reside in the BHO catchment area for at least 7 months in the measurement year, and must meet the denominator mental health need criteria specified in the Mental Health Service Penetration metric. • BHO Substance Use Disorder (SUD) populations must reside in the BHO catchment area for at least 7 months in the measurement year, and must meet the denominator SUD criteria specified in the SUD Treatment Penetration metric. • AAA populations must reside in the AAA catchment area for at least 7 months in the measurement year, and must receive Home- or Community-Based long-term services and supports in at least 7 months in the measurement year. • MCO populations must be enrolled with the MCO in at least 7 months in the measurement year.
Claim status for service contracting entity attribution	Include only final paid claims or accepted encounters for BHO attribution.

Denominator

Include in the measure denominator all individuals in the eligible population for the service contracting entity. In particular, note that persons who are dually eligible for Medicare or with Third-Party Liability (coverage) are included in the measure population.

Numerator

Include all denominator-eligible members with at least one arrest in the measurement year recorded in the Washington State Identification System (WASIS) arrest database maintained by the Washington State Patrol. The database is comprised of arrest charges for offenses resulting in fingerprint identification. The database provides a relatively complete record of felony and gross misdemeanor charges, but excludes some arrest charges for misdemeanor offenses that are not required to be reported.

Employment Rate
Measure Definition (EMP)

December 27, 2016
Medicaid Version 1.2

Description

The percentage of Medicaid enrollees with any earnings reported in Employment Security Department (ESD) employment data in the measurement year.

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

Eligible Population

Ages	Separate reporting for age groups 18 – 64 and 65+
Minimum Medicaid enrollment	A minimum of 7 months of Medicaid enrollment is required in the measurement year.
Anchor date	December 31 of the measurement year for calendar-year reporting
Identification window for Behavioral Health Service Needs	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months) for calendar-year reporting. For quarterly reporting a comparable 24-month period is used, anchored to the end of quarterly reporting period.
Benefit	Medicaid
Service contracting entity attribution	For Behavioral Health Organization (BHO), Area Agency on Aging (AAA) and Managed Care Organization (MCO) reporting, members must meet the additional attribution criteria defined below: • BHO Mental Health populations must reside in the BHO catchment area for at least 7 months in the measurement year, and must meet the denominator mental health need criteria specified in the Mental Health Service Penetration metric.

	• BHO Substance Use Disorder (SUD) populations must reside in the BHO catchment area for at least 7 months in the measurement year, and must meet the denominator SUD criteria specified in the SUD Treatment Penetration metric. • AAA populations must reside in the AAA catchment area for at least 7 months in the measurement year, and must receive Home- or Community-Based long-term services and supports in at least 7 months in the measurement year. • MCO populations must be enrolled with the MCO in at least 7 months in the measurement year.
Claim status for service contracting entity attribution	Include only final paid claims or accepted encounters for BHO attribution.

Denominator

Include in the measure denominator all individuals in the eligible population for the service contracting entity. In particular, note that persons who are dually eligible for Medicare or with Third-Party Liability (coverage) are included in the measure population.

Numerator

Include all members with at least one quarter in the measurement year with positive earnings recorded in ESD quarterly wage data. Note that ESD reported earnings data do not include self-employment, federal employment, or unreported earnings.

Homelessness Broad and Narrow Measure Definitions (HOME-N and HOME-B)

December 27, 2016
Medicaid Version 1.2

Description

The percentage of Medicaid enrollees who were homeless in at least one month in the measurement year. These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

Eligible Population

Ages	Separate reporting for age groups 0-17, 18 – 64 and 65+
Minimum Medicaid enrollment	A minimum of 7 months of Medicaid enrollment is required in the measurement year.
Anchor date	December 31 of the measurement year for calendar-year reporting

Identification window for Behavioral Health Service Needs	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months) for calendar-year reporting. For quarterly reporting a comparable 24-month period is used, anchored to the end of quarterly reporting period.
Benefit	Medicaid
Service contracting entity attribution	For Behavioral Health Organization (BHO), Area Agency on Aging (AAA) and Managed Care Organization (MCO) reporting, members must meet the additional attribution criteria defined below: • BHO Mental Health populations must reside in the BHO catchment area for at least 7 months in the measurement year, and must meet the denominator mental health need criteria specified in the Mental Health Service Penetration metric. • BHO Substance Use Disorder (SUD) populations must reside in the BHO catchment area for at least 7 months in the measurement year, and must meet the denominator SUD criteria specified in the SUD Treatment Penetration metric. • AAA populations must reside in the AAA catchment area for at least 7 months in the measurement year, and must receive Home- or Community-Based long-term services and supports in at least 7 months in the measurement year. • MCO populations must be enrolled with the MCO in at least 7 months in the measurement year.
Claim status for service contracting entity attribution	Include only final paid claims or accepted encounters for BHO attribution.
Data source for identifying homelessness	The DSHS Economic Services Administration's Automated Client Eligibility System (ACES); used by caseworkers to record information about client self-reported living arrangements and shelter expenses when determining eligibility for cash, food, and medical assistance.

Denominator

Include in the measure denominator all individuals in the eligible population for the service contracting entity. In particular, note that persons who are dually eligible for Medicare or with Third-Party Liability (coverage) are included in the measure population.

Numerator – Narrow

Include all denominator-eligible members with at least one month with a living arrangement status of "Homeless without Housing", "Emergency Shelter" or "Battered Spouse Shelter" recorded in the ACES eligibility data system.

Numerator – Broad

Include all denominator-eligible members with at least one month with a living arrangement status of "Homeless with Housing", "Homeless without Housing", "Emergency Shelter" or "Battered Spouse Shelter" recorded in the ACES eligibility data system.

Mental Health Service Penetration – Broad
Measure Definition (MH-B)

July 25, 2017
Medicaid Version 1.8

Description

The percentage of members with a mental health service need who received mental health services in the measurement year.

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

NOTE: Measure specification is currently undergoing revision to account for delivery system changes resulting from BHO and FIMC implementation.

Eligible Population

Ages	Separate reporting for age groups 6 – 17, 18 – 64 and 65+
Continuous enrollment	Applied only to the measurement year
Allowable gap	Member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year
Identification window	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months)
Benefit	Medicaid-only and dual eligibles excluding Part C enrollees Exclude persons with third-party liability (coverage)
Data sources	Medicaid MCO encounters and HCA-paid claims RSN/BHO encounter data and DBHR-paid behavioral health services Medicare Parts A and B claims and Medicare Part D encounters
Event/diagnosis	Members meeting the mental health service need criteria defined below
Claim status	Include only final paid claims or accepted encounters in measure calculation

Mental Health Service Need Definition

Mental health service need is identified by the occurrence of any of the following conditions:

1. Receipt of any mental health service meeting the numerator service criteria in the 24-month identification window
2. Any diagnosis of mental illness (not restricted to primary) in any of the categories listed in MH-Dx-value-set.xlsx in the 24-month identification window. These categories include:
    a. Psychotic Diagnosis Set 101
    b. Mania/Bipolar Diagnosis Set 102

c. Depression Diagnosis Set 103
d. Anxiety Diagnosis Set 104
e. ADHD Diagnosis Set 105
f. Disruptive/Impulse/Conduct Diagnosis Set 106
g. Adjustment Diagnosis Set 107

3. Receipt of any psychotropic medication listed in MH-Rx-value-set.xlsx in the 24-month identification window. These medications comprise the following drug therapy classes:
    a. Antianxiety Rx
    b. Antidepressants Rx
    c. Antimania Rx
    d. Antipsychotic Rx
    e. ADHD Rx
4. Any claim with a service procedure code in the following set: 90791, 90792, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90825, 90826, 90827, 90828, 90829, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90857, 90862, 90889, H0023, H0025, H0027, H0030, H0031, H0032, H0035, H0036, H0037, H0038, H0039, H0040, H0046, H1011, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, H2021, H2022, H2023, H2027, H2030, H2031, H2033, M0064, Q5008, S9480, S9482, S9484, S9485, T1025, T1026, T2038, T2048, 96101, 96102, 96103, 96110, 96111, 96116, 96118, 96119, 96120
5. Any psychiatric inpatient stay in the following facility types: Community Psychiatric Hospital, Evaluation & Treatment Center, Child Long-Term Inpatient, Child Study Treatment Center, Eastern and Western State Hospital
6. A tribal mental health encounter paid through ProviderOne

Denominator

Include in the denominator all individuals in the eligible population with a mental health service need in the 24-month identification window.

Numerator

Include in the numerator all individuals receiving at least one mental health services meeting at least one of the following criteria in the 12-month measurement year:

TABLE 1.
Numerator Service Criteria

Criterion	Value Sets
Mental health service modality from RSN/BHO encounter data	• Brief intervention treatment • Care coordination services • Child family team meeting • Co-occurring treatment • Crisis services • Day support • Engagement & outreach • Family treatment

	• Group treatment services • High intensity treatment • Housing and Recovery Through Peer Support (HARPS) • Individual treatment services • Intake evaluation • Medication management • Medication monitoring • Mental health clubhouse • Residential treatment services • Peer support • Psychological assessment • Offender Reentry Community Safety Program (ORCSP) • Rehabilitation case management • Special population evaluation • Stabilization services • Supported employment • Therapeutic psychoeducation • Community transition • Community based wraparound services Note: Classification of outpatient or residential BHO services is based on procedure code and modifier field values defined in the applicable BHO Service Encounter Reporting Instructions (SERI)
Tribal mental health encounter	A tribal mental health encounter paid through ProviderOne
Mental health provider taxonomy	Primary diagnosis code is a valid value in the MH-Dx-value-set.xlsx set AND Servicing provider taxonomy code is in the set: 101Y00000X, 101YM0800X, 101YP2500X, 103G00000X, 103T00000X, 103TB0200X, 103TC0700X, 103TC1900X, 103TC2200X, 103TF0000X, 103TH0100X, 103TP0016X, 103TP0814X, 103TP2700X, 103TP2701X, 103TR0400X, 104100000X, 1041C0700X, 106H00000X, 163WP0809X, 2080P0006X, 2084A0401X, 2084F0202X, 2084N0400X, 2084N0402X, 2084N0600X, 2084P0015X, 2084P0800X, 2084P0802X, 2084P0804X, 2084P0805X, 2084S0012X, 2084V0102X, 251S00000X, 261QM0801X, 273R00000X, 283Q00000X, 323P00000X, 363LP0808X, 364SP0808X
Mental health procedure code	90791, 90792, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90825, 90826, 90827, 90828, 90829, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90857, 90862, 90889, H0004, H0023, H0025, H0027, H0030, H0031, H0032, H0035, H0036, H0037, H0038, H0039, H0040, H0046, H1011, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, H2021, H2022, H2023, H2035, H2027, H2030, H2031, H2033, M0064, Q5008, S9480, S9482, S9484, S9485, T1025, T1026, T2038, T2048, 96101, 96102, 96103, 96110, 96111, 96116, 96118, 96119, 96120

Mental health condition management in primary care	Primary diagnosis code is a valid value in the MH-Dx-value-set.xlsx set AND Procedure code is in the set: 99201-99215 (Office), 99241-99255 (Consultation), or 99441-99444 (telephonic or online) AND (for Medicaid claims/encounters) Servicing provider taxonomy code is in the set: 101YA0400X, 101YM0800X, 101YP2500X, 103T00000X, 103TC0700X, 103TP0016X, 104100000X, 1041C0700X, 106H00000X, 163W00000X, 163WH0200X, 163WP0807X, 163WP0808X, 163WP0809X, 163WW0101X, 193200000X, 193400000X, 207LA0401X, 207LP2900X, 207P00000X, 207Q00000X, 207QA0000X, 207QA0401X, 207QA0505X, 207QG0300X, 207QH0002X, 207QS1201X, 207R00000X, 207RA0000X, 207RA0401X, 207RC0000X, 207RC0001X, 207RC0200X, 207RE0101X, 207RG0100X, 207RG0300X, 207RH0000X, 207RH0002X, 207RH0003X, 207RI0001X, 207RI0008X, 207RI0011X, 207RI0200X, 207RN0300X, 207RP1001X, 207RR0500X, 207RS0010X, 207RS0012X, 207RT0003X, 207RX0202X, 207V00000X, 207VC0200X, 207VG0400X, 207VM0101X, 207VX0000X, 207VX0201X, 208000000X, 2080A0000X, 2080H0002X, 2080P0006X, 2080P0008X, 2080P0201X, 2080P0202X, 2080P0204X, 2080P0205X, 2080P0206X, 2080P0207X, 2080P0208X, 2080P0210X, 2080P0214X, 2080P0216X, 2083P0901X, 2084A0401X, 2084F0202X, 2084N0400X, 2084N0402X, 2084P0015X, 2084P0800X, 2084P0802X, 2084P0804X, 2084P0805X, 208800000X, 208D00000X, 208M00000X, 208VP0000X, 208VP0014X, 251S00000X, 261Q00000X, 261QD1600X, 261QF0400X, 261QM0801X, 261QM1300X, 261QP0904X, 261QP0905X, 261QP2300X, 261QR0200X, 261QR0400X, 261QR0405X, 261QR1300X, 261QU0200X, 273R00000X,282N00000X, 282NC0060X, 282NC2000X, 282NR1301X, 283Q00000X, 320800000X, 324500000X, 363LA2100X, 363LA2200X, 363LC1500X, 363LF0000X, 363LG0600X, 363LP0200X, 363LP0808X, 363LP1700X, 363LP2300X, 363LW0102X, 363LX0001X, 363LX0106X, 364S00000X, 364SF0001X, 364SP0808X, 367A00000X For Medicare paid claims, allow any servicing provider taxonomy code under this criterion

Substance Use Disorder Treatment Penetration Measure Definition (AOD)

December 27, 2016
Medicaid Version 1.3

Description

The percentage of members with a substance use disorder treatment need who received substance use disorder treatment in the measurement year.

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

NOTE: Measure specification is currently undergoing revision to account for delivery system changes resulting from BHO and FIMC implementation.

Eligible Population

Ages	Separate reporting for age groups 12 – 17, 18 – 64 and 65+
Continuous enrollment	The measurement year
Allowable gap	Member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year
Identification window	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months)
Benefit	Medicaid-only and dual eligibles excluding Part C enrollees Exclude persons with third-party liability (coverage)
Data sources	Medicaid MCO encounters and HCA-paid claims RSN/BHO encounter data and DBHR-paid behavioral health services CARE assessment diagnoses for identification of SUD treatment need Medicare Parts A and B claims and Medicare Part D encounters
Event/diagnosis	Members meeting the substance use disorder treatment need criteria defined below
Claim status	Include only final paid claims or accepted encounters in measure calculation

Substance Use Disorder Treatment Need

Substance use disorder treatment need is identified by the occurrence of any of the following in the identification window:

1. Diagnosis of a drug or alcohol use disorder in any health service event (SUD-Tx-Pen-Value-Set-1.xlsx)
2. Receipt of a substance use disorder treatment service meeting numerator criteria:
    a. Procedure, DRG, revenue and related codes: SUD-Tx-Pen-Value-Set-2.xls
    b. NDC codes: SUD-Tx-Pen-Value-Set-3.xlsx
3. Receipt of brief intervention (SBIRT) services (SUD-Tx-Pen-Value-Set-4.xlsx)
4. Receipt of medically managed detox services (SUD-Tx-Pen-Value-Set-5.xlsx).

Denominator

Include in the denominator all individuals in the eligible population with a substance use disorder treatment need.

Numerator

Include in the numerator all individuals receiving at least one substance use disorder treatment service meeting at least one of the following criteria in the 12-month measurement year (SUD-Tx-Pen-Value-Set-2.xlsx and SUD-Tx-Pen-Value-Set-3.xlsx):

1. Inpatient or residential substance use disorder treatment services
2. Outpatient substance use disorder treatment services
3. Methadone opiate substitution treatment services
4. Other medication-assisted treatment using medications indicated in SUD-Tx-Pen-Value-Set-3.xlsx

Classification of BHO services is based on procedure code and modifier field values defined in the applicable Service Encounter Reporting Instructions (SERI).

Emergency Department Utilization Measure Definition (ED)

July 25, 2016
Medicaid Version 1.1

Description

Outpatient Emergency Department (ED) Visits per 1,000 Member Months

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

Eligible Population

Ages	Separate reporting for age groups 10 – 17, 18 – 64 and 65+
Medicaid enrollment	Continuous Medicaid coverage in the 6 months up to and including the denominator-compliant member month
Anchor date	December 31 of the measurement year
Identification window	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months)
Benefit	Full benefit Medicaid-only and dual eligibles excluding Part C enrollees Exclude persons with third-party liability (coverage)
Data sources	Medicaid MCO encounters and HCA-paid claims RSN/BHO encounter data and DBHR-paid behavioral health services CARE assessment diagnoses for identification of mental illness and substance use disorder Medicare Parts A and B claims and Medicare Part D encounters Long-term care service data for AAA affiliation
Service contracting entity attribution	For Behavioral Health Organization (BHO), Area Agency on Aging (AAA) and Managed Care Organization (MCO) reporting, members must meet the additional attribution criteria defined below: • Resided in the BHO service area continuously in the 6 months up to and including the qualifying service month AND presented an indication of a mental health treatment need in the 24 months leading up to and including the denominator-compliant member month • Resided in the BHO service area continuously in the 6 months up to and including the qualifying service month AND presented an indication of a substance use disorder treatment need in the 24 months leading up to and including the denominator-compliant member month • Resided in the AAA service area continuously in the 6 months up to and including the qualifying service month AND received ALTSA-funded in-home personal care services continuously in the 6 months up to and including the denominator-compliant member month • Enrolled with the MCO continuously in the 6 months up to and including the denominator-compliant member month
Event	Outpatient ED visits meeting the numerator criteria defined below
Claim status	Include only final paid claims or accepted encounters in measure calculation

Denominator

Medical coverage months in the eligible population in the measurement year.

Numerator

Outpatient ED visits during medical coverage months in the eligible population in the measurement year.

ED visits are defined by the following criteria:

- Claim or encounter is a hospital outpatient claim type AND
- One or more of the following criteria is met:
  - Revenue code in the set ('0450', '0451', '0452', '0456', '0459')
  - Procedure code in the set ('99281' ,'99282' ,'99283' ,'99284' ,'99285', '99288')
  - Place of service code = Emergency Department

Measure is expressed as a rate per 1,000 denominator member months in the measurement year.

Home- and Community-Based Long Term Services and Supports Use Measure Definition (HCBS)

July 25, 2016
Medicaid Version 1.1

Description

Proportion of months receiving long-term services and supports (LTSS) associated with receipt of services in home- and community-based settings during the measurement year.

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

Eligible Population

Ages	Separate reporting for age groups 18 – 64 and 65+
Medicaid enrollment	Enrolled in Medicaid coverage in the denominator-compliant member month
Anchor date	December 31 of the measurement year
Identification window for Behavioral Health Risk factors	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months)
Benefit	Full benefit Medicaid-only and dual eligibles excluding Part C enrollees Exclude persons with other third-party liability (coverage)
Data sources	Medicaid MCO encounters and HCA-paid claims RSN/BHO encounter data and DBHR-paid behavioral health services CARE assessment diagnoses for identification of mental illness and substance use disorder Medicare Parts A and B claims and Medicare Part D encounters Long-term care service data

Service contracting entity attribution	• For Behavioral Health Organization (BHO), Area Agency on Aging (AAA) and Managed Care Organization (MCO) reporting, members must meet the additional attribution criteria defined below: • Resided in the BHO service area in the qualifying service month AND presented an indication of a mental health treatment need in the 24 months leading up to and including the denominator-compliant member month • Resided in the BHO service area in the qualifying service month AND presented an indication of a substance use disorder treatment need in the 24 months leading up to and including the denominator-compliant member month • Resided in the AAA service area in the denominator-compliant member month • Enrolled with the MCO in the denominator-compliant member month

LTSS service criteria	Receipt of any one or more of the following service modalities in the index month:
	• Home- and community-based services
	  – In-home personal care services
	  – Adult family home services
	  – Adult residential care services
	  – Assisted living services
	• Nursing home services

Claim status	Include only final paid claims or accepted encounters in measure calculation

Denominator

Person-months associated with receipt of LTSS services by persons in the eligible population in the measurement year (includes HCBS and nursing home services).

Numerator

Person-months associated with receipt of home- and community-based LTSS by persons in the eligible population in the measurement year (excludes nursing home services).

Measure may be expressed as a rate per 1,000 member months or, equivalently, as a percentage of denominator-compliant member months.

Psychiatric Inpatient Readmissions – Medicaid Measure Definition (PCR-P)

Description

For members 18 years of age and older, the proportion of acute inpatient psychiatric stays during the measurement year that were followed by an acute psychiatric readmission within 30 days. Data are reported in the following categories:

1. Count of Index Hospital Stays (IHS) (denominator).
2. Count of 30-Day Readmissions (numerator).

NOTE: Measure specification is currently undergoing revision to account for delivery system changes resulting from BHO and FIMC implementation.

Definitions

IHS	Index hospital stay. An acute psychiatric inpatient stay with a discharge on or between January 1 and December 1 of the measurement year. Include stays that meet the inclusion criteria in the denominator section. A client may have multiple qualifying discharges in the measurement period.
Index Admission Date	The IHS admission date.
Index Discharge Date	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.
Index Readmission Stay	An acute psychiatric inpatient stay with an admission date within 30 days of a previous Index Discharge Date.
Index Readmission Date	The admission date associated with the Index Readmission Stay.
Classification Period	365 days prior to and including an Index Discharge Date.

Eligible Population Administrative Specification

Denominator	The eligible population.
Step 1	Identify all acute inpatient psychiatric stays with a discharge date on or between January 1 and December 1 of the measurement year. Include only acute admissions to behavioral healthcare facilities, as identified in Table 1 below.
Step 2	Acute-to–acute transfers: Keep the original admission date as the Index Admission Date, but use the transfer's discharge date as the Index Discharge Date.
Step 3	Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.
Step 4	Exclude stays with discharges for death from the observation set.
Step 5	Calculate continuous enrollment and determine whether the observation meets continuous enrollment criteria.

Table 1. Eligible Acute Inpatient Psychiatric Events

Event	Source
Community Psychiatric Hospital Admissions	ProviderOne
Evaluation & Treatment Center Admissions	ProviderOne, supplemented by DBHR Consumer Information System
Child Long-Term Inpatient Admissions	DBHR Consumer Information System

Child Study Treatment Center Admissions	DBHR Consumer Information System
Eastern and Western State Hospital Admissions	DBHR Consumer Information System

Numerator

At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date from the facilities identified in Table 1.

ATTACHMENT K
SUD Implementation Plan Protocol

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Introduction

Opioid misuse and addiction is a public health crisis in Washington State and across the country. In communities across the state, this epidemic is devastating families and overwhelming law enforcement and social services. In 2016, there were 694 opioid related deaths in Washington State. Of these deaths, 382 individuals died from a prescription opioid overdose, 278 died from a heroin overdose, and 90 died from a fentanyl overdose. This high mortality is due to the increase in heroin overdose deaths even though prescription opioid overdose deaths have decreased.

The state is committed to providing appropriate care for individuals with substance use disorder (SUD). In October 2016, Governor Jay Inslee issued Executive Order 16-09, marshalling the state's resources to combat this crisis, including preventing opioid use disorder (OUD) as well as treating it. In addition, Washington will respond to the opioid use public health crisis by utilizing its Section 1115 demonstration waiver to pursue the following goals, aligned with the Centers for Medicare and Medicaid Services (CMS):

1. Increased rates of identification, initiation and engagement in treatment for OUD and other SUDs;
2. Increased adherence to and retention in treatment for OUD and other SUDs;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUD; and
6. Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs.

The following implementation plan outlines Washington's path to provide a full continuum of care for all Medicaid beneficiaries with OUD and other SUDs, and expanding access and improving outcomes in the most cost-effective manner possible. The plan is organized by six key milestones identified by CMS:

1. Access to critical levels of care for OUD and other SUDs;
2. Widespread use of evidence-based, SUD-specific patient placement criteria;
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;
4. Sufficient provider capacity at each level of care, including Medication Assisted Treatment (MAT);
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
6. Improved care coordination and transitions between levels of care.

Washington has already made great progress on many of these milestones, and believes it can accomplish all six goals of the SUD waiver by focusing on a cohesive review processes for SUD

residential admission assessments, ensuring sufficient provider capacity and expansion of access to MAT, as well as enhancing care coordination.

Milestone 1: Access to critical levels of care for OUD and other SUDs

Washington State's Medicaid funded programs provide access to all critical levels of care for OUD and other SUD. Prepaid Inpatient Health Plan (PIHP) contracts with the state's Behavioral Health Organizations (BHOs) require BHOs to provide access to the American Society of Addition Medicine (ASAM) levels described below. As regions around the state move toward the Integrated Managed Care (IMC) model, contracts with Managed Care Organizations (MCOs) will retain these requirements.

The outpatient benefits described below are delivered pursuant to the "Chemical dependency treatment" service requirements located at (13)(d)(2)(c) on Page 40 of Attachment 3.1-A of the State Plan, while the "detox" and inpatient services are provided pursuant to the service requirements located at (13)(d)(2)(b) on Page 38 of Attachment 3.1-A of the State Plan.

Inpatient and detoxification (withdrawal management) services must be provided in state certified facilities. SUD counseling in the categories described below must be provided by a state licensed Chemical Dependency Professional (CDP) or trainee (CDP-T).

The Washington Administrative Code (WAC) outlines treatment requirements for the following service categories:

WAC Requirements by Service Category[33]	
Service Category	**WAC**
Outpatient SUD	WAC 388-877-0738 to 0753
Residential SUD	WAC 388-877-1108 to 1116
General Residential Requirements	WAC 388-877-1108
ASAM 3.5 Intensive Inpatient SUD	WAC 388-877-1110
ASAM 3.1 Recovery House	WAC 388-877-1112
ASAM 3.1 Long-Term SUD Residential SUD	WAC 388-877-1114
Specific Rules for Youth Residential SUD	WAC 388-877-1116
Withdrawal Management	WAC 388-877-1100 to 1106
Opioid Treatment Programs	WAC 388-877-1000 to 1025

[33] http://apps.leg.wa.gov/wac/default.aspx?cite=388-877

ASAM Level 1 Outpatient Services
Current State:

Currently, outpatient services consist of less than nine hours of service per week provided in both individual and group treatment services of varying duration and intensity according to a prescribed plan which is developed before treatment begins. Providers document an individual service plan review for each individual once a month for the first three months and quarterly thereafter or sooner if required by other laws.

State Plan Page Number/Section:

- (13)(d)(2)(c) on Page 40.

Future State:

- No changes are expected at this ASAM level of care.

Summary of Actions Needed:

- None.

ASAM Level 2.1 Intensive Outpatient Services
Current State:

Intensive outpatient services include a minimum of 72 hours of treatment for a maximum of 12 weeks. The treatment includes the following: at least three sessions are required each week during the first four weeks of treatment, with each session occurring on separate days of the week, and group sessions of at least one hour and attending self-help groups in addition to the 72 hours of treatment services.

State Plan Page Number/Section:

- (13)(d)(2)(c) on Page 40.
-

Future State:

- No changes are expected at this ASAM level of care.
-

Summary of Actions Needed:

- None.

ASAM Level 3 Residential Services
Current State:

Residential services are dependent upon initial and ongoing ASAM assessments. Treatment consists of individual and group counseling, education, and activities for clients who have completed withdrawal management services (formerly referred to as detox). This level of SUD treatment provides services in accordance with ASAM level 3.1 and 3.5. Note: ASAM level 3.7 is included in the withdrawal management section below. Length of stay is not fixed, although some treatment programs are oriented to offer 30 to 60 day programs. Actual length of stay is dependent on progress towards treatment goals and reassessment.

State Plan Page Number/Section:

- (13)(d)(2)(b) on Page 38.

Future State:

- No changes are expected at this ASAM level of care.

Summary of Actions Needed:

- None.

Medication Assisted Treatment
Current State:

Washington has two Medication Assisted Treatment (MAT) options: Opiate Treatment Programs (OTP) and Office Based Opiate Treatment Programs (OBOT). Traditionally OTP programs have provided methadone, but some providers are also providing Buprenorphine MAT services. The Department of Social and Health Services' Division of Behavioral Health and Recovery (DBHR) has certified 25 OTP programs in addition to four Veterans Administration OTP programs.

State Plan Page Number/Section:

- (13)(d)(2)(c) on Page 40
-

Future State:

- No changes are expected at this ASAM level of care.
-

Summary of Actions Needed:

- None.

Withdrawal Management
Current State:

Withdrawal management services are provided to assist in safe withdrawal from the physical effects of psychoactive substances. The need for withdrawal management (WM) services is determined by patient assessment using the ASAM guidelines.

There are three levels of detox facilities recognized in Washington. Assessment of severity, medical complications, and specific drug or alcohol withdrawal risk determine placement within each level of service. All programs are licensed under the single ASAM Withdrawal Management requirements.

Sub-acute Detox (ASAM 3.2-WM): Clinically Managed Residential Facilities are considered sub-acute detox. They have limited medical coverage by staff and counselors who monitor patients and generally, any treatment medications are self-administered. These facilities are regulated by the Department of Health (DOH) and are DBHR-certified.

Acute Detox (ASAM 3.7-WM): Medically Monitored Inpatient Programs are considered acute detox. They have medical coverage by nurses with physicians on-call at all times for consultation. They have "standing orders" and available medications to help with withdrawal symptoms. Facilities for these programs are not hospitals, but do have referral relationships. These facilities are regulated by DOH and are DBHR-certified.

Acute Hospital Detox ASAM 4.0-WM): Medically Managed Intensive Inpatient Programs are considered acute hospital detox. The programs have medical coverage by RN and nurses with doctors available 24/7. There is full access to medical acute care including ICU if needed. Doctors, nurses, and counselors work as a part of an interdisciplinary team who medically manage the care of the patient. These facilities are regulated by DOH and hospital licensed, but are not DBHR-certified. This level of care is considered hospital care and not part of the behavioral health benefits provided through BHOs/MCOs.

State Plan Page Number/Section:

- (13)(d)(2)(b) on Page 38.

Future State:

- No changes are expected at this ASAM level of care.

Summary of Actions Needed:

- None.

Milestone 2: Widespread use of evidence-based, SUD-specific patient placement criteria

Current State:

The state requires all SUD providers to assess and provide treatment services using the ASAM criteria. The DBHR currently requires SUD assessments as defined in the WAC. The ASAM Patient Placement Criteria (PPC) are used to guide admission, continued service, and discharge planning.

The BHO/MCO authorization process is an independent review of residential authorization treatment. The residential agency providing the services must obtain independent approval from the BHO or MCO. This review process varies by managed care organization but in all cases is required to be based upon medical necessity and ASAM placement criteria.

In the Fee-for-Service (FFS) system there are no managed care or administrative services organizations providing review of admissions to residential SUD facilities. In most cases, an individual in the FFS system is assessed by a licensed outpatient provider not associated with the residential facility. This independent provider determines whether the individual meets the ASAM residential level of care and when appropriate makes a referral to a residential facility.

Current Monitoring Activities

Current state rules (WACs) require providers to use ASAM criteria for admission, continued services, and discharge planning and decisions.

WAC Requirements by Service Category[34]	
Service Category	**WAC**
Outpatient SUD	WAC 388-877-0738 to 0753
Residential SUD	WAC 388-877-1108 to 1116

All agencies providing these services are monitored by the state licensing and certification team. This team provides on-site visits that include a clinical review of charts at least once every three years for outpatient and annually for residential facilities. This review includes monitoring of ASAM treatment standards for types of services, hours of clinical care and staff credentials. These audits include a review of the appropriateness of placement and length of stay.

In addition to the licensing activities, BHOs and MCOs are required to monitor providers for appropriateness of clinical decision making, including the use of ASAM for admission, continued services, and discharge planning.

Evidence Based Admission Criteria

The state believes the current WAC rules requiring providers to use ASAM for admission, continued services, and discharge planning and decisions meets the requirement for evidenced-based SUD placement criteria.

[34] http://apps.leg.wa.gov/wac/default.aspx?cite=388-877

Future State:

Independent Review Process

To avoid barriers and delays for access to care, the state's approach to independent review for the FFS system is to have initial assessments performed independently from the treating facility. Given that most of the individuals affected by this FFS requirement are AI/AN, this approach offers more flexibility and is preferred over requiring that assessments be performed by an entirely different organization. Because of the limited number of Tribal providers, requiring an entirely separate organization would force AI/AN individuals to seek assessments from non-Tribal providers.

Summary of Actions Needed:

Within 12 months, FFS staff within the Federal Programs team at DBHR/HCA will update the SUD FFS Billing Guide to include a requirement that any FFS SUD residential stays must include an assessment for residential ASAM level of care prior to admit to the residential facility, and that the assessment must be completed independently of the SUD residential facility.

Implementation Timeline, Milestone 2	
Date	**Action**
July 1, 2018	Effective date of 1115 SUD/IMD Waiver Amendment.
September 2018	Convene workgroup that includes subject matter experts and staff responsible for the FFS Billing Guide. Include data management staff.
November 2018	• Finalize data reporting content and format. • Assess needs for changes to the data reporting system.
January 2019	Complete billing guide changes. Distribute to providers.
February 2019	Complete any changes to the data reporting system.

Milestone 3: Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities

Provider Qualification and Treatment Standards
Current State:

WAC rules require programs to meet ASAM Criteria and to adhere to ASAM treatment standards for types of services, hours of clinical care and staff credentials. These standards are found in the following WAC sections:

WAC Requirements by Service Category[35]	
Service Category	**WAC**

[35] http://apps.leg.wa.gov/wac/default.aspx?cite=388-877

General Residential Requirements	WAC 388-877-1108
ASAM 3.5 Intensive Inpatient SUD	WAC 388-877-1110
ASAM 3.1 Recovery House	WAC 388-877-1112
ASAM 3.1 Long-Term Residential SUD	WAC 388-877-1114
Specific Rules for Youth Residential SUD	WAC 388-877-1116

In addition to meeting the WAC administrative and personnel requirements, an agency providing substance use disorder residential treatment services must ensure all SUD assessment and counseling services are provided by a CDP or a CDPT under the supervision of an approved supervisor.

All of the Medicaid-covered service components described in the sections below are rehabilitative services of diagnostic evaluation and face-to-face individual or group counseling, pursuant to the state plan.

Intensive inpatient services (ASAM 3.5 Intensive Inpatient SUD WAC 388-877-1110) are SUD residential treatment services that provide a minimum of 20 hours of treatment services, including a program of individual and group counseling, education, and activities. An agency providing intensive inpatient services must:

- Complete the individual service plan within five days of admission.
- Conduct and document at least weekly, one face-to-face individual substance use disorder counseling session with the individual.
- Document progress notes, referrals and discharge summaries within required timeframes.

Recovery house services (ASAM 3.1 Recovery House WAC 388-877-1112) are SUD residential treatment services that provide social, vocational, and recreational activities to assist individuals adjust to abstinence, and to assist aid in job training, employment, or participating in other types of community services. Recovery house services require program-specific certification by the department's division of behavioral health and recovery.

Youth residential services (WAC 388-877-1116) are substance use disorder residential treatment services provided to an individual 17 years of age or younger. The agency is required to ensure at least one adult staff member of each gender is present or on call at all times if co-educational treatment services are provided. All staff members are trained in safe and therapeutic techniques for dealing with a youth's behavior and emotional crisis, including:

- Verbal de-escalation.
- Crisis intervention.
- Anger management.
- Suicide assessment and intervention.
- Conflict management and problem solving skills.

- Group meetings to promote personal growth, leisure, and other therapy or related activities.

These programs must provide seven or more hours of supervised, structured recreation each week. Provide and document each youth one or more hours per day, five days each week, of supervised academic tutoring or instruction by a certified teacher when the youth is unable to attend school for an estimated period of four weeks or more.

Requirements for providers to use evidence based practices (e.g. motivational interview, cognitive-behavioral therapy).

Providers are not required to utilize any specific evidence-based practices. However, WAC 388-877-0410 (3)(c)(ii), does require agencies to develop and maintain a written internal quality management plan and process that continuously improves the quality of care through use of evidence-based and promising practices.

Requirements for availability of a physical exam or consultation with a physician/ARNP.

Residential SUD facilities are required to complete a health assessment or physical exam. The level of detail and type of exam depends on how the facility is licensed with the DOH. To qualify as a residential SUD facility, the facility must be licensed by DOH in one of the following categories:

- Hospital (chapter 246-320 WAC);
- Private psychiatric or alcoholism hospital (chapter 246-322 WAC);
- Private alcohol and substance use disorder hospital (chapter 246-324 WAC); or
- Residential treatment facility (chapter 246-337 WAC).

The physical exam requirements can be found in the WACs listed above under the "patient care services" section of each rule.

Future State:

No changes.

Summary of Actions Needed:

None.

Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards

Current State:

DBHR licenses and certifies treatment programs and regulates treatment agencies providing services for SUD, community mental health (voluntary and involuntary commitment services),

and problem and pathological gambling. The DBHR Certification, Licensing, and Customer Relations Section supports our state's goal to improve services to vulnerable adults.

There are approximately 584 licensed and certified SUD treatment agencies, 202 community mental health agencies offering treatment services at 553 sites, and 21 problem and pathological gambling treatment agencies. Certification and licensing activities reduce health risks for patients and family members by ensuring that treatment agencies are:

- Surveyed within 12 months of initial approval and every three years; and
- In compliance with regulations; and
- Evaluated rapidly when complaints are received.[36]

Current licensing and certification standards are driven by the Revised Code of Washington (RCW), Code of Federal Regulations, and federal block grants. These standards were established to ensure:

- Quality health care services of equal intensity, duration, and scope.
- Quality management.
- Consistent application of clinical standards and practices.
- Consistent implementation of patient health and safety standards.
- Certified and licensed chemical dependency and mental health professionals are operating within the scope of their practice.
- Consistent risk management monitoring of substance use disorder treatment programs and community mental health agencies.
- Rapid response to complaints regarding substance use disorder treatment programs, community mental health agencies, and providers to ensure patient health and safety.

Opioid Treatment Programs

The DBHR licenses and certifies opioid treatment programs (OTPs) in Washington State. DBHR helps ensure that programs comply with federal and state laws and regulations through regular on-site surveys.

DBHR is a federally recognized OTP Accreditation Body by the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. Each OTP must be accredited and can choose DBHR or another approved accreditation body.

DBHR, through its licensing and regulatory program, supports compliance with nationally recognized standards for agencies that provide SUD treatment services. DBHR integrated requirements and standards of the ASAM criteria in 1998. Washington administrative rules require licensed agencies to use the ASAM criteria for making admission, continued services,

[36] https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/licensing-and-certification-behavioral-health-agencies

and discharge decisions. Agencies must use the ASAM criteria while conducting and developing SUD assessments, individual service plans, treatment plan reviews transitioning to levels of care, and coordinating discharge planning.

Current Monitoring Activities

All state agencies providing these services are monitored by the state licensing and certification team. This team provides on-site visits that include a clinical review of charts at least once every three years for outpatient providers and annually for residential facilities. This review includes monitoring of ASAM treatment standards for types of services, hours of clinical care and staff credentials. These audits include a review of the appropriateness of placement and length of stay.

In addition to the licensing activities, BHOs and MCOs are required to monitor providers for appropriateness of clinical decision making, including the level and types of services provided in agreement with ASAM levels of care.

Future State:

No changes. The state believes the current WAC rules requiring providers to use ASAM for admission, continued services, and discharge planning and decisions meets this requirement.

Summary of Actions Needed:

None.

Implementation of requirement that residential treatment facilities offer MAT on-site or facilitate access off site

Current State:

The state does not require residential treatment facilities to offer MAT on-site. However, the state has promoted the use of MAT in these settings through provider training. Through these trainings, the state has encouraged providers to focus on patient choice when making decisions around the use of MAT. In addition, the state has utilized the Substance Abuse and Mental Health Services Administration's (SAMHSA) Prescription Drug and Opioid Addition (PDOA) and State Targeted Response (STR) grants to develop greater acceptance and availability of MAT.

Tribal and Urban Indian representatives in Washington have expressed objections to the requirement to offer or facilitate access to MAT for AI/AN clients. It is the state's understanding that CMS cannot offer an exemption for Tribal or Urban Indian residential treatment facilities at this time.

Tribal providers that do not provide of facilitate access to MAT as a treatment choice will not be included in the demonstration.

Future State:

The state will implement a requirement that residential treatment facilities offer MAT on-site or facilitate access off-site.

Summary of Actions Needed:

The HCA will work with the DOH to make these WAC changes. As of July 1, 2017 the policy and federal programs functions within DBHR will integrate into HCA. At the same time the DBHR licensing and certification team will become part of the DOH. These requirements will be implemented in two stages:

1. Within 12 months: The state will add to PIHP and MCO contracts a requirement that they require residential treatment providers to offer MAT on-site or facilitate access off-site.
2. Within 24 months: The state will update the WAC to include a requirement that residential treatment providers offer MAT on-site or facilitate access off-site.

Implementation Timeline, Milestone 3	
Contract Changes	
Date	**Action**
July 1, 2018	Effective date of 1115 SUD/IMD Waiver Amendment.
September 2018	• Begin developing new contract language that meets the requirements described above. • Convene group of subject matter experts to advise on development of requirements.
November 2018	Finalize new contract language.
January-March 2019 (or sooner)	Begin contract negotiations with MCOs/BHOs regarding new language.
April-June 2019 (or sooner)	Update MCO and BHO contracts to include the new requirements.
WAC Changes	
Date	**Action**
January 2019	Convene group that includes SUD subject matter experts and DOH/HCA staff responsible for updating WACs.
April 2019	Finalize draft WAC language.

May 2019	Begin public notice and rules hearing process.
September 2019	Finalize rules changes.
January 2020	Effective date of WAC changes.

Milestone 4: Sufficient provider capacity at critical levels of care including for Medication Assisted Treatment

Current State:

The state expects to develop the assessment described in this milestone within 12 months of demonstration approval. An initial assessment of providers enrolled in Medicaid and accepting new patients is described below.

Residential SUD Treatment

- 84 Providers – total licensed residential treatment agencies (includes withdrawal management). It is unknown at this time how many of these residential providers offer MAT services.
- 32 of these residential providers offer withdrawal management services.

Outpatient SUD Treatment

- There are 500 SUD outpatient providers, and 24 of these offer MAT services. The 24 agencies are licensed Opiate Treatment Programs (OTPs). Four new OTPs are planned for early 2018. Other licensed outpatient SUD agencies contract with waivered clinicians to provide MAT services.

Future State:

The state will complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the state including those that offer MAT:

- Outpatient services.
- Intensive outpatient services.
- MAT (medications as well as counseling and other services).
- Intensive care in residential and inpatient settings.
- Medically supervised withdrawal management.

The assessment will help the state determine whether it has sufficient provider capacity in the areas listed above. If any area is determined to be below capacity, the report will include the state's plans to increase availability of this service.

Summary of Actions Needed:

This activity will be completed within 12 months. The HCA will work with the state's data analytics team to complete this task.

Implementation Timeline, Milestone 4	
Date	**Action**
July 1, 2018	Effective date of 1115 SUD/IMD Waiver Amendment.
September 2018	• Convene workgroup that includes the state's data analytics team. • Outline the parameters of the data requirements.
November 2018	Finalize data reporting content and format.
January 2019	Complete data analysis.
February 2019	If any area is below capacity, determine next steps to increase availability of this service.
April 2019	Finalize the report and send to CMS.

Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD

Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse

Current State:

The Washington Agency Medical Directors' Group (AMDG) develops guidelines for medical providers caring for patients of state agency programs in Washington State. The AMDG 2015 Interagency Guideline on Prescribing Opioids for Pain recommends best practices for opioid-based and non-opioid pain management to improve care of patients with chronic pain and to reduce their risk of addiction and overdose.[37] These guidelines are published as an educational tool for medical providers caring for patients of state agency programs, and state agencies use the guidelines to evaluate health technologies, including devices, durable medical equipment, procedures, diagnostics, and off-label drug use.

[37] http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

Along with the AMDG Guideline, five prescribing profession boards and commissions have adopted rules on the management of chronic, non-cancer pain:

- Medical Quality Assurance Commission
- Board of Osteopathic Medicine and Surgery
- Nursing Care Quality Assurance Commission
- Dental Quality Assurance Commission
- Podiatric Medical Board

While still in draft form and being reviewed by the respective commissions and boards, each medical specialty will require at least one hour of continuing education for practitioners licensed to prescribe opioids. Prescribers will attest to having met this requirement.

The relevant WACs for each profession can be found in DOH's Pain Management Adopted Rules.[38]

For Washington's Apple Health (Medicaid) program, the Washington State Health Care Authority implemented clinical policies pertaining to opioid prescriptions on November 1, 2017. This policy is intended to be a prevention and patient safety tool and limits the quantity of opioids that can be prescribed to opiate naïve patients for non-cancer pain.[39] This policy takes effect through both managed care organizations and fee-for-service.

Programs administered by the Health Care Authority are also required to implement the recommendations put forth by the Dr. Robert Bree Collaborative. In 2017 the Bree Collaborative issued recommendations for Opioid Prescribing Metrics.[40] The HCA Medicaid program has adopted three of these measures used in annual reports to providers who are the highest prescribers in the areas of: numbers of patients on high dose opioids, number of patients receiving high MEDs of opioids and those receiving opioids concurrently with other sedative hypnotics. These reports are informational and meant for quality improvement.

Additionally, the following pain management resources are available to providers:

- The University of Washington Department of Anesthesiology and Pain Medicine's Pain Medicine Provider Toolkit has a comprehensive list of clinical tools and patient education materials.
- The University of Washington School of Medicine COPE program offers a suite of free CME courses for primary care doctors, nurses, physician assistants, and other health care specialists who treat patients with chronic pain and want to learn how to safely address opioid prescribing.

[38] https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/OpioidPrescribing/AdoptedRules
[39] https://www.hca.wa.gov/assets/billers-and-providers/opioid-policy.pdf
[40] http://www.breecollaborative.org/wp-content/uploads/Bree-Opioid-Prescribing-Metrics-Final-2017.pdf

- The WA State Department of Health Pain Management Resources website includes pain rules, dosage calculator, clinical tools, and CME training opportunities.
- The American Medical Association also offers CME courses and webinars on safe opioid prescribing.

Future State:

- No changes. Continue current activities.

Summary of Actions Needed:

- None.

Expanded coverage of, and access to, naloxone for overdose reversal

Current State:

DBHR has worked to increase Naloxone since 2015. Using Substance Abuse Block Grant (SABG) funding and working with the University of Washington Alcohol and Drug Abuse Institute (ADAI), DBHR has created a comprehensive website to provide education, locations for purchasing, and information on the distribution network. The collaboration between DBHR and ADAI has influenced changes to state laws including Washington State law RCW 69.50.315, which allows anyone "at risk for having or witnessing a drug overdose" to obtain naloxone and administer it in an overdose. This includes people who use opioids, family members, friends and professionals.

Washington State's 2015 "Naloxone law" RCW 69.41.095 also permits naloxone to be prescribed directly to an "entity" such as a police department, homeless shelter or social service agency for staff to administer if they witness an overdose when performing their professional duties. Additionally, RCW 69.41.095 also permits non-medical persons to distribute naloxone under a prescriber's standing order.

Immunity from liability. Several laws in Washington (commonly called "Good Samaritan" laws) give certain protections to laypersons trying to assist in a medical emergency. RCW 4.24.300 provides immunity from civil liabilities when responding in a medical emergency. RCW 69.50.315 further protects both the overdose victim and the person assisting in an overdose from prosecution for drug possession.

The Washington State Project to Prevent Prescription Drug/Opioid Overdose (WA-PDO)[41] is a collaborative five-year grant project between the DBHR and the ADAI with the purpose of preventing opioid overdose and deaths from opioid overdose, and building local infrastructure to

[41] The DBHR currently directs the grant to Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO) (FOA) No. SP-16-005: Catalogue of Federal Domestic Assistance (CFDA) NO.: 93.243.

plan, implement, evaluate and fund overdose prevention efforts in the long-term. WA-PDO will develop a statewide network of opioid overdose experts and interventions, leveraging ADAI's Center for Opioid Safety Education program (COSE) as the central hub and four regional nodes coordinating WA-PDO overdose prevention activities; this will efficiently extend core overdose prevention expertise and centralized resources at COSE to four diverse, high-need areas (HNA) across the state.

WA-PDO will reach adults who use prescription opioids/heroin and professionals and community members who may be first responders at an overdose. Core interventions include stakeholder engagement, overdose prevention/response training, and naloxone distribution. Over the five-year project our activities will reach 2,400 police, fire, and emergency medical services personnel responders; 13,200 lay responders, 1,400 health care providers; 120 pharmacies; and 160 community organizations across four priority regions.

The Washington State Targeted Response (WA-STR) Naloxone project will provide medication to vulnerable and underserved populations in partnership with ADAI. Despite the resources provided by the 2016 Preventing Death from Opioids (PDO) grant, there remains a substantial gap between need and availability of take-home-naloxone provided to those at highest risk for witnessing an overdose. This program will help meet this need by providing additional naloxone to places at both high relative risk (in terms of the local opioid overdose mortality rate) and high absolute risk (in terms of the total number of fatal opioid overdoses and estimated heroin using population).

Currently all Syringe Exchange programs in Washington are distributing Naloxone as a component of the work provided by ADAI utilizing funding provided through DBHR SABG, PDO and WA-STR funding. The website stopoverdose.org continues to be a major source of education and training. ADAI continues to provide outreach and training for professional first-responders requesting training and naloxone.

Future State:

- No changes. Continue current activities.

Summary of Actions Needed:

- None.

Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs

Current State:

The Washington State Department of Health Prescription Monitoring Program (sometimes referred to as Prescription Review) is a centralized online database that holds controlled

substance prescription information for all patients across the state. Prescribers are able to review their patients' prescription history information before they prescribe or dispense drugs. This allows them to look for duplicate prescribing, possible misuse, drug interactions and other potential concerns. More information and factsheets on program rules, registration, use, and reports are available on the Prescription Monitoring Program website.[42]

The HCA sends opioid prescribing reports to physicians as part of the Centers for Disease Control's (CDC) Prescription Drug Overdose grant. These reports are intended to inform providers of their prescribing practices to support quality improvement efforts. The metrics used in this report mirror the Dr. Robert Bree Collaborative Opioid Prescribing Metrics[43] and are tailored to HCA's Medicaid population where applicable. The best practices recommendations reflect the CDC's guidelines for prescribing opioids.[44]

Future State:

- No changes. Continue current activities.

Summary of Actions Needed:

- None.

Milestone 6: Improved care coordination and transitions between levels of care

Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities
Current state:

While the state understands the value of coordination between levels of care and expects providers to provide warm hand-offs during the transition between residential and outpatient treatment, there are not any rules or policies in place requiring this for SUD services. The concept of coordination between the outpatient and inpatient settings has long been a part of the mental health system through discharge planning requirements and dedicated "hospital liaison" positions. However, the state recognizes that the SUD residential and outpatient systems may not yet coordinate to this level.

Additional policies to ensure coordination of care for co-occurring physical and mental health conditions
Washington State is moving toward an integrated managed care system. In this system, each Medicaid individual's behavioral health and physical health care is coordinated by a single entity (an MCO). There is an expectation that having both behavioral health and physical health services managed by one organization will improve coordination among those systems.

[42] http://www.wapmp.org/
[43] http://www.breecollaborative.org/wp-content/uploads/Opioid-Prescribing-Metrics-Specifications-Draft-2017.pdf
[44] https://www.cdc.gov/drugoverdose/pdf/guidelines_factsheet-a.pdf

In addition to these system-wide changes, the state has current contract language requiring coordination with primary care providers (PCP) or, if the client does not have a PCP, that the behavioral health provider refer the individual to a PCP.

Future State:

The state will implement a requirement that MCOs, residential treatment providers, and outpatient providers work to develop policies and practices that enhance care coordination, including transitions between levels of care following residential treatment stays.

Summary of Actions Needed:

HCA will work with the DOH to make these WAC changes. As of July 1, 2017 the policy and federal programs functions within DBHR will integrate into HCA. At the same time the DBHR licensing and certification team will become part of the DOH.

1. Within 12 months: The state will add these requirements to PIHP and MCO contracts.
2. Within 24 months: The state will update the WAC to include these requirements

Implementation Timeline, Milestone 6	
Contract Changes	
Date	**Action**
July 1, 2018	Effective date of 1115 SUD/IMD Waiver Amendment
September 2018	• Begin developing new contract language that meets the requirements described above. • Convene group of subject matter experts to advise on development of requirements.
November 2018	Finalize new contract language.
January-March 2019 (or sooner)	Begin contract negotiations with MCOs/BHOs regarding new language.
April-June 2019 (or sooner)	Update MCO and BHO contracts to include the new requirements.
WAC Changes	
Date	**Action**
January 2019	Convene group that includes SUD subject matter experts and DOH/HCA staff responsible for updating WACs.
April 2019	Finalize draft WAC language.
May 2019	Begin public notice and rules hearing process.
September 2019	Finalize rules changes.
January 2020	Effective date of WAC changes.

Attachment A: SUD Health Information Technology (IT) Plan

The table below identifies Washington's SUD Health Information Technology (IT) Plan, including current and planned future state, and specific actions and timeline, to address needed enhancements over the course of the demonstration.

Section I. State Health IT / PDMP Assessment & Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed
5. Implementation of comprehensive treatment and prevention strategies to address Opioid Abuse and OUD, that is: *--Enhance the state's health IT functionality to support its PDMP; and* *--Enhance and/or support clinicians in their usage of the state's PDMP.*	*Provide an overview of current PDMP capabilities, health IT functionalities to support the PDMP, and supports to enhance clinicians' use of the state's health IT functionality to achieve the goals of the PDMP.*	*Provide an overview of plans for enhancing the state's PDMP, related enhancements to its health IT functionalities, and related enhancements to support clinicians' use of the health IT functionality to achieve the goals of the PDMP.*	*Specify a list of action items needed to be completed to meet the HIT/PDMP milestones identified in the first column. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item*
Prescription Drug Monitoring Program (PDMP) Functionalities			
Identify funding sources to enhance the functionality of the PDMP and support its use by clinicians			Funding is needed to support the design, development, operation, and/or maintenance of each of the tasks described below in the SUD HIT Plan. Contingent on the availability of funds, the Health Care Authority (HCA), in collaboration with the

			Department of Health (DOH), will: • Explore options for funding (i) PDMP enhancements (as described in the activities below) and (ii) the use of the PDMP by clinicians on behalf of Medicaid and non-Medicaid patients; and • Develop a financial mapping tool that identifies sources of funds (e.g., HITECH, MMIS, grants, private sector funds) that will be used to execute the activities in this SUD HIT Plan on behalf of Medicaid and non-Medicaid patients and their treating providers. For example, the ability to accurately match patient who are prescribed opioids with patients in the PDMP, and match patients in the PDMP with other data sources is

			critically important for most tasks in the SUD HIT Plan. Activities F and I below describe the need to explore options to enable patient matching. The financial mapping tool will identify funding sources that will be used to implement these activities. Timeline: 3 – 6 months
Enhanced interstate data sharing in order to better track patient specific prescription data	The Washington Prescription Monitoring Program[45] (PMP) is intended to improve patient care and stop prescription drug misuse by collecting dispensing records for Schedule II, III, IV and V drugs, and making the information available to medical providers and pharmacists as a tool in patient care. Washington State allows healthcare professionals licensed in and by	The state will continue current enhancement activities, and identify the most appropriate solution for additional state-to-state data sharing. Per the 2016 Washington State Interagency Opioid Working Plan,[46] the state is working to reduce current policy and technical barriers to enable	Contingent on the availability of funds, the Health Care Authority (HCA) and the Department of Health (DOH) will identify facilitators and barriers, as well as options to enhance interstate data sharing to better track of patient specific prescription data. Considerations will include identifying the costs of, and funding mechanisms for,

[45] https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PrescriptionMonitoringProgramPMP
[46] http://www.stopoverdose.org/FINAL%20State%20Response%20Plan_March2016.pdf

	other states to register for and access the Washington PMP. Washington provides links to three regional PDMP websites (AK, OR, and ID) and a link to the national PDMP training and TA center. Washington also has agreements with Oregon and Idaho allowing PDMP data exchange in emergency departments via the Emergency Department Information Exchange (EDIE).	sharing of PMP data with border states (Goal 4, Strategy 1). Currently under review are PMP InterConnect (per National Association of Boards of Pharmacy) and Rx Check (per Bureau of Justice Assistance). Solution must meet State of Washington data security standards and be HIPPA compliant.	supporting the collaboration and identification of options. HCA and DOH will develop and implement a strategy to identify the costs of and secure funding needed to support additional state-to-state data sharing. Timeline: 12-24 months.
Enhanced "ease of use" for prescribers and other state and federal stakeholders	DOH has offered education and training regarding the PMP, and provided guidance to providers regarding access to PMP and resources. Washington State rules support and require the use of the PMP for the following: (1) Opioid prescribing rules suggest that providers should include review of any available PMP data when evaluating patients for chronic non-cancer pain; (2) The workers' compensation	The state must develop solutions that effectively balance the need for security with ease of use to support provider use of the PMP. A workgroup of subject matter and technical experts from DOH, Washington Technology Solutions (WaTech) and the Office of Cyber Security are gathering feedback and evaluating options in collaboration with providers and professional associations that	Contingent on the availability of funds, HCA and DOH will identify and implement feasible PMP Portal enhancements per workgroup recommendations. Some enhancements may be contingent on availability of funds. If implementation of identified enhancements rely on acquiring funding, the state will work to identify potential funding sources to support the

	program requires prescribers to use the PMP.	meet the state's shared goals of security and patient safety.[47]	implementation of PMP Portal enhancements. HCA in collaboration with DOH will develop and implement a strategy to identify the costs of and secure funding needed to identify and implement PDMP enhancements to facilitate "ease of use" for prescribers and other stakeholders. Timeline: 12-24 months
Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange	The PMP's connection to HIE has been in place since late 2013. EDIE was the first to take advantage of that connection. EDIE is in use across all acute care hospitals in Washington State. PMP data went live on the EDIE system in November 2014. Through 2015 more than 2.2 million PMP queries were completed by EDIE, about 120% more than the number of queries made by all other health	Per the 2016 Washington State Interagency Opioid Working Plan,[49] the state is exploring options to require health care systems to connect to the PMP through the statewide electronic health information exchange (Goal 4, Strategy 1). DOH is also exploring alternative connectivity options	DOH will work to reintroduce legislation (ESHB 2489) during the 2019 legislative session. DOH will then work with partner agencies to prioritize and support adoption of bill. Implementation of enhanced PDMP connections to the statewide HIE is contingent on acquiring funding, including

[47] https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PrescriptionMonitoringProgramPMP/EaseofUseProject
[49] http://www.stopoverdose.org/FINAL%20State%20Response%20Plan_March2016.pdf

	care providers (HCPs) in all other health care settings over the PMP web portal for the year. The connection between the DOH PMP system vendor, OneHealthPort HIE and Epic EHR system were successfully piloted in the summer of 2015. EPIC developed and released a module to its Washington clients in December of 2015. This new module allows Epic users to transact and transmit PMP data directly to the patient record in the native EMR. At present providers can access the PMP by building a connection to the OneHealthPort HIE and integrating the PMP transaction into their EHR (rather than separately logging into the PMP Portal).	through the use of third party vendors. These vendors would provide application programming interface (API) options for medical entities whose vendor will not create the HIE connection, or for entities without the means to acquire the HIE connection. The state will pursue PDMP database vendor enhancements, use of state developed database architecture, or possible utilization of database architecture developed by another state.	funding for the following activities: • The state will identify additional third party vendors to develop API for HIE connections, and determine costs of per instance use, or single payment and "open source" distribution of state purchased API. • DOH and HCA will work to upgrade the PMP API interface to adopt standards identified by CMS. Per CMS rule-1694-p, the PMP API interface will need to be updated in response to the IPPS requirement to adopt NCPDP 2017071 by 2019 for e-prescribing. The interface currently uses an older widely adopted standard NCPDP 10.6. The state will require technical

	DOH has worked to support legislation (ESHB 2489[48]) that would mandate federally certified electronic health record systems to be utilized in the State of Washington to ensure the system can integrate with the state PMP via the HIE. However, legislation has not passed.		assistance and funding for needed upgrades to the PDMP system, any vendor fees, and additional staff to work on this Design, Development, and Implementation (DDI) work. The state will identify sources of additional funding for a state operated database, and pursue a public RFP per state contracting best practices for non-government entity. HCA and DOH will develop and implement a strategy to identify the costs of and secure funding as needed to upgrade the PDMP and enhance connectivity to the statewide health information exchange, including:

[48] http://apps2.leg.wa.gov/billsummary?BillNumber=2489&Year=2017&BillNumber=2489&Year=2017

			• upgrades to the new NCPDP standard (required by CMS), • any vendor fees, additional staff to work on this DDI work; and • changes to the health information exchange service provided by OneHealthPort, the statewide health information exchange organization, to support these PDMP enhancements. Timeline: 24+ months.
Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns[50] (see also "Use of PDMP" #2 below)	The primary goal for using the PMP is patient safety, with additional goals of providing the highest quality of care and reducing harm. The PMP informs the HCP of a patient's controlled substance prescription history. That helps prevent drug-drug interactions that may lead to an adverse outcome, and therapeutic duplication. It alerts the HCP to length of time a patient	The state will explore further enhancements to the PMP functionality, including additional tools or alerts for HCPs.	Contingent on the availability of funds, HCA and DOH, in collaboration with Health Care Providers (HCPs and Managed Care Organizations (MCOs) will (1) identify clinical decision support (CDS) tools or alerts that could be usefully integrated into the PMP; and (2) integrate

[50] Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: http://dx.doi.org/10.15585/mmwr mm6610a1.

	has taken prescription opioids, and understanding of undertreated pain. PMP data can alert the HCP of (1) patients receiving opioids, benzodiazepines, and other drugs that can create an adverse outcome at the same time, (2) patients receiving high morphine equivalent dose (MED) opioids, and (3) people who have potential abuse patterns, such as having seen five or more opioid prescribers and dispensers. The PMP also allows prescribers and dispensers to check for possible prescription misuse, multiple prescribers, adverse drug interactions, and undertreated pain.		these CDS into the PMP API. To the extent practical and appropriate, the CDS tools/alerts identified in this activity will support the use cases developed in Activities below. HCA and DOH will develop and implement a strategy to identify the costs of and secure funding as needed to identify and integrate CDS tools/alerts into the PMP API. Timeline: 12-24 months.
Current and Future PDMP Query Capabilities			
Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index (MPI) strategy with regard to PDMP query)	The PMP database via the OneHealthPort HIE requires a match of the requested patient record. The query via the HIE is a one-to-one return based on provider search criteria (ie. "John Smith" returns only "John Smith").	Per the 2016 Washington State Interagency Opioid Working Plan[51] the state will work to: (1) link PMP data to overdose death and hospitalization data to determine relationships between prescribing, patient risk behavior, and overdoses, and	Contingent on the availability of funds, HCA in collaboration with DOH will: 1. Consider the accuracy of patient matching for patients with data in the PDMP with other data

[51] http://www.stopoverdose.org/FINAL%20State%20Response%20Plan_March2016.pdf

	The MTP HIT Strategic Roadmap and HIT Operational Plan identify a need for improved patient entity matching, including a focus on and task to identify various Master Person Identifiers (MPIs) used across programs and discuss options and considerations of multiple vs. single MPI.	disseminate results to individual counties, (2) develop and disseminate population-level PMP reports on buprenorphine prescribing practices, (3) develop measures using PMP data to monitor prescribing trends and assess impact of interventions on prescribing practices, and (4) explore options to aggregate and analyze PMP data by health plan/payer. As part of future PDMP database development, RFP/architecture design will require improved clustering and aggregation of patient identifiers.	sources (e.g., data on hospitalizations, overdose deaths) 2. If the accuracy of patient matching needs improvement, then HCA, in collaboration with DOH will: (1) identify facilitators and barriers, and (2) explore options to link Patient Identifiers and Provider Identifiers across different systems to improve the accuracy of matching patients with data in the PDMP with other data sources; and 3. Develop and implement a strategy to improve the accuracy of patient matching with regard to the PDMP. HCA and DOH will develop and implement a strategy to identify consider the actions will include identifying the need for and if needed costs of and funding mechanisms needed to implement the strategy to improve the accuracy of for

			linking Patient Identifiers and Provider matching Identifiers across different systems Timeline: 12-24 months.
Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes			
Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow	As mentioned above, integration of the PMP, OneHealthPort HIE and Epic has occurred. The Epic EHR has the biggest footprint among Washington State health care providers (compared to other EHR vendors). The PMP has assisted eight medical entities move to data exchange production or testing across the state. This includes EHR systems utilizing Epic, Cerner, AllScripts and NextGen. Once medical entities move into production with a given EHR, PMP staff attempt to identify other healthcare providers/entities utilizing that EHR in order to	Per the 2016 Washington State Interagency Opioid Working Plan[52] the state will work to: (1) Promote the use of the PMP, including use of delegate accounts, among health care providers to help identify opioid use patterns, sedative co-prescribing, and indicators of poorly coordinated care/access. (2) Link PMP data to overdose death and hospitalization data to determine relationships between prescribing, patient risk behavior, and overdoses, and disseminate results to individual counties. (3) Develop and disseminate population-level PMP reports on buprenorphine	Contingent on the availability of funds, HCA in collaboration with DOH will sponsor work to: • identify for 3-5 use cases the clinical workflows/business processes for accessing the PDMP prior to prescribing an opioid or other controlled substance; and • develop change management guidance for implementing the identified clinical workflows/business processes

[52] http://www.stopoverdose.org/FINAL%20State%20Response%20Plan_March2016.pdf

	possibly connect those medical providers/entities to the HIE via the API already developed. The state is supportive of clinicians accessing the PDMP prior to prescribing an opioid and have developed this interface in conjunction with ONC and the vendor community.	prescribing practices. (4) Enhance medical, nursing, and physician assistant school curricula on pain management, PMP, and treatment of opioid use disorder. (5) Educate law enforcement on the PMP and how it works" (6) Increase PMP reporting frequency from weekly to daily. (7) Provide easy access to the PMP data for providers through electronic medical record systems. (8) Provide MED calculations within the PMP for chronic opioid patients with automated program alerts for providers. (9) Evaluate policy interventions for effectiveness and impact (e.g., pain management rules, mandatory PMP registration). Additionally, regional work is being completed by Accountable Communities of Health (ACH) to support and reinforce the 2016 Washington	HCA and DOH will develop and implement a strategy to identify the costs of and secure funding for the identification of the use cases and associated clinical work flows/business processes, and change management guidance Timeline: 24+ months.

		State Interagency Opioid Working Plan.	
Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription	As mentioned above, integration of the PMP, OneHealthPort HIE and Epic has occurred. The Epic EHR has the biggest footprint among Washington State health care providers (compared to other EHR vendors). The state is supportive of clinicians accessing the PDMP prior to prescribing an opioid and have developed this interface in conjunction with ONC and the vendor community.	As described above, the 2016 Washington State Interagency Opioid Working Plan[53] goals and strategies, as well as supportive regional work completed by ACHs, are intended to increase the use of the PMP prior to the issuance of an opioid prescription.	Contingent on the availability of funds: • In addition to pursuing the strategies described in the 2016 Washington State Interagency Opioid Working Plan, HCA and DOH will collaborate to identify facilitators and barriers to develop enhanced supports for clinician review of the PMP. • HCA in collaboration with DOH will develop and implement a strategy to identify the costs of and secure funding for any additional/enhanced

[53] http://www.stopoverdose.org/FINAL%20State%20Response%20Plan_March2016.pdf

			clinician supports to use the PDMP. Timeline: 24+ months.
Master Patient Index / Identity Management			
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	The master patient index, or Master Data Management (MDM), is a component of the Enterprise Architecture. The foundation was created with the Medicaid Eligibility and Enrollment modernization MMIS purchase of the IBM Truven software. The state recognizes limitations in currently supported patient matching in the PDMP, and intends to find ways to link this issue to improve data linkage and identity mapping.	DOH and HCA will explore feasibility and options of developing a shared Master Patient Index and Master Provider Index.	As described above and contingent on the availability of funds: HCA and DOH will explore the need to and options for enhancing patient matching (such as developing a shared Master Patient Index and Master Provider Index; or creating a the ability to crosswalk of patient/provider identifiers between the PDMP and other data sources); and implement a strategy to improve the accuracy of patient matching with regard to the PDMP. HCA, in collaboration with and DOH, will develop and implement a strategy to identify the costs of and secure funding to enhance the patient matching between the PDMP and other

			data sources. Timeline: 12-24 months.

Attestation Requirements

Statement 1*: Indicate whether the state has sufficient health IT infrastructure/" ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration.*

Washington State has Health IT infrastructure in place to support the goals of the SUD demonstration. This SUD HIT plan lists infrastructure enhancements, contingent on securing necessary funding, which support expanding effective and reusable health information technology and exchange capabilities statewide. The state agencies, HCA and DOH, will collaborate over the next 12-24 months to identify and pursue funding opportunities that will support improvements to the state health IT infrastructure.

HCA will lead the development of the financial mapping tool. HCA and DOH will collaborate in the development and implementation of the:

- SUD Monitoring Protocol that will provide the strategies to increase utilization and improve functionality of prescription drug monitoring programs as described above in the SUD Health Information Technology (IT) Plan; and
- Strategy to identify the costs of and secure funding needed for each of the activities identified about in the SUD Health IT Plan.

Statement 2*: Indicate whether the state's SUD Health IT Plan is "aligned with the state's broader State Health IT Plan (SMHP) and if applicable, the state's Behavioral Health (BH) Health IT Plan."*

Washington State's SUD Health IT plan is aligned with the broader State Medicaid Health IT Roadmap and Operational Plan approved by CMS under the Medicaid Transformation Project. Upon approval of the IMD Waiver, the state will review the Health IT Operational Plan and incorporate any additional tasks needed to align with approved SUD HIT Plan. Washington State is updating its State Medicaid Health IT Plan and commits to aligning the SMHP with the approved SUD HIT Plan.

Statement 3: *Indicate that the state will include appropriate standards referenced in the ONC Interoperability Standards Advisory (ISA) https://www.healthit.gov/isa/ and 45 CFR 170 Subpart B in subsequent MCO contract amendments or Medicaid funded MCO/ Health Care Plan re-procurements.*

The Washington State Health Care Authority includes appropriate standards referenced in the ONC Interoperability Standards Advisory (ISA) in its Managed Care contracts.

Section II. Implementation Administration
The state's point of contact for the SUD Health IT Plan is listed below.

Name and Title: Shaun Wilhelm, Deputy State HIT Coordinator
Telephone Number: (360) 725-0777
Email Address: shaun.wilhelm@hca.wa.gov

Attachment L: Monitoring Metric Supplemental Information

Medicaid Section 1115 SUD Demonstration Monitoring Protocol – Additional Information to Support Monitoring Metric Specifications

Revised and Resubmitted January 24, 2020

Background and Introduction

The State will leverage three different analytic teams to produce the required metric reporting. These analytic teams include the Department of Social and Health Services Research and Data Analysis Division, the Health Care Authority's Analytics, Research, and Measurement team, and the Health Care Authority's Division of Behavioral Health and Rehabilitation. Between the three analytic teams, the State has an extensive existing data infrastructure that the State intends to leverage for the CMS reporting requirements. This existing infrastructure currently completes reporting for various entities, including the Adult and Child Common Measure Set and substance use disorder related Substance Abuse Mental Health Services Administration (SAMHSA) reporting. This analytic infrastructure also supports a number of ongoing activities in the realm of health care transformation. These include, but are not limited to, Washington's movement towards the integration of behavioral and physical health care and all three initiatives of the initial Medicaid Transformation Project (Transformation through Accountable Communities of Health, Long-Term Services and Supports of the Aging Population, and Foundational Community Support Services).

The State analytic teams have reviewed the CMS provided specifications and reporting procedures. Per the instructions in the Monitoring Protocol, the State will explain any deviations from the CMS-provided specifications that are needed to match the health care context and data infrastructure within Washington State. The State created this attachment to minimize duplication of explanation of requested modifications which apply to multiple metrics, and to provide details on state-specified metrics that would not fit within the given metric workbook template.

The State thanks CMS for the opportunity to align the specifications with the State's health care context, data infrastructure, and existing 1115(a) demonstration. We welcome any questions or concerns from CMS regarding these requests.

Overview of 1115 SUD Demonstration Monitoring Metrics

This section describes the data sources the State will be drawing on, how the State will align the Substance Use Disorder (SUD) measurement periods with the State's broader 1115(a) demonstration reporting cycle, and will note the reporting level for all metrics.

Description of Data Sources

Integrated Client Databases. SUD demonstration monitoring metric production will use the integrated administrative data maintained in the Department of Social and Health Services Integrated Client Databases (ICDB). The ICDB was explicitly designed to support quasi-experimental evaluation of health and social service interventions in Washington State, and has been widely used in evaluation studies published in peer-reviewed journals[1] and for the production of performance and monitoring measures.

[1] For a recent example, see Jingping Xing, Candace Goehring and David Mancuso. Care Coordination Program For Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs Care Coordination Program For Washington State. Health Affairs, 34, no.4 (2015):653-661.

The underlying reporting arrays are regularly updated to align with State requirements. The State has analyzed completion factors based on the historical encounter data submitted to the State's MMIS by contracted MCOs responsible for SUD services. This completion factor analysis indicates that fewer than 90% of ultimately accepted encounters are uploaded and successfully accepted into the MMIS by five months from the month the service was provided to the client. Reporting with a 90-day lag would result in an even greater systematic undercount of services provided in the most recent reporting period. The State believes that reporting information that is known to be undercounted will negatively impact the IMD waiver program. The State requests a 6-month reporting lag to allow for reporting of information that is more complete. Even with the proposed 6-month reporting lag, we recommend provisions for updating information previously reported with more complete data when it becomes available.

The State also requests the ability to calculate the monthly metrics once per quarter. Per CMS' technical assistance document Reporting 1115 SUD Demonstration Monitoring Metrics "…if a state submits data on a quarterly basis, the submission should contain three monthly values for each monthly metric, each produced at the same time relative to their measurement periods." However, the underlying production schedule for the State's analytic environment is quarterly. The State is unable to change the global production cycle and fundamental infrastructure to accommodate this monitoring expectation. In addition, some of the data necessary for the monthly metrics is updated quarterly and would not be up to date for two months of each quarter. For example, information needed for the criminal justice involvement submetrics is received on a quarterly basis from the Washington State Identification System arrest database maintained by the Washington State Patrol. The State understands that part of CMS' reasoning for producing the monthly metrics at the same time relative to their measurement periods is due to the dynamic nature of Medicaid data. Observing a 6-month reporting lag mitigates this impact.

Death Certificate Data. The Washington State Department of Health maintains the death certificate data received from the Center for Health Statistics. The Health Care Authority's Analytics, Research, and Measurement team will work with the death certificate data for the two fatal overdose metrics. However, death certificate data is not finalized until Q4 in the year following the measurement year. For example, death certificate data for 2017 was not finalized until October 2018. This will result in additional lag time in reporting for the two fatal overdose metrics that require this data.

Measurement Period

Per CMS's instructions and in alignment with the Special Terms and Conditions (STCs) 72, 74, and the Schedule of State Deliverables for the Demonstration Period (XIII), Washington will align the reporting cycles for the SUD Demonstration Amendment with the broader section 1115(a) demonstration quarterly and annual reporting cycles. Table 1 shows the current reporting cycle to the broader section 1115(a) demonstration.

Aligning to this reporting cycle will require a small modification to the measurement periods in the technical specification document. The effective date of the Washington SUD demonstration is July 17, 2018. However, to align with this reporting structure, we will use July 1, 2018 as the start date for the measurement periods. This does not change the effective date of the demonstration. Washington is in favor of this modification, as it closely aligns with our current data infrastructure and reporting processes. For example, Medicaid enrollment is verified monthly in Washington, and thus all eligibility requirements will need to be based around calendar months.

TABLE 1.

Washington's 1115(a) Waiver Quarterly and Annual Reporting Cycle

Quarter/Annual Report Cycle	MTP Reporting Period	Report Due Date
DY2 Q4 (Annual Report DY2)	Jan 2018 – Dec 2018	03/01/2019
DY3 Q1	Jan 2019 – March 2019	06/03/2019
DY3 Q2	April 2019 – June 2019	09/03/2019
DY3 Q3	July 2019 – Sept 2019	12/02/2019
DY3 Q4 (Annual Report DY3)	Jan 2019 – Dec 2019	03/02/2020
DY4 Q1	Jan 2020 – March 2020	06/01/2020
DY4 Q2	April 2020 – June 2020	09/01/2020
DY4 Q3	July 2020 – Sept 2020	12/01/2020
DY4 Q4 (Annual Report DY4)	Jan 2020 – Dec 2020	03/01/2021
DY5 Q1	Jan 2021 – March 2021	06/01/2021
DY5 Q2	April 2021 – June 2021	09/01/2021
DY5 Q3	July 2021 – Sept 2021	12/01/2021
Final Report	Jan 2021 – Dec 2021	06/30/2022

In addition, this also aligns with reporting cycles for other related SUD projects and the Washington State fiscal year. The modified measurement periods for the monthly, quarterly, and annual metrics are described next and in the table below.

- For metrics with a monthly measurement period, the first monthly measurement period is the month the SUD demonstration began – July 1, 2018 to July 31, 2018. The second month is August 1, 2018 to August 31, 2018, and so forth.
- For metrics with a quarterly measurement period, the first quarter of the demonstration is the first three months of the demonstration – July 1, 2018 to September 30, 2018.
- For the CMS-constructed metrics with an annual measurement period, the first annual measurement period is the first twelve months of the demonstration – July 1, 2018 to June 30, 2019.
- For the established quality measures, the first annual measurement period is the calendar year in which the demonstration began – January 1, 2018 to December 31, 2018.

As previously discussed with CMS, the State believes setting the baseline to the year prior to the change in authorizing expenditure authority is needed to appropriately set demonstration targets, annual goals, and to ultimately respond to the demonstration hypothesis specific to the SUD amendment (STC 111e). Thus, the State requests to define the baseline year as July 1, 2017 – June 30, 2018 for the CMS-constructed metrics and January 1, 2017 – December 31, 2017 for the established quality measures.

The State will begin reporting after a monitoring protocol has been agreed upon by the State and CMS, and sufficient time is provided to implement the metric specifications as stated in the agreed upon monitoring protocol. The requested reporting schedule in Table 2 below may change depending on when the monitoring protocol is approved. The reporting schedule also specifies a baseline reporting period of July 1, 2017 – June 30, 2018 for CMS constructed metrics and January 1 – December 31, 2017 for established quality measures. In addition, Table 2 employs the 6-month reporting lag that is necessary for the State to submit data that does not substantially undercount the number of services provided.

TABLE 2.

Proposed Reporting Schedule for Washington Metrics for SUD Demonstration

Dates of reporting quarter	WA's SUD DY: Jul 1 – Jun 30	WA's broader 1115 DY: Jan 1 – Dec 31 (type of report)	Report due (per STCs schedule)	SUD metrics included in report	Reporting period(s) for SUD metrics in a given report†
Jul – Sept 2018	DY1 Q1	DY2 Q3 (quarterly)	12/1/2018	No SUD metrics reported. Monitoring protocol under development.	N/A
Oct – Dec 2018	DY1 Q2	DY2 Q4 (annual)	3/1/2019	No SUD metrics reported. Monitoring protocol under development.	N/A
Jan – Mar 2019	DY1 Q3	DY3 Q1 (quarterly)	6/1/2019	No SUD metrics reported. Monitoring protocol under development.	N/A
Apr – Jun 2019	DY1 Q4	DY3 Q2 (quarterly)	9/1/2019	No SUD metrics reported. Metric specifications being implemented by State.	N/A
Jul – Sept 2019	DY2 Q1	DY3 Q3 (quarterly)	12/1/2019	(1) Monthly metrics (2) CMS defined metrics* (3) Established quality metrics	(1) July 2017 – March 2019 (2) July 2017 – June 2018 (3) January – December 2017 January – December 2018
Oct – Dec 2019	DY2 Q2	DY3 Q4 (annual)	3/1/2020	(1) Monthly metrics (2) CMS defined metrics	(1) April – June 2019 (2) July 2018 – June 2019
Jan – Mar 2020	DY2 Q3	DY4 Q1 (quarterly)	6/1/2020	(1) Monthly metrics	(1) July – September 2019
Apr – Jun 2020	DY2 Q4	DY4 Q2 (quarterly)	9/1/2020	(1) Monthly metrics (2) Established quality metrics	(1) October – December 2019 (2) January – December 2019
Jul – Sept 2020	DY3 Q1	DY4 Q3 (quarterly)	12/1/2020	(1) Monthly metrics	(1) January – March 2020
Oct – Dec 2020	DY3 Q2	DY4 Q4 (annual)	3/1/2021	(1) Monthly metrics (2) CMS defined metrics	(1) April – June 2020 (2) July 2019 – June 2020
Jan – Mar 2021	DY3 Q3	DY5 Q1 (quarterly)	6/2/2021	(1) Monthly metrics	(1) July – September 2020
Apr – Jun 2021	DY3 Q4	DY5 Q2 (quarterly)	9/1/2021	(1) Monthly metrics (2) Established quality metrics	(1) October – December 2020 (2) January – December 2020
Jul – Sept 2021	DY4 Q1	DY3 Q3 (quarterly)	12/1/2021	(1) Monthly metrics	(1) January – March 2021
Oct – Dec 2021**	DY4 Q2	DY5 Q4 (annual)	3/1/2022	(1) Monthly metrics (2) CMS defined metrics	(1) April – June 2021 (2) July 2020 – June 2021

**Given the additional delay in complete death certificate data, reporting on Metric #26 and Metric #27 (overdose death count and rate) will be delayed by one year. Baseline information will be available for the Annual Report DY3, Year 1 information will be available for Annual Report DY4, etc. Additional information about this delay is describes in the next section.*

***SUD Demonstration ends on December 31, 2021. Data from July 1, 2021 to December 31, 2021 will not be available before the final annual report is due to CMS.*

†For reporting periods with multiple types of SUD metrics, the list number corresponds with the SUD metric list number in the prior column. For example, in DY2 Q1, the monthly metrics will be reported for the July 2017 through March 2019 time period. The CMS defined metrics will be reported for the July 2017 to June 2018 time period, and so forth.

Reporting Level

For each metric, the demonstration population is defined as the whole state. In addition, the State's SUD amendment is not focused on a particular geographic area or a specific subpopulation of Medicaid beneficiaries. Thus, per previous conversations with CMS, the State will not be reporting a separate model population.

Reporting 1115 SUD Demonstration Monitoring Metrics Defined by CMS

This section defines the subpopulations for metric reporting and provides additional information about the State's approach to metric calculation and reporting.

Subpopulation Definitions

- Age (children <18, adults 18-64, and older adults 65+): Age will be determined as of the first day of the measurement period. This is consistent with CMS provided instructions.
- Dual-eligible status (Medicaid only or Medicare-Medicaid eligible): Dual eligibility will be determined as of the first day of the measurement period. This is consistent with CMS provided instructions.
- Pregnancy status (yes, no): Pregnancy will be determined as of the first day of the measurement period. This is consistent with CMS provided instructions.
- Criminal Justice Status: The State will use data in the ICDB 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 6 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 6 months.
- OUD Diagnosis: The State will use an existing definition of OUD diagnosis which closely aligns with the HEDIS 2018 Opioid Abuse and Dependence value set. The OUD_Narrow_Flag in the ICDB incorporates the same codes as HEDIS 2018 Opioid Abuse and Dependence value set and one additional code, F1121 Opioid dependence, in remission. The OUD_Narrow_Flag has been used in a variety of research studies and reporting contexts and more appropriately reflects Washington State's approach to identifying those who may need or benefit from treatment for opioid use disorder under this SUD amendment and other opioid related initiatives within the state. In addition, the number of unique individuals who are captured in the ICDB OUD_Narrow_Flag and not the HEDIS 2018 Opioid Abuse and Dependence Value Set is minimal. Table 4 below shows the number of unduplicated persons in each time frame who would be included in the HEDIS 2018 value set versus the ICDB OUD_narrow_flag in three time periods.

Table 4.
Unique Persons Counted in HEDIS vs. ICDB OUD Value Set Over Time.

Unique Persons Counted In:	Jan 2016	Jan 2017	Jan 2018
HEDIS 2018 Opioid Abuse and Dependence Value Set	16,151	20,290	22,202
ICDB OUD_Narrow_Flag	16,495	20,715	22,917
Difference	344	425	715

Metric Calculation and Reporting

As CMS noted, Medicaid data is dynamic prior to reaching a data maturity threshold. For Washington State, that threshold is six-months. Observing a six-month data lag allows the State to represent the most complete data set for the measurement period. Any data lag less than six-months will result in potentially incomplete data and misrepresentative metric results. In addition, the six-month data lag allows for the inclusion of up to date information from data sources that are updated on a quarterly

cadence, such as the Washington State Identification System arrest database, which the State will be using to define the "criminally involved" subpopulation as noted above.

Using a six-month data lag also allows the State to leverage the existing quarterly performance measurement processes to calculate the required metrics. Thus, required monthly reporting will be calculated at the same time once per quarter. All the data will be, at a minimum, matured to six-months thus minimizing the likelihood of any variability due to data completeness.

Metric Specifications

This section provides additional detail on a subset of metric specifications. Other metric specification modifications are noted in the Monitoring Protocol 1115 SUD Metrics Workbook.

Metric #9: Intensive Outpatient and Partial Hospitalization Services

The State recommends dropping this metric as a required reporting metric. At this time, intensive outpatient services are not reported as a distinct type of service in the State's administrative data system. Thus, services that other states may identify as intensive outpatient services appear as outpatient services in Washington's data infrastructure. In addition, Washington does not provide partial hospitalization services and the provision of this service is not included in the STCs. The current Service Encounter Reporting Instructions (SERI v2019-1 effective July 1, 2019) does not contain codes for intensive outpatient services and/or partial hospitalizations for substance use disorder and no data is available to report on this metric.

The State updated the monitoring protocol to indicate a deviation from the technical specifications for Metric #8 (Outpatient Services).

Metric #18 and #21: PQA Metric Alignment with Medicaid Transformation Project 3A Performance Metrics

The State recommends using the Bree Collaborative metrics that are currently being used in the CMS approved project toolkit as pay-for-performance metrics[2] and in the Washington Statewide Common Measure Set[3] in lieu of the PQA stewarded metrics #18 and #21. Specifically, the Bree Collaborative metrics "Patients Prescribed High-Dose Chronic Opioid Therapy" and "Patients Prescribed Concurrent Opioids and Sedatives" are pay-for-performance metrics for Project, 3A: Addressing the Opioid Use Public Health Crisis, which is a required project for all Accountable Communities of Health (ACH). These two metrics are similar, but not identical, to Metric #18 (Use of Opioids at High Dosage in Persons Without Cancer) and Metric #21 (Concurrent Use of Opioids and Benzodiazepines).

The Dr. Robert Bree Collaborative (Bree Collaborative) was established by the Washington State Legislature in 2011 to identify ways to improve health care in Washington State. A diverse group of stakeholders are appointed by the Governor that represent all aspects of the Washington health care system[4]. Each year, the Bree Collaborative forms expert workgroups on health care service areas in need of improvement. In July of 2017, the Bree Collaborative put forth a set of opioid prescribing guidelines[5]

[2] CMS approved Medicaid Transformation Project Toolkit is available at https://www.hca.wa.gov/assets/program/project-toolkit-approved.pdf

[3] For more information about the Statewide Common Measure Set, see https://www.hca.wa.gov/about-hca/healthier-washington/performance-measures

[4] For more information about the Bree Collaborative, see http://www.breecollaborative.org/about/.

[5] The full set of opioid prescribing guidelines from the Bree Collaborative is available at http://www.breecollaborative.org/wp-content/uploads/Bree-Opioid-Prescribing-Metrics-Final-2017.pdf

to assist providers in understanding prescribing practices and the impact of the opioid epidemic across the state. Drawing on the extensive subject matter expert review the Bree Collaborative incorporated into their development of these metrics, two of these metrics are included in Initiative 1 of the Medicaid Transformation Project (Transformation through Accountable Communities of Health).

In addition, Washington is one of a few states that have developed a Statewide Common Measure Set as a foundation for health care accountability and performance measurement. Bree opioid prescribing metrics have been added to the Common Measure Set to improve measurement of progress toward healthier outcomes. As such, stakeholders across the state are already familiar with the Bree Collaborative metrics.

The proposed measures thus represent a carefully developed and reviewed set of metrics that provide essential information about opioid use in the State in the context of larger efforts to address substance use disorder and improve health among State residents. The use of Bree metrics in this context would help the State to further align opioid-related projects within the state.

There are differences between the details of the PQA measures and the measures the State proposes to use. The State feels these differences potentially make the State's measures more informative and applicable to the Washington health care context:

- The State's measures include prescribing to children.
  - Most opioid prescriptions are not for children but they are at particularly high risk for dependence and other complications when they are prescribed.
- PQA's measure for concurrent use of opioids and other drugs includes only benzodiazepines as additional drugs. The State's measure includes other sedatives such as barbiturates and muscle relaxants (carisoprodol [Soma]), and commonly prescribed sleep aids such as eszopiclone (Lunesta), suvorexant (Belsomra), zaleplon (Sonata), and zolpidem (Ambien).
  - These drugs were included in the State's proposed measure after extensive clinical consideration of which drugs presented heightened risks when used with opioids.
- The State's measures will capture some problematic opioid usage that could be missed in the PQA approach.
  - The PQA measure may omit prescriptions that fit the measure definitions but bridge the end and beginning of two measurement years.
- The State's measures include a two-year lookback window (measurement year and the year prior to the measurement year) rather than a one-year lookback for cancer diagnoses.
  - The longer lookback allows for more complete information about cancer status
- While the State's recommended high dosage measure can be used to report usage at the 120 MED level, the State recommends adopting the 90 MED threshold recommended by CDC and in accordance with the 2019 PQA specification update.

Overall, use of the Bree specified measures in lieu of the PQA metrics will allow the State to provide enhanced information that will coordinate well with the State's other efforts to address substance use disorder and improve population health. Detailed specifications of the two Bree measures are below.

Patients Prescribed Chronic Concurrent Opioids and Sedatives

Metric Description: Percent of Medicaid beneficiaries prescribed chronic opioids and a concurrent chronic sedative prescription, among beneficiaries prescribed chronic opioids. The Bree Collaborative

recommends quarterly reporting. All qualifying observations for a given quarter count towards the overall, annual estimate for the measurement year. This means that an individual who meets the eligibility criteria and has at least 60 days supply of opioids and has a concurrent sedative prescription in two calendar quarters in the measurement year will contribute 2 qualifying observations to each metric threshold calculation.

Definition of terms used in this metric:

- *Days Supply in Quarter:* The number of days each prescription should last (days supply) is generally provided for each prescription. Days supply is calculated at the pharmacy by dividing the number of units (e.g., tablets, capsules, patches) dispensed by the maximum number of units to be used in one day. The total days supply is the sum of the days supply from all opioid prescriptions prescribed during the calendar quarter, including overlapping prescriptions (and includes days that may extend into the next calendar quarter).
- *Chronic Opioid Prescription:* ≥60 days supply of opioids prescribed in the calendar quarter.
- *Chronic Concurrent Opioid and Sedative Prescription:* ≥60 days supply of opioids prescribed and ≥60 days supply of sedatives prescribed in the same calendar quarter.

Data Source: Medicaid claims/encounter and enrollment data.

Identification Window: Four quarters that comprise the measurement year.

Eligible Population	
Age	All ages.
Gender	N/A
Minimum Medicaid enrollment	3 out of 3 months for each qualifying quarter.
Allowable gap in Medicaid enrollment	None within each qualifying quarter.
Medicaid enrollment anchor date	N/A
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid and beneficiaries with primary insurance other than Medicaid.

Denominator: Medicaid beneficiaries who meet the above eligibility criteria, with a ≥60 days supply of opioids in the calendar quarter.

Required exclusions for denominator.

- Eligible population exclusions are listed in the eligible population table above.
- Metric specific exclusions:
    - Beneficiaries in hospice care.
    - Beneficiaries with a cancer diagnosis.
    - All prescriptions for buprenorphine are excluded.

Numerator: Beneficiaries must qualify for inclusion in the denominator to be eligible for inclusion in the numerator. Medicaid beneficiaries who meet the above eligibility criteria and prescribed ≥60 days

supply of opioids and prescribed ≥60 days supply of sedative hypnotics, benzodiazepines, carisoprodol, and/or barbiturates in the same calendar quarter (note: these sedative classes are updated frequently).

Sedative Classes	**Generic Names**
Benzodiazepines	- Alprazolam - Chlordiazepoxide - Clonazepam - Clorazepate - Diazepam - Estazolam - Flurazepam - Lorazepam - Midazolam - Oxazepam - Quazepam - Temazepam - Triazolam
Barbiturates	- Butabarbital - Butalbital - Mephobarbital - Phenobarbital - Secobarbital
Skeletal muscle relaxants	- Carisoprodol
Non-benzodiazepine hypnotic	- Chloral hydrate - Eszopiclone - Meprobamate - Suvorexant - Zalelon - Zolpidem

Required exclusions for numerator.

- All prescriptions for buprenorphine are excluded.

Patients Prescribed High-Dose Chronic Opioid Therapy

Metric Description: Percent of Medicaid beneficiaries prescribed chronic opioid therapy hreater than or equal to 90mg morphine equivalent dosage in a quarter. The Bree Collaborative metric is based on quarterly reporting. All qualifying observations for a given quarter count towards the overall, annual estimate for the measurement year. This means that an individual who meets the eligibility criteria and has at least 60 days supply of opioids in three calendar quarters in the measurement year will contribute 3 qualifying observations to each metric threshold calculation.

Definition of terms used in this metric:

- *Days Supply in Quarter:* The number of days each prescription should last (days supply) is generally provided for each prescription. Days supply is calculated at the pharmacy by dividing the number of units (e.g., tablets, capsules, patches) dispensed by the maximum number of units to be used in one day. The total days supply is the sum of the days supply from all opioid

prescriptions prescribed during the calendar quarter, including overlapping prescriptions (and includes days that may extend into the next calendar quarter).

- *Chronic Opioid Prescription:* ≥60 days supply of opioids prescribed in the calendar quarter.
- *Average Morphine Equivalent Dose (MED) per day, inclusive of overlapping opioid prescriptions:* The MED for each prescription is calculated by multiplying the number of units prescribed by the strength per unit and then multiplying by the conversion factor (see list of conversion factors). The total MED is the sum of the MED from all opioid prescriptions prescribed during the calendar quarter, including overlapping prescriptions (and includes MED that may extend into the next calendar quarter). The total MED of all opioids is divided by 90 days to produce the average MED per day value.

Data Source: Medicaid claim/encounter and enrollment data.

Identification Window: Four quarters that comprise the measurement year.

Eligible Population	
Age	All ages.
Gender	N/A
Minimum Medicaid enrollment	3 out of 3 months for each qualifying quarter.
Allowable gap in Medicaid enrollment	None within each qualifying quarter.
Medicaid enrollment anchor date	N/A
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid and beneficiaries with primary insurance other than Medicaid.

Denominator: Medicaid beneficiaries who meet the above eligibility criteria, with a ≥60 days supply of opioids in the calendar quarter.

Required exclusions for denominator.

- Eligible population exclusions are listed in the eligible population table above.
- Metric specific exclusions:
  - Beneficiaries in hospice care.
  - Beneficiaries with a cancer diagnosis.
  - All prescriptions for buprenorphine are excluded.

Numerator: Beneficiaries must qualify for inclusion in the denominator to be eligible for inclusion in the numerator and greater than or equal to 90mg morphine equivalent dosage in a quarter.

Morphine Equivalent Dosage Conversion Factors: The MED for each prescription is calculated by multiplying the number of units prescribed by the strength per unit and then multiplying by the conversion factor. The total MED is the sum of the MED from all opioid prescriptions prescribed during the calendar quarter, including overlapping prescriptions (and includes MED that may extend into the next calendar quarter). The total MED of all opioids is divided by 90 days. Conversion factors are updated by the Washington State Agency Medical Directors' Group.

Opioid Prescriptions	Conversion Factor
Belladonna alkaloids/opium alkaloids	1
Butorphanol tartrate	7
Codeine	0.15
Dihydrocodeine	0.25
Fentanyl buccal, sublingual or lozenge	0.13
Fentanyl film or oral spray	0.18
Fentanyl nasal spray	0.16
Hydrocodone	1
Hydromorphone	4
Levomethadyl acetate hydrochloride	8
Levorphanol tartrate	11
Meperidine hydrochloride	0.1
Methadone, 1 – 20 mg/day	4
Methadone, 21 – 40 mg/day	8
Methadone, 41 – 60 mg/day	10
Methadone ≥61 – 80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3
Pentazocine	0.37
Propoxyphene	0.23
Tapentadol	0.4
Tramadol	0.1

Required exclusions for numerator.

- All prescriptions for buprenorphine are excluded.

Metric #22: Continuity of Pharmacotherapy for Opioid Use Disorder

The State would like to modify the specifications provided for this measure to ensure internal measure consistency and broader consistency with the other measures reported in this monitoring protocol and the Washington health care context.

- Use the OUD_Narrow_Flag (as described in the subpopulation definition section above) to identify opioid use disorder.
- Limit the continuation of pharmacotherapy metric to users of Buprenorphine and Buprenorphine-Naloxone combination therapy for opioid use disorder. This will exclude users of other therapy, such as Naltrexone and Methadone. The State's billing data does not account for all of the services delivered that are necessary to compute this measure. Pharmacy claims are more comprehensive and reflect more accurate service delivery in Washington State.
- The State is able to identify those who receive Methadone. However, the billing practices do not allow for the calculation of days covered by Methadone administration (unlike Buprenorphine and Buprenorphine combination medications). This is a requirement for the calculation of this metric. Based on the State's proposal of including only those who are prescribed Buprenorphine and Buprenorphine combination medications as pharmacotherapy for an opiate use disorder, approximately 60% of those receiving treatment will be captured. The State does not expect that the excluded services would be substantially affected by the demonstration.
- Restrict the measurement year to a 12 month period (rather than two years), but allow for identification of opioid use disorder with a two year look back window (measurement year and year prior to measurement year). This will facilitate the identification of a more stable population and decrease the likelihood of missing qualifying instances of treatment due to attrition of Medicaid enrollees.

The State also notes inconsistencies in how the measure is calculated based on the CMS supplied description of the numerator/denominator (percent of adults with pharmacotherapy for opioid use disorder who have at least 180 days of continuous treatment) and the final metric calculation directions (dividing the numerator by the denominator for *each unit of measurement*). The final metric calculation instructions appears to result in a proportion of days covered metric (similar to the HEDIS Anti-depression Medication Management metric). The State will use the initial description and calculate the percentage of adults with pharmacotherapy for opioid use disorder who have at least 180 days of continuous treatment.

HIT Metric Specifications

During the initial review of the monitoring protocol by CMS, some concerns were noted about the selected HIT metrics. Per the conversation the State had with ONC and CMS staff on May 1, 2019 from 1-2pm PST, the State has not made any modifications to the HIT metrics as submitted with the initial Monitoring Protocol.

***Q1: Statewide Fatal Drug Overdose*.** The State considered the sample metrics provided by CMS, including sample metrics related to use of the Prescription Drug Monitoring Program (PDMP) and selected the metric on statewide fatal drug overdoses (including submetrics all opioids, heroin, prescription opioids, and synthetic opioids). This metric (and submetrics) will be reported to CMS and displayed using the public-facing, technology-enabled PDMP dashboard. The CMS report and PDMP dashboard will be used to monitor whether fatal drug overdoses (including by type of drug) are slowing.

Metric Description: Number of fatal drug overdoses in the state of Washington, not restricted to Medicaid beneficiaries. Submetrics are reported for the following types of drugs: all opioids, heroin, prescription opioids (excluding synthetic opioids), and synthetic opioids (not methadone).

Data Source: Department of Health death certificate data.

Identification Window: Measurement year (July 1 – June 30 of relevant year)

Eligible Population	
Age	All Ages
Gender	N/A
Minimum Medicaid enrollment	N/A – measure is not restricted to Medicaid beneficiaries
Allowable gap in Medicaid enrollment	N/A – measure is not restricted to Medicaid beneficiaries
Medicaid enrollment anchor date	N/A – measure is not restricted to Medicaid beneficiaries
Medicaid benefit and eligibility	N/A – measure is not restricted to Medicaid beneficiaries

Statewide Fatal Drug Overdoses: Information on the underlying cause of death is extracted from death certificates for deaths that occurred in the relevant measurement period.

All drugs is defined by the following ICD-10 codes as underlying cause of death:

- X40-X44: Accidental poisonings by drugs.
- X60-X64: Intentional self-poisoning by drugs.
- X85: Assault by drug poisoning.
- Y10-Y14: Drug poisoning of undetermined intent.

Statewide Fatal Drug Overdoses – All Opioids: Information on the underlying cause of death is extracted from death certificates for deaths that occurred in the relevant measurement period.

All opioids is defined by the following ICD-10 codes in the multiple causes of death field:

- T40.0 (Opium)
- T40.1 (Heroin)
- T40.2 (Natural and Semi-synthetic opioids)
- T40.3 (Methadone)
- T40.4 (Synthetic opioids, other than methadone)
- T40.6 (Other and Unspecified narcotics)

Statewide Fatal Drug Overdoses – Heroin: Information on the underlying cause of death is extracted from death certificates for deaths that occurred in the relevant measurement period.

Heroin is defined by the following ICD-10 codes in the multiple causes of death field:

- T 40.1 (Heroin)

Statewide Fatal Drug Overdoses – Prescription Opioids (excluding synthetic opioids): Information on the underlying cause of death is extracted from death certificates for deaths that occurred in the relevant measurement period.

Prescription opioids is defined by the following ICD-10 codes in the multiple causes of death field:

- T40.2 (Natural and Semi-synthetic opioids)
- T40.3 (Methadone)

Statewide Fatal Drug Overdoses – Synthetic Opioids (Not Methadone): Information on the underlying cause of death is extracted from death certificates for deaths that occurred in the relevant measurement period.

Synthetic opioids (not methadone) is defined by the following ICD-10 codes in the multiple causes of death field:

- T40.4 (Synthetic opioids, other than methadone)

Q2: Substance Use Disorder Treatment Penetration Rate. After reviewing the list of sample metrics provided by CMS, the State was concerned about the limitations and uncertainties in technology adoption by providers treating individuals with SUD (e.g., limited use of close loop referral services, lack of an electronic consent management system, limitations and variations in provider/resource directories). Thus, the State is proposing a metric that relies on the use of electronic claims/encounter data to identify individuals with a SUD treatment need who received a qualifying SUD service.

Metric Description: Percent of Medicaid beneficiaries aged 12 and older with a substance use disorder treatment need identified within the past two years, who received at least one qualifying substance use disorder treatment during the measurement year.

Data Source: Administrative data.

Identification Window: Measurement year and the year prior to the measurement year.

Eligible Population	
Age	Age 12 and older. Age is as of the last day of the measurement year.
Gender	N/A
Minimum Medicaid enrollment	Measurement year. Enrollment must be continuous.
Allowable gap in Medicaid enrollment	One gap of one month during the measurement year.
Medicaid enrollment anchor date	Last day of measurement year.
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid and beneficiaries with primary insurance other than Medicaid.

Denominator: Medicaid beneficiaries, aged 12 and older on the last day of the measurement year, with a substance use disorder treatment need identified in either the measurement year or the year prior to the measurement year.

Substance use disorder treatment need is identified by the occurrence of any of the following in the identification window:

1. Diagnosis of a drug or alcohol use disorder in any health service event (SUD-Tx-Pen-Value-Set-1)
2. Receipt of brief intervention (SBIRT) services (SUD-Tx-Pen-Value-Set-4)
3. Receipt of medically managed detox services (SUD-Tx-Pen-Value-Set-5)
4. Receipt of a substance use disorder treatment service meeting numerator criteria:
    a. Procedure and DRG codes indicating receipt of inpatient/residential, outpatient, or methadone OST: SUD-Tx-Pen-Value-Set-2

b. NDC codes indicating receipt of other forms of medication assisted treatment for SUD: SUD-Tx-Pen-Value-Set-3
c. Outpatient encounters meeting procedure code and primary diagnosis criteria: SUD-Tx-Pen-Value-Set-6.xls: procedure code in SUD-Tx-Pen-Value-Set-6 AND primary diagnosis code in SUD-Tx-Pen-Value-Set-1
d. Outpatient encounters meeting taxonomy and primary diagnosis criteria: billing or servicing provider taxonomy code in SUD-Tx-Pen-Value-Set-7 AND primary diagnosis code in SUD-Tx-Pen-Value-Set-1

Value sets required for the denominator.

Name	Value Set
SUD-Tx-Pen- Value-Set-1	All value sets are available upon request.
SUD-Tx-Pen-Value-Set-2	
SUD-Tx-Pen-Value-Set-3	
SUD-Tx-Pen-Value-Set-4	
SUD-Tx-Pen-Value-Set-5	
SUD-Tx-Pen-Value-Set-6	
SUD-Tx-Pen-Value-Set-7	

Numerator: Include in the numerator all individuals receiving at least one substance use disorder treatment service meeting at least one of the following criteria in the 12-month measurement year:

1. Procedure and DRG codes indicating receipt of inpatient/residential, outpatient, or methadone OST: SUD-Tx-Pen-Value-Set-2
2. NDC codes indicating receipt of other forms of medication assisted treatment for SUD: SUD-Tx-Pen-Value-Set-3
3. Outpatient encounters meeting procedure code and primary diagnosis criteria:
    a. Procedure code in SUD-Tx-Pen-Value-Set-6 AND
    b. Primary diagnosis code in SUD-Tx-Pen-Value-Set-1
4. Outpatient encounters meeting taxonomy and primary diagnosis criteria:
    a. Billing or servicing provider taxonomy code in SUD-Tx-Pen-Value-Set-7 AND
    b. Primary diagnosis code in SUD-Tx-Pen-Value-Set-1

Value sets required for the numerator.

Name	Value Set
SUD-Tx-Pen- Value-Set-1	All value sets are available upon request.
SUD-Tx-Pen-Value-Set-2	
SUD-Tx-Pen-Value-Set-3	
SUD-Tx-Pen-Value-Set-6	
SUD-Tx-Pen-Value-Set-7	

Q3: Foundational Community Supports Beneficiaries with Inpatient or Residential Substance Use Disorder Service. After reviewing the list of sample metrics provided by CMS, as with metric Q2, the State was concerned about the limitations and uncertainties in technology adoption by providers treating individuals with SUD (e.g., lack of use of shared care plans, lack of connectivity between correctional health systems and community-based providers, limitations and variations in

provider/resource directories). Thus, the State focused on developing a metric that links delivery of recovery supports provided through the Foundational Community Supports (FCS) program (implemented as part of the Medicaid Transformation Program) to persons who had received SUD services in an inpatient or residential treatment facility. The metric relies on the use of electronic eligibility and claims/encounter data.

Metric Description: Percent of Foundational Community Supports (FCS) eligible Medicaid beneficiaries, age 18 and older, with a substance use disorder related inpatient or residential treatment stay within the past two years, who enrolled in at least one FCS service during the measurement year.

Data Source: Administrative data.

Identification Window: Measurement year and the year prior to the measurement year.

Eligible Population	
Age	Age 18 and older. Age is as of the last day of the measurement year.
Gender	N/A
Minimum Medicaid enrollment	Measurement year. Enrollment must be continuous.
Allowable gap in Medicaid enrollment	One gap of one month during the measurement year.
Medicaid enrollment anchor date	Last day of measurement year.
Medicaid benefit and eligibility	Beneficiaries who qualify for Medicaid in any of the following categories: Categorically Needy Blind/Disabled, Categorically Needy Aged, Categorically Needy Apple Health for Workers with Disabilities (HWD), Categorically Needy Pregnant Women, Affordable Care Act Expansion Adults, Categorically Needy Family Medical, Categorically Needy Children, Children's Health Insurance Program (CHIP), Categorically Needy Children- Foster Care between 18 to 26 Years of Age

Denominator: Medicaid beneficiaries, who meet the eligibility requirements as stated above, with a substance use disorder related inpatient or residential treatment stay within the measurement year or the year prior to the measurement year.

Numerator: Beneficiaries must qualify for inclusion in the denominator to be eligible for inclusion in the numerator. Include in the numerator all individuals who ever enrolled in at least one FCS service during the measurement year.

September 2019 Release of Updated Medicaid Section 1115 Substance Use Disorder (SUD) Demonstration Monitoring Tools: Monitoring Protocol Alignment Form

The Centers for Medicare & Medicaid Services (CMS) September 2019 release of the section 1115 substance use disorder (SUD) demonstration monitoring protocol tools incorporates updated guidance on reporting metrics and narrative information, and other clarifications reflecting the valuable feedback shared by states during review and use of the earlier release of these tools.

States with a monitoring protocol submitted to or approved by CMS as of October 2019 are not required to resubmit the protocol using the updated monitoring protocol tools. Instead, CMS developed this form to support states in providing the key information included in the updated protocol tools, or propose an alternative plan. States should review the monitoring protocol updates detailed in the sections below and select the appropriate checkboxes to complete the Section 1115 SUD Demonstration Monitoring Protocol Alignment Form. States should submit the completed form to the Performance Management Database and Analytics (PMDA) system under the deliverable designated as "SUD Monitoring Protocol," and upload this with the set of documents that represent the state's completed monitoring protocol. After reviewing the form, CMS will reach out to the state if there are any additional information needed, and will inform the state when the form is deemed complete and final. If the state has any questions while completing this form, please email the 1115 monitoring and evaluation TA mailbox (1115MonitoringAndEvaluation@cms.hhs.gov) and copy the demonstration's CMS project officer on the message.

1. Updates to Section 1115 SUD Demonstration Technical Specifications for Monitoring Metrics (Version 2.0)

In the monitoring workbook of the state's protocol (Part A), CMS asked the state to review the technical specification for each metric and either attest to reporting the metric according to the specification, or propose deviations from the specification for CMS approval. CMS recently released an updated version of the section 1115 SUD demonstration technical specifications manual (Version 2.0, dated August 23, 2019). Relative to the Version 1.0 manual released in October 2018, the Version 2.0 manual contains critical revisions to specifications for the following CMS-constructed metrics:

- Metric #5: Medicaid Beneficiaries Treated in an Institution for Mental Disease (IMD) for SUD
- Metric #6: Any SUD Treatment
- Metric #10: Residential and Inpatient Services
- Metric #25: Readmissions for SUD

- Metric #29: SUD Spending Within IMDs
- Metric #31: Per Capita SUD Spending within IMDs
- Metric #36: Average Length of Stay in IMDs

These changes reflect the valuable feedback shared by states during review and use of the first version of the technical specifications manual, and are critical for ensuring the metrics are calculated consistently across states.

To promote consistent reporting across states and within a state over time, CMS requests that the state review updates to each of these metrics described in the accompanying Summary of Updates to the Section 1115 SUD Demonstrations Technical Specifications for Monitoring Metrics (Version 2.0), and respond below to confirm whether it will require deviations from the specifications (other than those already described in the state's submitted or approved protocol).

☒ The state reviewed the Summary of Updates to the Section 1115 SUD Demonstration Technical Specifications for Monitoring Metrics (Version 2.0) and attests it does not require any deviations from the specifications (other than those already described in the state's submitted or approved protocol).

☐ The state has reviewed the Summary of Updates to the Section 1115 SUD Demonstration Technical Specifications for Monitoring Metrics (Version 2.0) and proposes the following deviations: *Insert narrative description of proposed deviations from the revised specification, indicating to which metric(s) the proposed deviation applies. State should provide justification for any proposed deviation.*

2. Clarifications to baseline reporting periods

Recent updates to the section 1115 SUD metric technical specifications manual and monitoring tools have implications for the baseline reporting periods for certain metrics. The updated technical specifications manual (Version 2.0) and monitoring tools released in September 2019 include updated guidance related to baseline reporting periods for the following metrics:

- **Metric #22 (Continuity of Pharmacotherapy for Opioid Use Disorder)** is an established quality measure that is calculated over a 2-year period. The baseline reporting period for this metric should be the calendar year in which the state's demonstration began, and the year prior. The updated manual contains additional guidance clarifying the baseline reporting period for measures calculated over a 2-year period.

- **Metric #25 (Readmissions among Beneficiaries with SUD)** is now considered to be a CMS-constructed metric. The baseline reporting period for this metric should be aligned with the baseline reporting period for other CMS-constructed metrics.

- **Metric #32 (Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD)** is now clearly categorized in the monitoring workbook as an established quality measure. The baseline reporting period for this metric should be aligned with the baseline reporting period for other established quality measures.

CMS requests the state review the baseline reporting period guidance for these metrics and respond below to confirm it will align reporting with the provided guidance, or propose deviations.

☐ The state reviewed the baseline reporting period guidance for Metrics #22, #25, and #32 and will align its baseline reporting with the updated guidance for each metric.

☒ The state has reviewed the baseline reporting period guidance for Metrics #22, #25, and #32 and proposes the following deviations: *The state requests to maintain the agreed upon deviation for Metric #22 (See Attachment A).*

ATTACHMENT M
Health IT Protocol

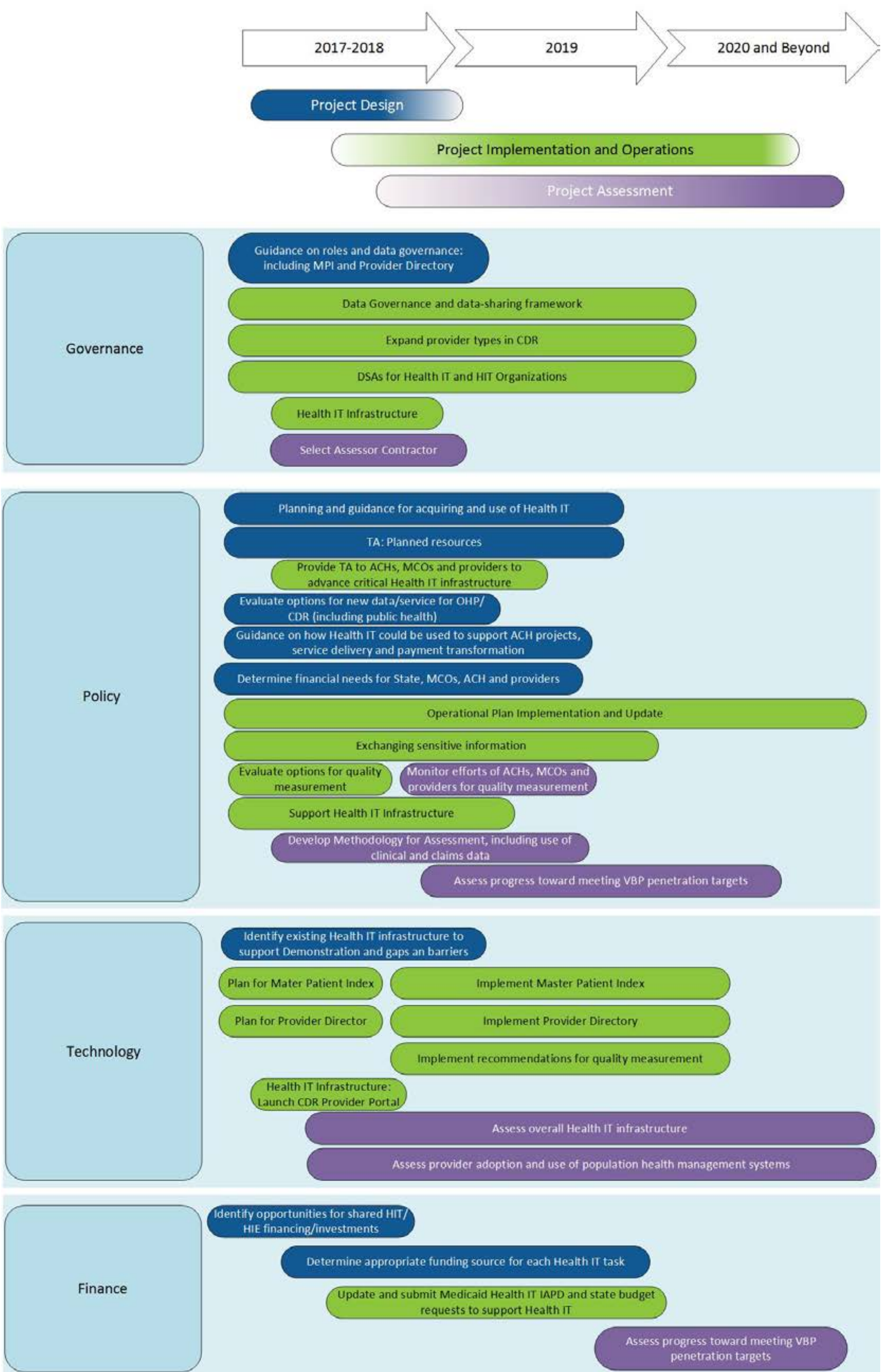
Introduction

The Washington State Medicaid Transformation Demonstration is a five-year agreement between the state and the federal government that provides up to $1.1 billion in federal investment for regional and statewide health system transformation projects that benefit Apple Health (Medicaid) Clients. Achieving health system transformation for Washington State will require the use of interoperable health information technology (Health IT) and health information exchange (HIE). Interoperable Health IT[54] and HIE[55] have the potential to improve the quality, continuity, coordination, and safety of patient care, while at the same time reducing unnecessary and costly services. Furthermore, the use of these technologies will help facilitate the State's broader goals of moving toward value-based purchasing.

This Health IT Strategic Roadmap identifies activities necessary to advance the use of interoperable Health IT and HIE across the care continuum in support of the programmatic objectives of the Demonstration. The Roadmap divides efforts into the three phases of the Demonstration: Project Design, Project Implementation and Operations, and Project Assessment, and articulates the role the State, Medicaid Managed Care Organizations, providers and Accountable Communities of Health (ACH) have in advancing Health IT and HIE. In addition to this Roadmap, the State has created an Operational Plan that details the first 16 months (remainder of 2017 and 2018) of activities that provide actionable steps to advance Health IT and HIE in support of the Demonstration. The Operational Plan is appended to this document and will be revised quarterly to reflect progress and document next steps. The Operational Plan will be updated in 2018 to provide the details for 2019 and annually mid-year for the details of the following year. The following diagram highlights the key elements of the strategic roadmap and operational plan:

[54] Health Information Technology is the range of technologies to store, share, and analyze health information, including clinical and claims related data

[55] Health information exchange is the electronic exchange of health information to facilitate delivery system and payment transformation, care coordination and improved health outcomes



Washington Health IT/HIE Roadmap
2017-2018
2019
2020 and Beyond
Project Design
Project Implementation and Operations
Project Assessment
Governance
Guidance on roles and data governance: including MPI and Provider Directory
Data Governance and data-sharing framework
Expand provider types in CDR
DSAs for Health IT and HIT Organizations
Health IT Infrastructure
Select Assessor Contractor
Policy
Planning and guidance for acquiring and use of Health IT
TA: Planned resources
Provide TA to ACHs, MCOs and providers to advance critical Health IT infrastructure
Evaluate options for new data/service for OHP/ CDR (including public health)
Guidance on how Health IT could be used to support ACH projects, service delivery and payment transformation
Determine financial needs for State, MCOs, ACH and providers
Operational Plan Implementation and Update
Exchanging sensitive information
Evaluate options for quality measurement
Monitor efforts of ACHs, MCOs and providers for quality measurement
Support Health IT Infrastructure
Develop Methodology for Assessment, including use of clinical and claims data
Assess progress toward meeting VBP penetration targets
Technology
Identify existing Health IT infrastructure to support Demonstration and gaps an barriers
Plan for Mater Patient Index
Implement Master Patient Index
Plan for Provider Director
Implement Provider Directory
Implement recommendations for quality measurement
Health IT Infrastructure: Launch CDR Provider Portal
Assess overall Health IT infrastructure
Assess provider adoption and use of population health management systems
Finance
Identify opportunities for shared HIT/ HIE financing/investments
Determine appropriate funding source for each Health IT task
Update and submit Medicaid Health IT IAPD and state budget requests to support Health IT
Assess progress toward meeting VBP penetration targets

Background
Washington State understands the role of and need for interoperable Health IT and HIE to enable the efficient exchange and use of health information, a foundational requirement to achieving the triple aim. In 2009, the Washington State Legislature passed Substitute Senate Bill 5501 to accelerate the secure electronic exchange of high-value health information within the state. This legislation resulted in the designation of OneHealthPort as the lead HIE organization. Subsequently, a clinical data repository (CDR) was created to address some of the challenges with interoperability.

Purpose and Goals
Washington State is undertaking an innovative and ambitious agenda through the Demonstration to advance coordination of care and improve patient outcomes that will be supported, in part, through its use of the CDR and additional activities identified in this Roadmap. The purpose of the Roadmap is to identify the broad goals of how Health IT and HIE will support the Demonstration, recognizing that the more detailed tasks are identified, expanded upon, and tracked in the accompanying operational plan. The Roadmap is built on the following goals:

- Develop policies and procedures to advance the widespread use of interoperable Health IT and HIE across the care continuum;
-
- Coordinate at the regional and statewide level to ensure that interoperable Health IT and HIE efforts are shared and identified best practices are shared throughout the state;
- Improve coordination and integration among behavioral health, physical health, and Home and Community Based Services (HCBS) providers, as well as community-level collaborators;
- Support the acquisition and implementation of interoperable Health IT particularly for providers who are ineligible for the Electronic Health Record (EHR) incentive program;
- Encourage use of clinical and claims data by the State, ACHs, payers, and others to support a variety of health improvement activities as represented by ACH project plans;
- Develop or expand the critical infrastructure needed to facilitate population health management, including prescription drug monitoring, disease registries and electronic lab reporting;
- Support the electronic exchange of interoperable clinical health information, using standards identified in Interoperability Standards Advisory (ISA);
- Support the development and use of a Medicaid enterprise master patient index and comprehensive provider directory strategy to facilitate more efficient information exchange;

- Align with the Washington State Health IT & HIE Strategy; and
- Ensure the roadmap provides guidance & alignment throughout the duration of the Demonstration, as well as beyond the Demonstration's end date.

Demonstration Health IT Framework
The work of the Health IT Strategic Roadmap is intended to align with the Demonstration's three phases of work: design, implementation and operations, and assessment. These phases are cyclical, with project assessment feeding into future project design. Activities described in this document require work by the State and the ACHs to assemble the infrastructure, develop policies and procedures, and implement incentives to advance the use of Health IT and HIE in support of broader Demonstration activities. As described in this document, these phases support, and are consistent with, the three project stages (design, implementation and operations, and assessment) in the State's approved DSRIP Planning Protocol. This framework recognizes the varying levels of interoperability that exist among regions and providers in the state, allowing regional efforts to advance Health IT and HIE in coordination with the broader statewide approach.

Project Design

Initial phase August to December 2017

During the project design phase, the State will engage and collaborate with ACHs, providers, payers, OneHealthPort, and other stakeholders to develop and disseminate the tasks and deliverables (which will inform the Operational Plan) to advance the use of Health IT for population health management.

This phase will identify the gaps and opportunities to advance in the Health IT and HIE infrastructure, policies and procedures, and incentives necessary to facilitate population health management. ACHs will be expected to identify payers (including Medicaid MCO payers) and providers (e.g., physical health, behavioral health, long-term services and supports, and other community-based services/providers) to collaborate with the State and other stakeholders to assist in and inform the development of the Operational Plan.

The State will provide guidance to the ACHs on how Health IT and HIE elements will be required for incorporation in the ACH project plans and what resources will be made available to support project implementation. ACHs will incorporate this guidance into their project plans to be submitted in November.

Task	Additional Description	Proposed Due Date
The State will engage and collaborate with ACHs, providers, payers (including Medicaid MCOs), OneHealthPort, and other stakeholders to develop and disseminate an Operational Plan	The Operational Plan will address the following topics: Governance: • Roles of stakeholders • Data governance • Health IT governance Policy: • Shared policies and technical standards for secure Health IT and HIE systems • Performance measures related to the adoption and use of Health IT and HIE Technology: • Types of and how population health management systems that could be used to support: ACH projects, service delivery and payment transformation, and quality and performance management • Gaps and barriers Finance • Determine financial needs for State, MCOs, ACHs and providers • Determine appropriate funding source, including role of Medicaid Financing (IAPDU-SPA-Waiver)	2017

The State will develop and disseminate guidance for planning, acquisition and use of Health IT and HIE	Policy: • This guidance will include interoperable HIT and HIE to support ACH activities Finance: • Opportunities for shared HIT/HIE financing/investments	2017 -2018
The State will identify technical assistance needs to assist in the acquisition, adoption, implementation, and use of Health IT and HIE. The State will notify ACHs of these planned resources.	Policy: • State will develop and make available to ACHs TA resources for HIT/HIE activities in support of Demonstration activities. TA resources may include assistance related to: o Billing IT and HIT applications; o Vendor evaluation and selection criteria; o Workflow considerations; and o Use of the CDR	*2017 – 2018 (initially and ongoing through 2020)*
The State will determine the need, and if so how and when, to integrate key Medical, clinical, and public health data with the Clinical Data Repository	Policy: This data will potentially include: • Assessment and care plan data; and • Public Health data such as: o Immunizations o Prescription drug monitoring	2017-2018

Project Implementation and Operations

Initial phase January 2018-

The project implementation phase will consist of implementing the Operational Plan, collaboratively addressing the Health IT and HIE gaps, aligning statewide initiatives, and positioning the ACHs and state for success in their programmatic objectives.

The Operational Plan will seek to identify and address gaps in Health IT and HIE, prioritizing the most important elements to support Health IT and HIE and ACH-proposed projects. The State will focus on several elements, including data governance and data sharing frameworks, facilitating HIE across multiple provider types, and developing a master patient index and statewide provider directory.

The State is also committed to ongoing alignment among all Health IT- and HIE-related activities within the state, including State Innovation Model efforts, Medicaid Health IT Plan, and Health IT Implementation Advanced Planning Document (IAPD).

During the project implementation phase, ACHs will assist the State in identifying critical gaps and will collaborate with providers, payers, and other stakeholders to develop and support the use of best practices in leveraging Health IT and HIE to support their transformation efforts.

Task	Additional Description	Proposed Due Date
The State will implement, review, update, and disseminate the Operational Plan	Policy: The State, in collaboration with stakeholders, will: • Annually update the Operational Plan and implement Accordingly • Identify and share emerging best practices • Identify and assist in resolving emerging issues; and • Provide quarterly updates on progress on implementing the Operational Plan to CMS/ONC	2017, 2018, 2019, 2020
State will support and advance critical HIT/HIE infrastructure	The State will support several activities needed to advance the HIT/HIE infrastructure, including: Governance: • The State will develop and disseminate guidance to the ACHs, payers and providers related to exchange of information, including data governance and data sharing framework • The State will develop and disseminate guidance to the ACHs, payers and providers related to onboarding and registration of additional provider types, including expanding the provider types sending and receiving content from the CDR	2018

Task	Additional Description	Proposed Due Date
	• The State will develop and disseminate guidance to the ACHs, payers and providers related to establishing electronic health information sharing agreements with HIT/HIE organizations Policy: This includes developing and disseminating guidance and providing TA to the ACHs, payers, providers, and other stakeholders on the activities, including the following: • Supporting the onboarding of additional providers to the CDR • Use of Consolidated Clinical Document Architecture (C-CDA) in electronic health information exchange activities • The State will develop and disseminate guidance to the ACHs, payers, providers, and other stakeholders related to exchanging sensitive information (e.g. SUD data) Technology: • Launching of the CDR provider portal • Develop and/or purchase other technology as identified and needed	
The State will disseminate information on efforts to streamline Behavioral Health reporting	Policy: State will seek to align reporting requirements to support and align with HIE/HIT standards and support data use	2018

Task	Additional Description	Proposed Due Date
	State will disseminate information on the results of the alignment effort, including requirements	
The State will determine and implement the most appropriate method for the creation and management of the Master Patient Index	Policy: • Document gaps and barriers in existing State infrastructure • Identify work plan for developing a Master Patient Index for use across information systems (e.g. MMIS, OHP) Technology: • Acquire /implement technology solution based on work plan	2018-2019
The State will determine and implement the most appropriate method for the creation and management of the Provider Directory	Policy: • Document gaps and barriers in existing State infrastructure • Identify work plan for developing a Provider Directory for use across information systems (e.g. MMIS, OHP) Technology: • Acquire/implement technology solution based on work plan	2018-2019
The State will evaluate options and draft recommendations for leveraging clinical and claims data to support needed quality measurement/analytic activities of the state,	Policy: • The state with stakeholder input will evaluate options for leveraging clinical and claims data to support needed quality measurement/analytic activities of the state, MCOs, ACHs, providers and payers.	2018

Task	Additional Description	Proposed Due Date
MCOs, ACHs, providers and payers.	• Based on the evaluation of options, the state will draft recommendations for leveraging clinical and claims data to support needed quality measurement/analytic activities of the state, MCOs, ACHs, providers and payers.	
State will implement approved recommendations for leveraging clinical and claims data to support quality measurement/analytic activities of the state and will oversee the efforts of the Medicaid MCOs, ACHs and providers	Technology: • The State will implement approved recommendations for leveraging clinical and claims data to support quality measurement/analytic activities of the state	

The State will use the HIT/HIE Strategic Roadmap and Operational Plan to update and align key documents and activities	Policy:
	
	• Based on the completion of the OP for 2017-2018, the state will update as needed
	  • SIM HIT documents;
	  • State Medicaid HIT plan;
	  • Health IT IAPD; and
	  • Medicaid EHR Incentive Program
	State initiated MACRA Advanced Alternative Payment models.
	
	• Based on the updated OP for 2019, the state will update as needed the same documents.
		2017 for 2017 and 2018

Task	Additional Description	Proposed Due Date
	• Based on the updated OP for 2020, the state will update as needed the same documents.	2018 for 2019 2019 for 2020
The state will update and submit Medicaid Health IT IAPD and state budget requests to support implementation of Health IT, including interoperable HIE and services	Finance: • Prepare Implementation Advance Planning Document Update • Prepare state budget requests	As required

Project Assessment

Initial phase beginning January 2019

The project assessment phase will focus on assessing the direction of the Health IT and HIE in ACH projects and their utility in achieving the goals of the Demonstration. The assessment for each project will be tailored to the specifics of the project and will be conducted by an independent, external evaluator. Assessments will include a mix of qualitative and quantitative analysis, using a variety of data types including clinical, administration, and survey data.

Information obtained through these assessments will be made available to future project planning efforts to ensure any identified shortcomings are not repeated.

Task	Additional Description	Proposed Due Date
The State will contract with and support an independent external evaluator	This evaluator will perform the following: • Develop a methodology to qualitatively and quantitatively assess the impact of the	2019

	Demonstration on delivery systems, clinical care, health outcomes, and costs; • Assess overall Medicaid system performance under the DSRIP program; • Assess overall Health IT infrastructure; • Assess progress toward meeting VBP penetration targets; • The State will oversee the efforts of the Medicaid MCOs, ACHs and providers; • Assess progress toward meeting VBP penetration targets; and • Assess impact of the Demonstration on provider adoption and use of population health management systems, including the use of interoperable HIT and HIE. • •	

It is understood that the Health IT and HIE needs of the State and the ACHs are evolving, which will require both the Roadmap and the Operational Plan to be updated regularly. HCA will provide annual updates to the Health IT Roadmap to document changes in priorities and highlight progress made during the duration of the Demonstration. HCA will also provide reports and updated Operational Plan quarterly to document the progress towards completing activities identified in the Health IT Strategic Roadmap.

ATTACHMENT N

Corrective Action Plan

Medicaid Transformation Project
Corrective Action Plan Request - Updated

I. Background Concerning the Corrective Action Plan Request

Washington State Health Care Authority (HCA) has committed to the federal government that spending for the Medicaid Transformation Project (MTP) will be budget neutral. In setting the baseline for budget neutrality negotiations with the federal government, the state used Medicaid costs from calendar year (CY) 2011-2013. Since then, Long Term Services and Supports (LTSS) costs have grown.

The largest drivers of LTSS costs are not Medicaid policies, but rather include changes to the State's and city minimum wage laws, collective bargaining agreements with individual providers and adult family homes, and the US Department of Labor's home care overtime rule. The historical data used to develop the current budget neutrality caps did not include these large LTSS cost increases. Because of this, the state's current projections show Medicaid Transformation spending will exceed budget neutrality. It is important to acknowledge these cost drivers are not associated with MTP initiatives. HCA does not anticipate the level of increases that are occurring in LTSS Medicaid programs (not associated with the 1115 waiver) to change in future biennia. This is due to the continued increases in our caseload which result in a case mix change in the overall Medicaid program, the continued rise in the state's minimum wage, and the corresponding impact on direct care worker wages and benefits in the LTSS industry.

HCA met with CMS, through a series of meetings over the past year, including an in-person visit in May 2019, to address our projected budget neutrality exceedance. After months of discussion, CMS agreed to a proposal which provides prospective adjustments to help offset the projected two year budget neutrality overage. HCA's corrective action plan request addresses the projected budget neutrality exceedance by requesting a carve out of LTSS costs and a reduction in Transformation programs expenditure limits.

II. Description of the Corrective Action Plan Request

This corrective action includes two primary components: budget neutrality methodology adjustments and reductions to Designated State Health Programs (DSHP), Delivery System Reform Incentive Payments (DSRIP), Medicaid Alternative Care (MAC), Tailored Support for Older Adults (TSOA) and Foundational Community Supports (FCS) expenditure limits. As of February 2020, HCA projects an overage of $394.4M at the end of demonstration year 2 (CY 2018). The adjustments proposed in this

request will offset the two year overage and allow HCA to meet budget neutrality over the life of the demonstration.

a. Proposed adjustments to the budget neutrality methodology in Section XI: Monitoring Budget Neutrality for the Demonstration

The proposed methodology includes the following adjustment assumptions:

- The methodology will include the original data baseline as in the previous budget neutrality agreement when calculating the adjusted Without Waiver (WOW) PMPMs for the non-expansion adult population beginning in DY3 (CY 2019);
- The state will use the same baseline data period of CY2011-2013 and carve out LTSS costs in order to calculate the revised DY3-5 WOW PMPMs;
- LTSS costs will only be included in DY1 and DY2 for the non-expansion adult population;
- All LTSS will be carved out from both the WOW and WW side beginning in DY3 (January 1, 2019); and
- The state will use the post-LTSS carve out trend rate of 4.0%.

b. Proposed reductions to annual DSHP, DSRIP, MAC, TSOA and FCS expenditure limits

In addition to the budget neutrality methodology adjustment, the state proposes reductions to DSHP, DSRIP, MAC, TSOA and FCS funding limits to support budget neutrality over the life of the waiver. As a result of the proposed DSHP reduction, the original DSHP phase down approach within the STCs will need to be revisited. The proposed expenditure limits for the programs mentioned above have been pasted in Appendix A (table 11) for reference.

III. Analysis of the Impact of the Proposed Corrective Action Plan

Based on current projections, the proposed adjustments submitted in this request will result in budget neutrality over the life of the demonstration.

The combination of the budget neutrality methodology adjustment and program reductions allows the state to achieve budget neutrality while also adequately supporting critical WA goals related to Value-Based Payment (VBP) attainment, quality improvement, integrated care, Substance Use Disorder (SUD) response efforts, critical services to address social determinants of health, and related cost savings/avoidance expectations.

The updated 1115 waiver budget neutrality template accompanies this corrective action plan request and has been pasted in Appendix A for reference.

Appendix A: Proposed Methodology Adjustments Beginning in DY3

1. Overview of Budget Neutrality Workbook

As described in the waiver application:

Actual populations included in the calculations are limited to only those clients with full scope Title XIX or Title XXI coverage.
Base year enrollment numbers are adjusted to reflect the most up-to-date projections from Washington State's Caseload Forecast Council.
http://www.cfc.wa.gov/default.htm
The Caseload Forecast Council is statutorily authorized by the State to provide the official Medical caseload forecasts used in all Washington State's budgeting estimations.
Base year (CY 2016) per-capita costs for eligibility groups (1-5) are based on historical total costs and enrollment for all Medicaid services provided under Washington's State Plan for the populations described.
A weighted avearge of CY2011-2013 & CY2015-2016 is the base for calculating historical total costs, enrollment and baseline (CY 2016) in this workbook.

Eligibility Groups Included:

1	Disabled Adults and Children= MN Blind/Disabled + HWD/Medicaid Buy-In + CN BCCT + CN Bl/Dis(excludes presumptive SSI)
2	Non-disabled Children=CN Children + SCHIP + CN Family Medical<19
3	Non-ABD 'Classic' Adults=CN family Medical>=19 + CN Pregnant Women
4	ACA Expansion Adults
5	Aged=CN Aged + MN Aged
6	Hypothetical populations=supportive housing, supported employment, Medicaid Alternative Cae (MAC)
7	Expansion population=Tailored Supports for Older Adults

Service Modalities Included:
Medical = includes all medical services excluding Medicare part D Clawback payments
Long-term Support Services = Nursing homes, residential care, In-home care, adult family homes, assisted living, managed care
Mental Health = all Medicaid mental health services paid outside of the medical benefit, excluding state hospital inpatient
Substance use Disorder treatment = Medicaid portion only, as provided by the program budget

Worksheet:	Contents Description:
Historic Data	**Caseload and Expenditures from CY2011-2013** Average monthly caseloads were included in the waiver application table 10. See tab "Inputs"
WOW	Projected caseload and expenditures by eligibility group, WITHOUT the waiver. Trends based on data from Office of the Actuary Report - see tab "Trend Projections" Eligible member months - see tab "caseload projections"
WW	Projected caseload and expenditures by eligibility group, WITH the waiver. Trends based on data from Office of the Actuary Report - see tab "Trend Projections" Eligible member months - see tab "caseload projections"
DSH	DSH allotment deferred not applicable to Washington's waiver
Summary	Summary of expenditures by eligibility group, with and without waiver
Inputs	Details of historic caseload and expenditures CY2014-2016
Trend projections	Historic and future projections from Office of the Actuary Report (table 16) https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2014.pdf
Hypos-exp	Monthly caseload and expenditure projections for hypothetical populations With waiver projections include targeting of services
Caseload Projections	Average monthly caseloads by calendar year Enrollment projections for the five year Demonstration period are based upon the most recent Caseload Forecast Council's forecasts for the Demonstration years. The Caseload Forecast Council is statutorily authorized by the State to provide the official Medical caseload forecasts used in all Washington State's budgeting estimations. http://www.cfc.wa.gov/default.htm

2. Proposed Without Waiver PMPMs beginning in DY3 and proposed trend rate of 4.0% (excludes LTSS costs)

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	CY2016 BASE YEAR DY 00	TREND RATE 2	CY2017 DEMONSTRATION YEARS (DY) DY 01	CY2018 DY 02	CY2019 DY 03	CY2020 DY 04	CY2021 DY 05	TOTAL WOW
Non-Expansion Populations										
Pop Type:	**Medicaid**									
Eligible Member Months	n.a.	n.a.	4,608,843	n.a.	4,683,310	4,743,704	4,802,722	4,859,686	4,915,937	
PMPM Cost	4.0%	36	$ 617.30	4.0%	$ 641.99	$ 667.67	$ 694.38	$ 722.16	$ 751.05	
Total Expenditure					$ 3,006,638,428	$ 3,167,228,745	$ 3,334,914,191	$ 3,509,470,956	$ 3,692,114,668	$ 16,710,366,988
Expansion Adults										
Pop Type:	**Medicaid**									
Eligible Member Months	n.a.	n.a.	7,303,402	n.a.	7,466,264	7,497,354	7,525,448	7,546,643	7,569,742	
PMPM Cost	n.a.	n.a.	$426.88	see trend tab	$ 450.55	$ 472.21	$ 495.89	$ 521.22	$ 546.91	
Total Expenditure					$ 3,363,925,072	$ 3,540,325,436	$ 3,731,794,385	$ 3,933,461,229	$ 4,139,967,608	$ 18,709,473,729

3. Proposed With Waiver PMPMs beginning in DY3 (excludes LTSS costs)

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS								
	CY2016		CY2017	CY2018	CY2019	CY2020	CY2021	
			DEMONSTRATION YEARS (DY)					TOTAL WW
ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DY 01	DY 02	DY 03	DY 04	DY 05	
Non-Expansion Populations								
Pop Type:	**Medicaid**							
Eligible Member Months	4,608,843	n.a.	4,683,310	4,743,704	4,802,722	4,859,686	4,915,937	
PMPM Cost	$ 617.30	0.9%	$ 622.86	$ 628.47	$ 634.13	$ 639.84	$ 645.60	
	reduc -->	**3.1%**						
Total Expenditure			$ 2,917,046,701	$ 2,981,275,554	$ 3,045,550,183	$ 3,109,421,591	$ 3,173,729,086	$ 15,227,023,115
Expansion Adults								
Pop Type:	**Medicaid**							
Eligible Member Months	7,303,402	n.a.	7,466,264	7,497,354	7,525,448	7,546,643	7,569,742	
PMPM Cost	$ 426.88	see trend tab	$ 437.32	$ 444.79	$ 453.30	$ 462.41	$ 470.86	
Total Expenditure			$ 3,265,146,404	$ 3,334,747,995	$ 3,411,285,557	$ 3,489,643,158	$ 3,564,288,727	$ 17,065,111,841
Exp Pop 1	**TSOA**							
Pop Type:	**Expansion**							
Eligible Member Months								
PMPM Cost								
Total Expenditure			$2,094,037	$6,226,036	$10,749,449	$13,282,397	$13,919,239	$ 46,271,158

4. Three years of current WA State budget data used for baseline calculation

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:

REVISED: MEDICAL & BH ONLY - WITHOUT LTSS COSTS

Non-Expansion Populations	CY 2011	CY 2012	CY 2013	3-YEARS
TOTAL EXPENDITURES	$ 2,223,422,597	$ 2,287,482,943	$ 2,448,662,181	$ 6,959,567,721
ELIGIBLE MEMBER MONTHS	4,381,553	4,422,122	4,462,043	
PMPM COST	$ 507.45	$ 517.28	$ 548.78	
TREND RATES				
	ANNUAL CHANGE			
TOTAL EXPENDITURE	.	2.88%	7.05%	
ELIGIBLE MEMBER MONTHS	.	0.93%	0.90%	
PMPM COST	.	1.94%	6.09%	4.00%

LTSS COSTS ONLY

Non-Expansion Populations	CY 2011	CY 2012	CY 2013	3-YEARS
TOTAL EXPENDITURES	$ 1,427,423,069	$ 1,462,290,033	$ 1,520,174,660	$ 4,409,887,761
ELIGIBLE MEMBER MONTHS	4,381,553	4,422,122	4,462,043	
PMPM COST	$ 325.78	$ 330.68	$ 340.69	
TREND RATES				
	ANNUAL CHANGE			
TOTAL EXPENDITURE	.	2.44%	3.96%	
ELIGIBLE MEMBER MONTHS	.	0.93%	0.90%	
PMPM COST	.	1.50%	3.03%	2.30%

COMBINED MEDICAL, BH, & LTSS - ORIGINAL SUBMISSION

Non-Expansion Populations	CY 2011	CY 2012	CY 2013	3-YEARS
TOTAL EXPENDITURES	$ 3,650,845,666	$ 3,749,772,975	$ 3,968,836,841	$ 11,369,455,482
ELIGIBLE MEMBER MONTHS	4,381,553	4,422,122	4,462,043	
PMPM COST	$ 833.23	$ 847.96	$ 889.47	
TREND RATES				
	ANNUAL CHANGE			
TOTAL EXPENDITURE	.	2.71%	5.84%	
ELIGIBLE MEMBER MONTHS	.	0.93%	0.90%	
PMPM COST	.	1.77%	4.90%	3.30%

5. Budget Neutrality Summary

Without-Waiver Total Expenditures

	CY2017	CY2018	CY2019	CY2020	CY2021	
	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Non-Expansion Populations	$ 3,006,638,428	$ 3,167,228,745	$ 3,334,914,191	$ 3,509,470,956	$ 3,692,114,668	$ 16,710,366,988
Hep C Rx Costs	$ 131,821,200	$ 136,171,300	$ 140,664,952	$ 145,306,896	$ 150,102,023	$ 704,066,371
Total Costs	$ 3,138,459,628	$ 3,303,400,045	$ 3,475,579,143	$ 3,654,777,852	$ 3,842,216,691	$ 17,414,433,359
Eligibles	4,683,310	4,743,704	4,802,722	4,859,686	4,915,937	
PMPM	$ 670.14	$ 696.38	$ 723.67	$ 752.06	$ 781.58	
~~Expansion Adults~~	~~$ 3,363,925,072~~	~~$ 3,540,325,436~~	~~$ 3,731,794,385~~	~~$ 3,933,461,229~~	~~$ 4,139,967,608~~	~~$ 18,709,473,729~~
~~Hypotheticals~~						
~~All~~						
TOTAL	$ 3,138,459,628	$ 3,303,400,045	$ 3,475,579,143	$ 3,654,777,852	$ 3,842,216,691	$ 17,414,433,359

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Non-Expansion Populations	$ 2,917,046,701	$ 2,981,275,554	$ 3,045,550,183	$ 3,109,421,591	$ 3,173,729,086	$ 15,227,023,115
Hep C Rx Costs	$ 131,821,200	$ 136,171,300	$ 140,664,952	$ 145,306,896	$ 150,102,023	$ 704,066,371
Total Costs	$ 3,048,867,901	$ 3,117,446,854	$ 3,186,215,135	$ 3,254,728,487	$ 3,323,831,109	$ 15,931,089,486
Eligibles	4,683,310	4,743,704	4,802,722	4,859,686	4,915,937	
PMPM	$ 651.01	$ 657.18	$ 663.42	$ 669.74	$ 676.13	
~~Expansion Adults~~	~~$ 3,265,146,404~~	~~$ 3,334,747,995~~	~~$ 3,411,285,557~~	~~$ 3,489,643,158~~	~~$ 3,564,288,727~~	~~$ 17,065,111,841~~
Expansion Populations						
~~Exp Population - TSOA~~	~~$ 2,094,037~~	~~$ 6,226,036~~	~~$ 10,749,449~~	~~$ 13,282,397~~	~~$ 13,919,239~~	~~$ 46,271,158~~
~~Hypotheticals~~						
~~All~~						
TOTAL	$ 3,048,867,901	$ 3,117,446,854	$ 3,186,215,135	$ 3,254,728,487	$ 3,323,831,109	$ 15,931,089,486

VARIANCE	$ 89,591,727	$ 185,953,191	$ 289,364,008	$ 400,049,364	$ 518,385,583	$ 1,483,343,873

6. Inputs by Population and Eligibility

Population	**2014**	**2015**	**2016**
ELIGIBLES			
Disabled	1,818,313	1,801,007	1,823,350
Non-Disabled Children	8,892,595	9,456,880	9,956,041
Non-ABD 'Classic' Adults	1,933,680	1,947,281	1,881,541
Expansion Adults	4,858,655	6,668,892	7,303,402
Aged	857,855	880,882	903,951
EXPENDITURES			
Disabled	$1,819,641,959	$1,909,255,215	$2,107,762,734
Non-Disabled Children	$1,426,894,169	$1,477,973,736	$1,656,635,064
Non-ABD 'Classic' Adults	$889,178,108	$849,803,061	$812,168,771
Expansion Adults	$3,067,612,192	$2,807,542,892	$3,117,660,147
Aged	$1,179,301,030	$1,273,545,466	$1,389,908,182

MEDICAL				
COHORT	Children		1	1
YEAR		2014	2015	2016
TOTAL_MED		$1,327,708,126	$1,374,841,255	$1,533,416,760
ELIGIBLES		8,892,595	9,456,880	9,956,041
COHORT	Classic' Adults		2	2
YEAR		2014	2015	2016
TOTAL_MED		$825,042,770	$781,274,798	$749,260,172
ELIGIBLES		1,933,680	1,947,281	1,881,541
COHORT	Disabled		3	3
YEAR		2014	2015	2016
TOTAL_MED		$1,071,234,259	$1,123,672,664	$1,231,609,464
ELIGIBLES		1,818,313	1,801,007	1,823,350
COHORT	Aged		4	4
YEAR		2014	2015	2016
TOTAL_MED		$111,152,393	$122,814,483	$129,617,952
ELIGIBLES		857,855	880,882	903,951
COHORT	Expansion Adul		5	5
YEAR		2014	2015	2016
TOTAL_MED		$2,800,146,114	$2,448,637,189	$2,674,514,579
ELIGIBLES		4,858,655	6,668,892	7,303,402

AOD				
COHORT	Children		1	1
YEAR		2014	2015	2016
TOTAL_AOD		$12,784,926	$11,325,072	$23,296,849
COHORT	Classic' Adults		2	2
YEAR		2014	2015	2016
TOTAL_AOD		$28,663,765	$29,917,501	$22,960,449
COHORT	Disabled		3	3
YEAR		2014	2015	2016
TOTAL_AOD		$20,429,045	$20,150,762	$27,784,170
COHORT	Aged		4	4
YEAR		2014	2015	2016
TOTAL_AOD		$827,525	$946,192	$1,191,521
COHORT	Expansion Adul		5	5
YEAR		2014	2015	2016
TOTAL_AOD		$73,252,548	$87,951,709	$149,905,925

LTSS				
COHORT	Children		1	1
YEAR		2014	2015	2016
TOTAL_LTSS		$684,908	$162,147	$143,664
COHORT	Classic' Adults		2	2
YEAR		2014	2015	2016
TOTAL_LTSS		$3,171,385	$4,688,041	$5,492,384
COHORT	Disabled		3	3
YEAR		2014	2015	2016
TOTAL_LTSS		$522,409,936	$560,567,662	$634,202,035
COHORT	Aged		4	4
YEAR		2014	2015	2016
TOTAL_LTSS		$1,051,068,594	$1,133,059,517	$1,241,289,311
COHORT	Expansion Adul		5	5
YEAR		2014	2015	2016
TOTAL_LTSS		$22,050,885	$29,155,397	$32,566,721

MH				
COHORT	Children		1	1
YEAR		2014	2015	2016
TOTAL_MH		$85,716,209	$91,645,262	$99,777,791
COHORT	Classic' Adults		2	2
YEAR		2014	2015	2016
TOTAL_MH		$32,300,187	$33,922,720	$34,455,766
COHORT	Disabled		3	3
YEAR		2014	2015	2016
TOTAL_MH		$205,568,719	$204,864,126	$214,167,065
COHORT	Aged		4	4
YEAR		2014	2015	2016
TOTAL_MH		$16,252,517	$16,725,274	$17,809,398
COHORT	Expansion Adul		5	5
YEAR		2014	2015	2016
TOTAL_MH		$172,162,645	$241,798,597	$260,672,923
		$512,000,278	$588,955,980	$626,882,943

7. Trends Projections

Projections: From CMS Actuary										
		2013	2014	2015	2016	2017	2018	2019	2020	2021
1	*Disabled*	$17,352	$17,755	$18,285	$18,927	$19,790	$20,682	$21,609	$22,573	$23,577
2	*Children*	$2,807	$2,844	$2,926	$3,002	$3,144	$3,307	$3,492	$3,685	$3,884
3	*'Classic' Adults*	$4,391	$4,650	$4,817	$4,964	$5,220	$5,504	$5,816	$6,152	$6,509
4	*Exp Adults*	...	$5,517	$4,281	$3,606	$3,806	$3,989	$4,189	$4,403	$4,620
5	*Aged*	$15,483	$15,630	$15,999	$16,626	$17,505	$18,296	$19,098	$19,946	$20,838

		Baseline Years				Demonstration Years				
1	*Disabled*	...	2.32%	2.99%	3.51%	4.56%	4.51%	4.48%	4.46%	4.45%
2	*Children*	...	1.32%	2.88%	2.60%	4.73%	5.18%	5.59%	5.53%	5.40%
3	*'Classic' Adults*	...	5.90%	3.59%	3.05%	5.16%	5.44%	5.67%	5.78%	5.80%
4	*Exp Adults*	...	5.90%	3.59%	3.05%	5.55%	4.81%	5.01%	5.11%	4.93%
5	*Aged*	...	0.95%	2.36%	3.92%	5.29%	4.52%	4.38%	4.44%	4.47%

** - Newly elig use classic adults as proxy for baseline years*

8. Hypothetical – Caseload and Expenditures

	Without Waiver					
	Hypothetical - MAC		Hypothetical - Supported Housing		Hypothetical - Supported Employment	
Month	Caseload	All Funds	Caseload	All Funds	Caseload	All Funds
Jan-17	864	$431,806	948	$547,586	813	$447,123
Feb-17	1,732	$865,914	1,899	$1,096,531	1,629	$895,724
Mar-17	2,605	$1,302,333	2,852	$1,646,839	2,447	$1,345,804
Apr-17	3,482	$1,741,072	3,807	$2,198,512	3,268	$1,797,370
May-17	4,364	$2,182,142	4,765	$2,751,551	4,092	$2,250,423
Jun-17	5,251	$2,625,550	5,725	$3,305,961	4,918	$2,704,967
Jul-17	6,143	$3,071,306	6,687	$3,861,743	5,747	$3,161,007
Aug-17	7,039	$3,519,421	7,652	$4,418,899	6,579	$3,618,546
Sep-17	7,940	$3,969,902	8,619	$4,977,434	7,414	$4,077,588
Oct-17	8,846	$4,422,760	9,588	$5,537,348	8,251	$4,538,136
Nov-17	9,756	$4,878,004	10,560	$6,098,645	9,091	$5,000,194
Dec-17	10,671	$5,335,643	11,535	$6,661,326	9,934	$5,463,766
Jan-18	11,591	$5,882,623	12,512	$7,333,777	10,780	$6,017,789
Feb-18	12,516	$6,352,019	13,491	$7,907,719	11,628	$6,491,399
Mar-18	13,446	$6,823,875	14,472	$8,483,075	12,479	$6,966,557
Apr-18	14,381	$7,298,202	15,456	$9,059,847	13,333	$7,443,267
May-18	15,320	$7,775,009	16,443	$9,638,038	14,190	$7,921,533
Jun-18	16,265	$8,254,306	17,431	$10,217,650	15,049	$8,401,358
Jul-18	17,214	$8,736,103	18,423	$10,798,688	15,912	$8,882,746
Aug-18	18,168	$9,220,410	19,416	$11,381,152	16,777	$9,365,702
Sep-18	19,128	$9,707,237	20,413	$11,965,045	17,645	$9,850,229
Oct-18	20,092	$10,196,593	21,411	$12,550,371	18,516	$10,336,330
Nov-18	21,061	$10,688,489	22,412	$13,137,132	19,389	$10,824,011
Dec-18	22,035	$11,182,935	23,416	$13,725,330	20,266	$11,313,274
Jan-19	23,015	$11,855,141	23,445	$13,948,506	21,145	$11,981,185
Feb-19	23,999	$12,362,210	23,474	$13,965,822	22,027	$12,481,012
Mar-19	24,989	$12,871,899	23,503	$13,983,161	22,912	$12,982,457
Apr-19	25,983	$13,384,217	23,532	$14,000,521	23,800	$13,485,525

May-19	26,983	$13,899,175	23,561	$14,017,902	24,690	$13,990,219
Jun-19	27,988	$14,416,784	23,591	$14,035,305	25,584	$14,496,543
Jul-19	28,998	$14,937,052	23,620	$14,052,730	26,481	$15,004,501
Aug-19	30,013	$15,459,992	23,649	$14,070,176	27,380	$15,514,098
Sep-19	31,033	$15,985,614	23,679	$14,087,644	28,282	$16,025,337
Oct-19	32,059	$16,513,928	23,708	$14,105,134	29,187	$16,538,222
Nov-19	33,090	$17,044,944	23,737	$14,122,645	30,095	$17,052,758
Dec-19	34,126	$17,578,675	23,767	$14,140,178	31,006	$17,568,949
Jan-20	34,217	$17,889,914	23,796	$14,370,099	31,058	$17,861,935
Feb-20	34,308	$17,937,600	23,826	$14,387,939	31,109	$17,891,435
Mar-20	34,400	$17,985,413	23,855	$14,405,802	31,160	$17,920,984
Apr-20	34,491	$18,033,354	23,885	$14,423,687	31,212	$17,950,582
May-20	34,583	$18,081,422	23,915	$14,441,593	31,263	$17,980,229
Jun-20	34,675	$18,129,619	23,944	$14,459,522	31,315	$18,009,925
Jul-20	34,768	$18,177,944	23,974	$14,477,474	31,367	$18,039,670
Aug-20	34,860	$18,226,398	24,004	$14,495,447	31,418	$18,069,464
Sep-20	34,953	$18,274,981	24,034	$14,513,443	31,470	$18,099,307
Oct-20	35,047	$18,323,693	24,064	$14,531,462	31,522	$18,129,199
Nov-20	35,140	$18,372,536	24,093	$14,549,502	31,574	$18,159,141
Dec-20	35,234	$18,421,508	24,123	$14,567,565	31,627	$18,189,133
Jan-21	35,328	$18,747,670	24,153	$14,804,435	31,679	$18,492,461
Feb-21	35,422	$18,797,643	24,183	$14,822,815	31,731	$18,523,003
Mar-21	35,516	$18,847,749	24,213	$14,841,217	31,783	$18,553,595
Apr-21	35,611	$18,897,988	24,243	$14,859,642	31,836	$18,584,238
May-21	35,706	$18,948,361	24,273	$14,878,091	31,889	$18,614,931
Jun-21	35,801	$18,998,868	24,304	$14,896,561	31,941	$18,645,675
Jul-21	35,896	$19,049,510	24,334	$14,915,055	31,994	$18,676,470
Aug-21	35,992	$19,100,287	24,364	$14,933,572	32,047	$18,707,316
Sep-21	36,088	$19,151,200	24,394	$14,952,112	32,100	$18,738,212
Oct-21	36,184	$19,202,248	24,424	$14,970,675	32,153	$18,769,160
Nov-21	36,281	$19,253,432	24,455	$14,989,261	32,206	$18,800,159
Dec-21	36,377	$19,304,753	24,485	$15,007,870	32,259	$18,831,209
CY2017	***68,692***	***$34,345,852***	***74,636***	***$43,102,375***	***64,183***	***$35,300,648***
CY2018	***201,217***	***$102,117,801***	***215,295***	***$126,197,823***	***185,964***	***$103,814,193***
CY2019	***342,274***	***$176,309,632***	***283,265***	***$168,529,725***	***312,590***	***$177,120,807***

CY2020	***416,676***	***$217,854,384***	***287,514***	***$173,623,536***	***376,095***	***$216,301,004***
CY2021	***430,201***	***$228,299,709***	***291,826***	***$178,871,307***	***383,617***	***$223,936,430***

	With Waiver							
	Hypothetical - MAC		Hypothetical - Supported Housing		Hypothetical - Supported Employment		Expansion - TSOA	
Month	**Caseload**	**All Funds**	**Caseload**	**All Funds**	**Caseload**	**All Funds**	**Caseload**	**All Funds**
Jan-17	115	$57,574	156	$90,346	76	$41,821	79	$26,327
Feb-17	231	$115,455	313	$180,917	152	$83,780	159	$52,794
Mar-17	347	$173,644	470	$271,713	229	$125,878	239	$79,402
Apr-17	464	$232,143	628	$362,733	306	$168,114	320	$106,152
May-17	582	$290,952	786	$453,979	383	$210,490	401	$133,043
Jun-17	700	$350,073	945	$545,452	460	$253,005	483	$160,078
Jul-17	819	$409,508	1,103	$637,150	538	$295,660	565	$187,255
Aug-17	939	$469,256	1,262	$729,076	615	$338,455	647	$214,576
Sep-17	1,059	$529,320	1,422	$821,229	693	$381,391	730	$242,042
Oct-17	1,179	$589,701	1,582	$913,609	772	$424,467	813	$269,652
Nov-17	1,301	$650,400	1,742	$1,006,218	850	$467,685	897	$297,408
Dec-17	1,423	$711,419	1,903	$1,099,055	929	$511,045	981	$325,310
Jan-18	1,546	$784,350	2,064	$1,210,003	1,008	$562,864	1,065	$358,659
Feb-18	1,669	$846,936	2,226	$1,304,697	1,088	$607,163	1,150	$387,277
Mar-18	1,793	$909,850	2,388	$1,399,626	1,167	$651,606	1,236	$416,046
Apr-18	1,917	$973,094	2,550	$1,494,787	1,247	$696,194	1,322	$444,965
May-18	2,043	$1,036,668	2,713	$1,590,183	1,327	$740,928	1,408	$474,036
Jun-18	2,169	$1,100,574	2,876	$1,685,814	1,408	$785,808	1,495	$503,258
Jul-18	2,295	$1,164,814	3,040	$1,781,679	1,488	$830,834	1,582	$532,633
Aug-18	2,422	$1,229,388	3,204	$1,877,780	1,569	$876,006	1,670	$562,161
Sep-18	2,550	$1,294,298	3,368	$1,974,117	1,650	$921,326	1,758	$591,842
Oct-18	2,679	$1,359,546	3,533	$2,070,690	1,732	$966,793	1,847	$621,678
Nov-18	2,808	$1,425,132	3,698	$2,167,500	1,814	$1,012,407	1,936	$651,668
Dec-18	2,938	$1,491,058	3,863	$2,264,547	1,896	$1,058,169	2,025	$681,814
Jan-19	3,069	$1,580,685	3,868	$2,301,369	1,978	$1,120,641	2,115	$722,798
Feb-19	3,200	$1,648,295	3,873	$2,304,226	2,060	$1,167,392	2,206	$753,713

Mar-19	3,332	$1,716,253	3,878	$2,307,087	2,143	$1,214,294	2,297	$784,789
Apr-19	3,464	$1,784,562	3,883	$2,309,951	2,226	$1,261,348	2,388	$816,024
May-19	3,598	$1,853,223	3,887	$2,312,819	2,309	$1,308,553	2,480	$847,421
Jun-19	3,732	$1,922,238	3,892	$2,315,690	2,393	$1,355,911	2,572	$878,979
Jul-19	3,866	$1,991,607	3,897	$2,318,565	2,477	$1,403,423	2,665	$910,699
Aug-19	4,002	$2,061,332	3,902	$2,321,444	2,561	$1,451,087	2,759	$942,583
Sep-19	4,138	$2,131,415	3,907	$2,324,326	2,645	$1,498,905	2,852	$974,629
Oct-19	4,275	$2,201,857	3,912	$2,327,211	2,730	$1,546,877	2,947	$1,006,840
Nov-19	4,412	$2,272,659	3,916	$2,330,100	2,815	$1,595,003	3,041	$1,039,216
Dec-19	4,550	$2,343,823	3,921	$2,332,993	2,900	$1,643,284	3,137	$1,071,757
Jan-20	4,562	$2,385,322	3,926	$2,370,928	2,905	$1,670,688	3,145	$1,090,733
Feb-20	4,574	$2,391,680	3,931	$2,373,871	2,910	$1,673,447	3,153	$1,093,640
Mar-20	4,587	$2,398,055	3,936	$2,376,819	2,915	$1,676,211	3,162	$1,096,555
Apr-20	4,599	$2,404,447	3,941	$2,379,769	2,919	$1,678,980	3,170	$1,099,478
May-20	4,611	$2,410,856	3,946	$2,382,724	2,924	$1,681,753	3,179	$1,102,409
Jun-20	4,623	$2,417,283	3,951	$2,385,682	2,929	$1,684,530	3,187	$1,105,347
Jul-20	4,636	$2,423,726	3,955	$2,388,644	2,934	$1,687,312	3,196	$1,108,294
Aug-20	4,648	$2,430,186	3,960	$2,391,609	2,939	$1,690,099	3,204	$1,111,248
Sep-20	4,660	$2,436,664	3,965	$2,394,578	2,944	$1,692,890	3,213	$1,114,210
Oct-20	4,673	$2,443,159	3,970	$2,397,551	2,948	$1,695,686	3,221	$1,117,180
Nov-20	4,685	$2,449,671	3,975	$2,400,528	2,953	$1,698,487	3,230	$1,120,158
Dec-20	4,698	$2,456,201	3,980	$2,403,508	2,958	$1,701,292	3,238	$1,123,144
Jan-21	4,710	$2,499,689	3,985	$2,442,589	2,963	$1,729,663	3,247	$1,143,030
Feb-21	4,723	$2,506,352	3,990	$2,445,622	2,968	$1,732,520	3,256	$1,146,076
Mar-21	4,735	$2,513,033	3,995	$2,448,658	2,973	$1,735,382	3,264	$1,149,131
Apr-21	4,748	$2,519,732	4,000	$2,451,698	2,978	$1,738,248	3,273	$1,152,194
May-21	4,761	$2,526,448	4,005	$2,454,742	2,983	$1,741,119	3,282	$1,155,265
Jun-21	4,773	$2,533,182	4,010	$2,457,789	2,988	$1,743,994	3,291	$1,158,345
Jul-21	4,786	$2,539,935	4,015	$2,460,840	2,993	$1,746,874	3,299	$1,161,432
Aug-21	4,799	$2,546,705	4,020	$2,463,896	2,997	$1,749,760	3,308	$1,164,528
Sep-21	4,812	$2,553,493	4,025	$2,466,954	3,002	$1,752,649	3,317	$1,167,632
Oct-21	4,825	$2,560,300	4,030	$2,470,017	3,007	$1,755,544	3,326	$1,170,745
Nov-21	4,837	$2,567,124	4,035	$2,473,084	3,012	$1,758,444	3,335	$1,173,865
Dec-21	4,850	$2,573,967	4,040	$2,476,154	3,017	$1,761,348	3,344	$1,176,994
CY2017	***9,159***	***$4,579,447***	***12,314***	***$7,111,477***	***6,003***	***$3,301,791***	***6,314***	***$2,094,037***

CY2018	***26,829***	***$13,615,707***	***35,522***	***$20,821,425***	***17,394***	***$9,710,098***	***18,495***	***$6,226,036***
CY2019	***45,637***	***$23,507,951***	***46,736***	***$27,805,781***	***29,238***	***$16,566,718***	***31,460***	***$10,749,449***
CY2020	***55,557***	***$29,047,251***	***47,437***	***$28,646,210***	***35,177***	***$20,231,377***	***38,298***	***$13,282,397***
CY2021	***57,360***	***$30,439,961***	***48,149***	***$29,512,042***	***35,881***	***$20,945,544***	***39,541***	***$13,919,239***

9. Historical Data CY06-16

WASHINGTON STATE HISTORICAL MEDICAID EXPENDITURES & ELIGIBLES - by CALENDAR YEAR & PROGRAM										Report Date =	22-Mar-16	
Program - Population	CY 2006	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	
SUD TX - Annual Expenditures												
DISABLED CHILDREN & ADULTS	$7,133,941	$7,748,711	$8,732,091	$9,010,080	$7,754,015	$11,821,459	$13,458,615	$15,415,034	$20,429,045	$20,150,762	$27,784,170	
NON-DISABLED CHILDREN	$6,110,683	$6,097,484	$6,798,332	$6,517,057	$6,154,257	$9,510,107	$10,280,130	$10,693,318	$12,784,926	$11,325,072	$23,296,849	
NON-ABD 'CLASSIC' ADULTS	$9,582,559	$10,533,848	$11,812,878	$11,503,785	$8,788,654	$13,086,530	$17,834,023	$21,009,594	$28,663,765	$29,917,501	$22,960,449	
EXPANSION ADULTS	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	$73,252,548	$87,951,709	$149,905,925	
ELDERS	$210,600	$165,140	$196,330	$196,588	$198,065	$292,502	$328,578	$475,222	$827,525	$946,192	$1,191,521	
LTSS - Annual Expenditures												
DISABLED CHILDREN & ADULTS	$334,506,773	$367,813,257	$417,259,220	$455,440,258	$477,580,687	$481,018,750	$489,613,549	$512,635,809	$522,409,936	$560,567,662	$634,202,035	
NON-DISABLED CHILDREN	$448 754	$636 714	$943 003	$707 086	$746 206	$743 447	$492 624	$596 708	$684 908	$162 147	$143 664	
NON-ABD 'CLASSIC' ADULTS	$2,255,240	$2,498,686	$2,986,489	$2,979,586	$3,051,708	$2,376,118	$2,170,232	$2,336,461	$3,171,385	$4,688,041	$5,492,384	
EXPANSION ADULTS	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	$22,050,885	$29,155,397	$32,566,721	
ELDERS	$801,237,168	$841,653,052	$905,658,694	$933,860,002	$951,621,781	$944,028,201	$970,506,252	$1,005,202,390	$1,051,068,594	$1,133,059,517	$1,241,289,311	
MH - Annual Expenditures												
DISABLED CHILDREN & ADULTS	$163,920,559	$165,170,561	$160,675,091	$165,676,831	$182,643,803	$201,497,477	$201,684,316	$208,442,855	$205,568,719	$204,864,126	$214,167,065	
NON-DISABLED CHILDREN	$68,939,389	$76,149,608	$80,031,703	$84,981,760	$95,429,366	$105,271,147	$105,269,898	$111,828,281	$85,716,209	$91,645,262	$99,777,791	
NON-ABD 'CLASSIC' ADULTS	$15,567,014	$17,851,785	$19,695,755	$23,318,044	$28,803,476	$30,140,880	$29,473,567	$30,377,278	$32,300,187	$33,922,720	$34,455,766	
EXPANSION ADULTS	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	$172,162,645	$241,798,597	$260,672,923	
ELDERS	$12 556 250	$13 105 326	$13 952 692	$13 424 332	$15 311 622	$16 964 275	$18 429 231	$19 137 512	$16 252 517	$16 725 274	$17 809 398	
MEDICAL - Annual Expenditures												
DISABLED CHILDREN & ADULTS	$845,625,646	$954,282,753	$1,096,667,179	$1,174,578,132	$1,163,619,188	$1,094,146,465	$1,164,470,776	$1,299,930,917	$1,071,234,259	$1,123,672,664	$1,231,609,464	
NON-DISABLED CHILDREN	$987,400,718	$1,065,934,992	$1,177,281,127	$1,182,475,824	$1,239,182,553	$1,287,144,759	$1,285,736,614	$1,294,993,069	$1,327,708,126	$1,374,841,255	$1,533,416,760	
NON-ABD 'CLASSIC' ADULTS	$609 753 090	$611 965 075	$655 813 209	$728 125 773	$755 547 619	$753 065 507	$740 602 474	$748 333 883	$825 042 770	$781 274 798	$749 260 172	
EXPANSION ADULTS	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	$2,800,146,114	$2,448,637,189	$2,674,514,579	
ELDERS	$147,982,991	$154,264,494	$161,319,457	$141,777,716	$115,554,633	$102,407,502	$101,201,363	$105,539,886	$111,152,393	$122,814,483	$129,617,952	
TOTAL - Annual Expenditures												
DISABLED CHILDREN & ADULTS	$1,351,186,919	$1,495,015,281	$1,683,333,581	$1,804,705,300	$1,831,597,693	$1,788,484,151	$1,869,227,255	$2,036,424,614	$1,819,641,959	$1,909,255,215	$2,107,762,734	
NON-DISABLED CHILDREN	$1,062,899,545	$1,148,818,798	$1,265,054,164	$1,274,681,727	$1,341,512,382	$1,402,669,459	$1,401,779,265	$1,418,111,376	$1,426,894,169	$1,477,973,736	$1,656,635,064	
NON-ABD 'CLASSIC' ADULTS	$637 157 902	$642 849 394	$690 308 331	$765 927 188	$796 191 456	$798 669 035	$790 080 296	$802 057 216	$889 178 108	$849 803 061	$812 168 771	
EXPANSION ADULTS	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	$3,067,612,192	$2,807,542,892	$3,117,660,147	
ELDERS	$961,987,009	$1,009,188,012	$1,081,127,173	$1,089,258,638	$1,082,686,101	$1,063,692,480	$1,090,465,424	$1,130,355,011	$1,179,301,030	$1,273,545,466	$1,389,908,182	
NON-EXPANSION POPS - Medical & BH Only	$1,812,332,650	$1,935,087,692	$2,128,864,683	$2,267,611,281	$2,278,221,074	$2,223,422,597	$2,287,482,943	$2,448,662,181	$2,311,471,180	$2,334,288,522	$2,428,855,958	
NON-EXPANSION POPS - LTSS Only	$1 137 999 181	$1 211 964 995	$1 325 904 403	$1 392 279 845	$1 432 254 176	$1,427,423,069	$1,462,290,033	$1,520,174,660	$1 576 649 916	$1 698 315 220	$1 880 983 730	
NON-EXPANSION POPS - Medical, BH, & LTSS	$2,950,331,831	$3,147,052,687	$3,454,769,085	$3,659,891,126	$3,710,475,251	$3,650,845,666	$3,749,772,975	$3,968,836,841	$3,888,121,096	$4,032,603,741	$4,309,839,687	
										$2,313,000	$7,103,900	<-- HEP-C Family
										$22,131,000	$53,678,000	<-- HEP-C Disabled
												Other
												Other
									$0	$24,444,000	$60,781,900	Total Additional
NON-EXPANSION POPS - REV	$2,950,331,831	$3,147,052,687	$3,454,769,085	$3,659,891,126	$3,710,475,251	$3,650,845,666	$3,749,772,975	$3,968,836,841	$3,888,121,096	**$4,057,047,741**	**$4,370,621,587**	Revised Overall Total

ELIGIBLES - Annual Member Months											
DISABLED CHILDREN & ADULTS	1,544,576	1,573,852	1,615,872	1,663,538	1,762,214	1,851,898	1,887,003	1,913,440	1,818,313	1,801,007	1,823,350
NON-DISABLED CHILDREN	6,240,874	6,328,901	6,646,291	7,399,057	7,999,905	8,324,806	8,404,510	8,440,614	8,892,595	9,456,880	9,956,041
NON-ABD 'CLASSIC' ADULTS	1,539,435	1,452,108	1,445,986	1,515,725	1,610,959	1,725,990	1,712,637	1,707,833	1,933,680	1,947,281	1,881,541
EXPANSION ADULTS	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	4,858,655	6,668,892	7,303,402
ELDERS	747,013	746,056	750,796	764,743	782,798	803,665	822,482	840,770	857,855	880,882	903,951
NON-EXPANSION POPS	3,831,024	3,772,016	3,812,654	3,944,007	4,155,971	4,381,553	4,422,122	4,462,043	4,609,848	4,629,169	4,608,843
Average PMPM											
DISABLED CHILDREN & ADULTS	$874 79	$949 91	$1,041 75	$1,084 86	$1,039 37	$965 76	$990 58	$1,064 27	$1,000 73	$1,060 10	$1,155 98
NON-DISABLED CHILDREN	$170 31	$181 52	$190 34	$172 28	$167 69	$168 49	$166 79	$168 01	$160 46	$156 29	$166 39
NON-ABD 'CLASSIC' ADULTS	$413 89	$442 70	$477 40	$505 32	$494 23	$462 73	$461 32	$469 63	$459 84	$436 41	$431 65
EXPANSION ADULTS	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	$631 37	$420 99	$426 88
ELDERS	$1 287 78	$1 352 70	$1 439 97	$1 424 35	$1 383 10	$1 323 55	$1 325 82	$1 344 43	$1 374 71	$1 445 76	$1 537 59
NON-EXPANSION POPS	$770 12	$834 32	$906 13	$927 96	$892 81	$833 23	$847 96	$889 47	$843 44	$871 13	$935 12
Average PMPM % Grwth											
DISABLED CHILDREN & ADULTS		*8.6%*	*9.7%*	*4.1%*	*-4.2%*	*-7.1%*	*2.6%*	*7.4%*	*-6.0%*	*5.9%*	*9.0%*
NON-DISABLED CHILDREN		*6.6%*	*4.9%*	*-9.5%*	*-2.7%*	*0.5%*	*-1.0%*	*0.7%*	*-4.5%*	*-2.6%*	*6.5%*
NON-ABD 'CLASSIC' ADULTS		*7.0%*	*7.8%*	*5.8%*	*-2.2%*	*-6.4%*	*-0.3%*	*1.8%*	*-2.1%*	*-5.1%*	*-1.1%*
EXPANSION ADULTS		*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*-33.3%*	*1.4%*
ELDERS		*5.0%*	*6.5%*	*-1.1%*	*-2.9%*	*-4.3%*	*0.2%*	*1.4%*	*2.3%*	*5.2%*	*6.4%*
NON-EXPANSION POPS		*8.3%*	*8.6%*	*2.4%*	*-3.8%*	*-6.7%*	*1.8%*	*4.9%*	*-5.2%*	*3.3%*	*7.3%*

10. Caseload Projections

Average Monthly Caseloads by Calendar Year

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
All Disabled	128,715	131,154	134,656	138,628	146,851	154,325	157,250	159,453	151,526	150,084	151,946	154,170	155,179	155,935	156,611	157,293
Children Non-Disabled	520,073	527,408	553,858	616,588	666,659	693,734	700,376	703,385	741,050	788,073	829,670	846,670	852,390	858,280	864,756	871,972
Adults Non-ABD	128,286	121,009	120,499	126,310	134,247	143,833	142,720	142,319	161,140	162,273	156,795	158,586	159,324	159,975	160,475	161,021
Expansion Adults	0	1	2	3	4	5	6	7	404,888	555,741	608,617	622,189	624,779	627,121	628,887	630,812
Aged	62,251	62,171	62,566	63,729	65,233	66,972	68,540	70,064	71,488	73,407	75,329	77,521	80,806	84,317	87,888	91,348
All Disabled	1,544,576	1,573,852	1,615,872	1,663,538	1,762,214	1,851,898	1,887,003	1,913,440	1,818,313	1,801,007	1,823,350	1,850,034	1,862,143	1,871,216	1,879,335	1,887,516
Children Non-Disabled	6,240,874	6,328,901	6,646,291	7,399,057	7,999,905	8,324,806	8,404,510	8,440,614	8,892,595	9,456,880	9,956,041	10,160,041	10,228,683	10,299,361	10,377,072	10,463,660
Adults Non-ABD	1,539,435	1,452,108	1,445,986	1,515,725	1,610,959	1,725,990	1,712,637	1,707,833	1,933,680	1,947,281	1,881,541	1,903,029	1,911,885	1,919,699	1,925,699	1,932,248
Expansion Adults	0	12	24	36	48	60	72	84	4,858,655	6,668,892	7,303,402	7,466,264	7,497,354	7,525,448	7,546,643	7,569,742
Aged	747,013	746,056	750,796	764,743	782,798	803,665	822,482	840,770	857,855	880,882	903,951	930,247	969,676	1,011,807	1,054,653	1,096,173
Non-Expansion Adults	3,831,024	3,772,016	3,812,654	3,944,007	4,155,971	4,381,553	4,422,122	4,462,043	4,609,848	4,629,169	4,608,843	4,683,310	4,743,704	4,802,722	4,859,686	4,915,937

11. Proposed Medicaid Transformation program limits

DSHP Annual Limits	DEMONSTRATION YEARS (DY)					
	CY2017 DY 01	CY2018 DY 02	CY2019 DY 03	CY2020 DY 04	CY2021 DY 05	TOTAL
Original Maximum Allowable DSHP	$240,000,000	$216,000,000	$190,080,000	$157,766,400	$124,635,456	$928,481,856
Proposed Maximum Allowable DSHP	$240,000,000	$216,000,000	$117,008,060	$76,543,710	$98,879,556	$748,431,326
Proposed Reduction	$0	$0	$73,071,940	$81,222,690	$25,755,900	$180,050,530

DSRIP Annual Limits	DEMONSTRATION YEARS (DY)					
	CY2017 DY 01	CY2018 DY 02	CY2019 DY 03	CY2020 DY 04	CY2021 DY 05	TOTAL
Original Maximum Allowable DSRIP	$242,100,000	$240,600,000	$235,900,000	$217,300,000	$190,000,000	$1,125,900,000
Proposed Maximum Allowable DSRIP	$242,100,000	$240,600,000	$235,900,000	$151,510,022	$124,210,022	$994,320,044
Proposed Reduction	$0	$0	$0	$65,789,978	$65,789,978	$131,579,956

MAC and TSOA Annual Limits	DEMONSTRATION YEARS (DY)					
	CY2017 DY 01	CY2018 DY 02	CY2019 DY 03	CY2020 DY 04	CY2021 DY 05	TOTAL
Original Maximum Allowable MAC and TSOA	$5,979,600	$19,327,770	$36,832,950	$53,179,830	$57,363,570	$172,683,720
Proposed Maximum Allowable MAC and TSOA	$5,979,600	$19,327,770	$23,039,000	$35,493,000	$49,451,000	$133,290,370
Proposed Reduction	$0	$0	$13,793,950	$17,686,830	$7,912,570	$39,393,350

FCS Annual Limits	DEMONSTRATION YEARS (DY)					
	CY2017 DY 01	CY2018 DY 02	CY2019 DY 03	CY2020 DY 04	CY2021 DY 05	TOTAL
Original Maximum Allowable FCS	$14,992,000	$33,226,000	$47,238,000	$51,782,000	$53,383,000	$200,621,000
Proposed Maximum Allowable FCS	$14,992,000	$33,226,000	$27,346,190	$39,155,919	$42,494,053	$157,214,162
Proposed Reduction	$0	$0	$19,891,810	$12,626,081	$10,888,947	$43,406,838

	DEMONSTRATION YEARS (DY)					
	CY2017 DY 01	CY2018 DY 02	CY2019 DY 03	CY2020 DY 04	CY2021 DY 05	TOTAL
Total Proposed Reduction (all programs)	**$0**	**$0**	**$106,757,700**	**$177,325,579**	**$110,347,395**	**$394,430,673**

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

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

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

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

State may submit additional supporting documents in Section 3.

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

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

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

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

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

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

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

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

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

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

This template is being finalized for review and approval by OMB through the Paperwork Reduction Act (PRA). Until such time, its use is optional, although it conveys the nature and extent of implementation information that CMS is seeking on SMI/SED demonstrations. When this template is OMB approved, then the state will be required to use it.

2. Required implementation information, by SMI/SED milestone

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

This template only includes SMI/SED policies.

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

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

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

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

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

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

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

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

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

	a review of the patient's hospitalization, condition upon discharge, and recommendations for follow-up and continuing care. Discharge planning must be coordinated with outpatient providers. 3. (E&T) WAC 246-337-095 Evaluation and Treatment Centers must document a discharge summary including recommendations for follow up care. 4. (Inpatient MH) WAC 246-341-1126(d) The initial treatment plan must include a plan for discharge and follow up care. 5. (Crisis Stabilization and Crisis Triage) WAC 246-341-1150 and WAC 246-341-1142 Crisis stabilization and crisis triage units must coordinate with outpatient providers and develop a discharge plan with dates, times, and addresses of follow up care appointments. (All BHA) WAC 246-341-0640 Related to documentation of discharge, including requirements around coordination and information sharing with community based providers. This provision applies to all Behavioral Health Administrations. **Relevant Managed Care Contract Requirements:** As mentioned under Milestone II.E, the state requires Managed Care Organizations to ensure individuals are screened for comorbid conditions. Coordination with physical health and substance use disorder providers is part of the screening and referral process. Managed Care organizations are also required to ensure coordination occurs between inpatient and outpatient levels of care. Contract requirements include: 1. Managed Care Organizations are required to be actively involved in discharge planning. (16.4.6) 2. Managed Care Organizations must develop a plan with inpatient facilities regarding discharge planning responsibilities. This includes a follow-up call within two to three business days of discharge. (14.17) 3. Individuals have a follow up outpatient appointment within seven calendar days of discharge from an inpatient facility. (6.10.1) 4. To monitor proper post-discharge care, the state mandates a 30-day readmission performance measure. (7.3.7)

	Relevant Fee-for-Service Programs: The following programs available to beneficiaries covered by the Medicaid fee-for-service program support pre-discharge planning and care transitions: Health Home program – This program provides care management and coordination, transition planning, support for the individual and family, referrals to support services in the hopes of promoting better health. Services are provided by a care coordinator who works with the patient and family to develop a health action plan, assist in transitions between types of care and work with providers. Beneficiaries with a chronic condition, including SMI, and at risk for a second condition are eligible. 1. Primary Care Case Management (PCCM) program – This program provides primary care case management through enrolled Indian health service, Tribal, and Urban Indian Health program providers, including support for pre-discharge planning and care transitions. 2. Medicaid Administrative Claiming programs – these programs partially reimburse governmental entities, including the Indian Health Service and Tribes, for time staff spent helping individuals apply for, understand, and access Medicaid services. **Current Statewide Strategies:** The state has invested in several strategies to improve coordination of care and post discharge treatment for individuals leaving inpatient care. Some of these efforts are described below. 1. The Peer Bridgers program delivers services to individuals in state and community hospitals prior to discharge and after their return to their communities. The Peer Bridger develops a relationship of trust with the participant. In developing this trust, the Peer Bridger may function as a role model, peer support, a mentor, a teacher, an advocate, and an ally as they communicate hope and encouragement. 2. State Plan Services: Washington's Medicaid State Plan includes a rehabilitation case management service allowing liaisons from the community to actively participate in discharge planning for individuals receiving psychiatric inpatient care. Currently, when these services occur in an IMD, state-only funds are used for ineligible services.

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

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

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

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

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

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

	advocate, and an ally as they communicate hope and encouragement. 2. Crisis Triage and Stabilization Investments: Between 2017-18, the state funded several new triage and crisis stabilization facilities across the state. Three facilities are open and four expected to open in the coming year, for a total of 102 crisis stabilization and triage beds across six regions of the state. The 2019 state Legislature funded even more 16-bed triage and stabilization facilities. The Legislature also funded Mobile Outreach Crisis Teams. 3. The Legislature recently funded five mental health peer respite centers to divert individuals from crisis services as well as a pilot program to provide mental health drop-in center services. 4. The Housing and Recovery through Peer Services (HARPS) program builds on the successes of the Permanent Options for Recovery-Centered Housing (PORCH) project. PORCH provided consumers with meaningful choice and control of housing and support services, using peer housing specialists. The HARPS project reduces homelessness and supports the recovery and resiliency of individuals with serious mental illness. Each team consists of three full-time employees (a mental health professional and two certified peer counselors). One of the priority target populations for the HARPS program is individuals discharging from inpatient psychiatric care. The state Legislature recently funded four additional HARPS teams with a focus on individuals discharging from forensic facilities. 5. Program for Assertive Community Treatment (PACT) teams provide wrap around services for individuals in outpatient treatment. When the individual is in an inpatient facility, the PACT team coordinates care with the inpatient unit and works to ensure stable housing and follow-up care. Currently there are 14 PACT teams across the state. In May 2019 the Legislature provided funding for eight additional PACT teams statewide. 6. Washington State's Department of Commerce announced $7.1 million in grants to six health care providers across Washington, adding 71 additional beds to facilities that help people with a wide variety of behavioral health issues. Twenty-eight of the new beds are dedicated as an alternative to treatment in state psychiatric hospitals. These grants are part of the governor's five-year plan to modernize and transform the state's mental health care systems by shifting out of large institutions to smaller, community-based facilities. 7. Co-Responders with Law Enforcement: The state continues to expand programs that fund mental health

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

	Summary of Actions Needed: N/A

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

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

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

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

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

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

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

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

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

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

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

allowing liaisons from the community to actively participate in discharge planning for individuals receiving psychiatric inpatient care. This is currently a state funded service for individuals in institute of mental disease facilities.

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

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

6. Step Down Facilities: The Legislature appropriated funding for a new community facility type to address the need for additional discharge placements for individuals leaving the state psychiatric hospitals. Intensive behavioral health treatment facilities serve individuals who possess higher levels of behavioral challenges that existing alternative behavioral health facilities cannot accommodate.

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

8. Program for Assertive Community Treatment (PACT) teams provide wrap around services for individuals in outpatient treatment. When the individual is in an inpatient facility, the PACT team coordinates care with the inpatient unit and works to ensure stable housing and follow-up care. Currently there are 14 PACT teams across

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

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

<table>
<tr><th>Prompts</th><th>Summary</th></tr>
<tr><td colspan="2">SMI/SED.Topic_5. Financing Plan</td></tr>
<tr><td colspan="2">State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.</td></tr>
<tr><td>F.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.</td><td>Current Status

Crisis Triage and Stabilization services: the state has funded several new triage and crisis stabilization facilities across the state. Current capacity is a total of 105 crisis stabilization and triage beds in eight facilities across six regions of the state. The 2019 state Legislature funded additional 16-bed triage and stabilization facilities. The Legislature also enhanced funding for Mobile Crisis Outreach. .

Step Down Facilities: the Legislature appropriated funding for a new community facility type to address the need for additional discharge placements for individuals leaving the state psychiatric hospitals. Intensive behavioral health treatment facilities serve individuals who possess higher levels of behavioral challenges that existing alternative behavioral health facilities cannot accommodate.

Peer Respite Centers: the Legislature recently funded five mental health peer respite centers to divert individuals from crisis services as well as a pilot program to provide mental health drop-in center services.

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

Co-Responders with Law Enforcement: The state continues to expand programs that fund mental health professionals who ride along with law enforcement as they respond to calls where mental health conditions may be involved.</td></tr>
</table>

Future Status

- To better serve the needs of the individual and in an effort to prevent needless hospitalization or unwarranted incarceration, the state is implementing programs designed to intervene at the point of contact with law enforcement. By broadening the options available through WAC the state provides law enforcement discretion in determining the level of care needed to better address the needs of the individual. The state is establishing broader guidelines for utilizing community based interventions as primary options. By working with licensed mental health professionals, mobile crisis response services and community crisis stabilization or crisis triage facilities, law enforcement officers are able to safely release individuals to settings which can address stabilization concerns and better determine level of acuity, housing needs, behavioral health needs, rather than placing them in the judicial systems where individuals may decompensate without treatment.

- Enhancement of Mobile Crisis Response Teams (eMCR): currently the enhancement was only in three of the states ten regions. The state anticipates continuing to develop enhanced capacity in the remaining seven regions in stages. This enhanced MCR services are designed to work in a coordinated effort with Co-responders services to provide pre-arrest diversions by reducing its response time in an effort to free law enforcement from addressing behavioral health by handing off these services to programs designed to better meet their needs. The MCR model integrates a multidisciplinary approach to improve behavioral health outcomes. The MCR services includes teams of licensed clinicians, community behavioral health specialists, and individuals with lived experience and, is designed to operate 24-hours, seven days a week.

- Development of six additional enhanced Crisis Stabilization and Crisis Triage facilities equipped to accept police drop-offs or mental health holds for evaluations by a mental health professional. These enhanced facilities are a place for individuals recovering from a behavioral health crisis to receive stabilization support from a multi-disciplinary treatment team. While designed to reduce the impact of individuals that are unduly incarcerated due to a lack of pre-arrest options for officers, as mentioned above, the state has taken wide steps to address this through WAC. These enhanced facilities will be operated 24-hours, seven days a weeks by a multidisciplinary team of clinicians, Certified Peers with lived experience, prescribers and behavioral health specialist. 171 crisis triage beds will be added.

- Development of short-term emergency hotel and motel vouchers for individuals that are homeless or unsafely sheltered in facilities that further contribute to exposure to environments that lead to interaction with problematic elements. Working in unison with the Housing and Recovery through Peer Services (HARPS), a program which is designed to serves and support individuals that experience behavioral health disorders (either

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

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

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

<table>
<tr><th>Prompts</th><th>Summary</th></tr>
<tr><td colspan="2">SMI/SED. Topic_6. Health IT Plan</td></tr>
<tr><td colspan="2">As outlined in State Medicaid Director Letter (SMDL) #18-011, “[s]tates seeking approval of an SMI/SED demonstration ... will be expected to submit a Health IT Plan (“HIT Plan”) that describes the state’s ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration’s goals.”[1] The HIT Plan should also describe, among other items, the:
• Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and
• Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.
Please complete all Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state’s demonstration proposal.</td></tr>
<tr><td colspan="2">Statements of Assurance</td></tr>
<tr><td>Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period</td><td>Behavioral Health Provider Survey:
From January 9 through April 12 2019, HCA fielded the Behavioral Health Provider Survey (BHPS), a web-based survey of publicly funded behavioral health agencies that provided mental health and/or substance use disorder services. Out of the 611 behavioral health agencies eligible to participate, 316 completed and another 30 partially completed the survey, for a 56.6 percent response rate. The 2019 survey included questions regarding the providers’ adoption and use of electronic health records, including certified electronic health records. Findings from the 2019 survey included:

• Regardless of type and size, 85% of behavioral health agencies overall reported using an electronic health record or a certified electronic health record.
    o 15% of behavioral health agencies use a paper record system.
    o More substance use disorder agencies (29.8%) use a paper record system than mental health (18.3%) and mental health substance use disorder agencies (7.2%)

• 93% of mental health substance use disorder agencies reported using an electronic health records or certified electronic health records system compared to 82% of mental health only and 70% of substance use disorder only agencies.

• 91% of large agencies use an electronic health records or certified electronic health records system compared to 87% of medium and 84% of small agencies.</td></tr>
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	• Regardless of type and size, over 90% of agencies using a paper record system plan or are thinking of transitioning to electronic health records. HCA recognizes that the 2019 survey responses by behavioral health agencies regarding their use of electronic health records or certified electronic health records exceed or is nearly the same as rates of electronic health records and certified electronic health records use reported by physicians eligible for the HITECH Electronic Health Records incentive programs. The Office of the National Coordinator for Health IT reports that in 2017 almost 86% of physicians reported using any electronic health records and nearly 80% reported using a certified electronic health records (https://dashboard.healthit.gov/quickstats/pages/physician-ehr-adoption-trends.php). Given that behavioral health agencies were not eligible for incentives or technical assistance available to physicians via the HITECH electronic health records Incentive Programs, the 2019 survey findings raise questions not only about the relative extent of electronic health records or certified electronic health records adoption among behavioral health agencies but also about its use and functions in behavioral health agencies' clinical operations and wider role in a healthcare ecosystem. Following consultation with the Office of the National Coordinator for Health IT, HCA modified the electronic health records questions in our Behavioral Health Provider survey to reflect the electronic health records questions that are expected to be included in a future Substance Abuse and Mental Health Services Administration survey on Health IT. HCA supplemented these questions by including additional functionality required in the Mental Health Institute of Mental Disease Waiver. As a result, the 2020 HCA Behavioral Health Provider survey will attempt to drill down on specific uses of the electronic health records by the behavioral health (including mental health) providers. The 2020 Behavioral Health Provider survey questions will gather information about specific functionality, use and exchange, including: • Use of electronic health records to create and use electronic care plans; • Use of electronic health records to record referrals, including closed loop referrals; and • Use of electronic health records to support interoperable screenings, intake, and assessments tools. Responses to these questions will help us: • Target needed enhancements to electronic health record functionality required by the Mental Health Institute of Mental Disease Waiver; and Identify and make available supports for the use this functionality by behavioral health agencies that provide

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

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

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

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

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

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

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

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

<table>
<tr><th>Prompts</th><th>Summary</th></tr>
<tr><td colspan="2">To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact. [3]

Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System." [4]</td></tr>
<tr><td colspan="2">Closed Loop Referrals and e-Referrals (Section 1)</td></tr>
<tr><td>1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider</td><td>Current State:
1) # and/or % of Behavioral Health Providers who have adopted "Certified" EHRs (CEHRT-Certified EHR Technologies) and utilize it for e-referrals and or closed loop referrals.
2) # and/or % of Behavioral Health Providers who utilize "Direct" secure messaging for e-referrals and or closed loop referrals
3) # and/or % of Primary Care Providers who have adopted "Certified" EHRs (CEHRT-Certified EHR Technologies) that are utilizing it for e-referrals and or closed loop referrals with mental health providers
4) # or % of Primary Care Providers who utilize "Direct" secure messaging for e-referrals and or closed loop referrals with Mental Health Providers

Behavioral Health Provider Survey:
As described in Assurance Statement #1 above, responses by behavioral health agencies (including those providing mental health services) to the 2019 Behavioral Health Provider survey raise questions about the relative extent of electronic health records/certified electronic health records adoption among these agencies and their use of electronic health records/certified electronic health records to support the behavioral health agencies' clinical operations and wider role in a health care ecosystem.

As a result, the 2020 HCA Behavioral Health Provider survey will drill down on specific uses of the electronic health records by the behavioral health (including mental health) providers and gather information about specific functionality, use and exchange, including the use of electronic health records to record referrals, including closed loop referrals.</td></tr>
</table>

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

	• Identify, prioritize, and methods to address gaps in an interoperable health information technology infrastructure to support these services, including electronic care plans and closed loop referrals. HCA staff will summarize for the Medicaid Transformation Priorities Steering Committee gaps identified by the workgroup and suggested methods for addressing these gaps. Task 2-05: HCA staff will engage and collaborate with Accountable Communities of Health and Managed Care Organization representatives to identify: • Mechanisms that are being/could be used to support close loop referrals (e.g., digital health commons) and e-referrals (e.g., use of collective medical tools, including mental health providers' use of these tools and considerations that are needed to advance the use of these tools (including aligning with health IT standards to support interoperable exchange and standard implementation across the state).
	Future State: Contingent on the availability of funds, mental health providers in Washington State will pilot the use Health IT functionalities to support referrals in care, including closed loop referrals.

	Summary of Actions Needed:
	
	• HCA will conduct a survey in 2020 of behavioral health providers' adoption and use of certified electronic health records technologies including the use of this technology to support electronic referrals to and from physicians and mental health providers.
	  o The HCA/DBHR is leading the survey of behavioral health providers.
	  o Preliminary survey results will be published by July 2020.
	
	• Contingent on the availability of funds, HCA will engage a contractor to support Tasks 8-01 and 8-02; and integrate information that emerges from Tasks 8-04 and 2-05 into written documents describing:
	  o Current practices and opportunities to support and advance the use of health information technology-enabled integrated person-level care including the use of e-consults and close-loop referral processes, interoperable care plans, and population health.
	  o The availability of standards in the Interoperability Standards Advisory to support interoperable exchange of this content.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

  - If needed, and in consultation with HCA, create a framework for prioritizing which intake, assessment and screening tools should be made electronic and linked with health IT standards (including FHIR). For example, the framework would take into account intake, assessment and screening tools:

    - Used for different populations and conditions (including for patients experiencing their first episode of psychosis);
    - That are required to be used in Washington State;
    - That are freely available for use (e.g., open source);
    - That are electronic;
    - That have been (at least partially) linked to health IT standards;
    - That other states that have received a Mental Health Institute of Mental Disease Waiver are seeking to advance.

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

- Contingent on the availability of funds, a contract for this scope of work will be awarded in July and work will be complete in December 2020.

- Contingent on the availability of funds, by February 2021, the Steering Committee and the Mental Health Institute of Mental Disease Waiver workgroup will collectively determine which intake, screening, and assessment tools will be linked with health IT standards to support interoperable exchange and re-use.

- Based on decisions made by the Medicaid Steering Committee and Mental Health Institute of Mental Disease Waiver workgroup and contingent on the availability of funds, HCA will engage a contractor to:

  - Specify requirements and design open source FHIR-Based APIs that could be implemented using certified electronic health records for the exchange intake, screening, and assessment tools; and

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

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

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

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

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

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

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

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

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

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

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

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

Section 3: Relevant documents
Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.

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

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

Attachment P: SMI Monitoring Protocol

Medicaid Section 1115 SMI/SED Demonstrations Monitoring Protocol (Part A) - Planned metrics (Version 2.0)
State *Washington*
Demonstration Name *Washington State Medicaid Transformation Project (MTP) Demonstration*

Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Planned Metrics

Standard information on CMS-provided metrics											Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Milestone or reporting topic	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline Reporting Period (MM/DD/YYYY-- MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data source, definition, codes, target population, etc.)	State plans to phase in reporting (Y/N)	Report in which metric will be phased in (Format SMI/SED DYQ; Ex. DY1Q3)	Explanation of any plans to phase in reporting over time
1	SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Treatment Settings (SUB-2)	Two rates will be reported for this measure: 1. SUB-2: Patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. 2. SUB-2a: Patients who received the brief intervention during the hospital stay.	Milestone 1	Established quality measure	Annual metrics that are an established quality measure	Medical record review or claims	Year	Annually	Recommended	N								
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Percentage of children and adolescents ages 1 to 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.	Milestone 1	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
3	All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20)	Number of all-cause ED visits per 1,000 beneficiary months among adult Medicaid beneficiaries age 18 and older who meet the eligibility criteria of beneficiaries with SMI.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Decrease	Decrease	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	The rate of unplanned, 30-day, readmission for demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. The measurement period used to identify cases in the measure population is 12 months from January 1 through December 31.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Decrease	Decrease	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
5	Medication Reconciliation Upon Admission	Percentage of patients for whom a designated prior to admission (PTA) medication list was generated by referencing one or more external sources of PTA medications and for which all PTA medications have a documented reconciliation action by the end of Day 2 of the hospitalization.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Electronic/paper medical records	Year	Annually	Recommended	N								
6	Medication Continuation Following Inpatient Psychiatric Discharge	This measure assesses whether psychiatric patients admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2019 - 12/31/2020	Increase	Increase	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
7	Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH)	Percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: • Percentage of discharges for which the child received follow-up within 30 days after discharge • Percentage of discharges for which the child received follow-up within 7 days after discharge	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
8	Follow-up After Hospitalization for Mental Illness: Age 18 and older (FUH-AD)	Percentage of discharges for beneficiaries age 18 years and older who were hospitalized for treatment of selected mental illness diagnoses or intentional self-harm and who had a follow-up visit with a mental health practitioner. Two rates are reported: • Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge • Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA-AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of alcohol or other drug (AOD) abuse dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: • Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit • Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
10	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
11	Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (count)	Number of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health.	Milestone 2	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Recommended	N								
12	Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (rate)	Rate of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health.	Milestone 2	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Recommended	N								
13	Mental Health Services Utilization - Inpatient	Number of beneficiaries in the demonstration population who use inpatient services related to mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Consistent	Consistent	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
14	Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization	Number of beneficiaries in the demonstration population who used intensive outpatient and/or partial hospitalization services related to mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
15	Mental Health Services Utilization - Outpatient	Number of beneficiaries in the demonstration population who used outpatient services related to mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
16	Mental Health Services Utilization - ED	Number of beneficiaries in the demonstration population who use emergency department services for mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Decrease	Decrease	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
17	Mental Health Services Utilization - Telehealth	Number of beneficiaries in the demonstration population who used telehealth services related to mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
18	Mental Health Services Utilization - Any Services	Number of beneficiaries in the demonstration population who used any services related to mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
19a	Average Length of Stay in IMDs	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD. Three rates are reported: • ALOS for all IMDs and populations • ALOS among short-term stays (less than or equal to 60 days) • ALOS among long-term stays (greater than 60 days)	Milestone 3	CMS-constructed	Other annual metrics	Claims State-specific IMD database	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Stabilize at no more than	Stabilize at no more than	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
19b	Average Length of Stay in IMDs (IMDs receiving FFP only)	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD receiving federal financial participation (FFP). Three rates are reported: • ALOS for all IMDs and populations • ALOS among short-term stays (less than or equal to 60 days) • ALOS among long-term stays (greater than 60 days)	Milestone 3	CMS-constructed	Other annual metrics	Claims State-specific IMD database	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Stabilize at no more than	Stabilize at no more than	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
20	Beneficiaries With SMI/SED Treated in an IMD for Mental Health	Number of beneficiaries in the demonstration population who have a claim for inpatient or residential treatment for mental health in an IMD during the reporting year.	Milestone 3	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Consistent	Consistent	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
21	Count of Beneficiaries With SMI/SED (monthly)	Number of beneficiaries in the demonstration population during the measurement period and/or in the 11 months before the measurement period.	Milestone 4	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
22	Count of Beneficiaries With SMI/SED (annually)	Number of beneficiaries in the demonstration population during the measurement period and/or in the 12 months before the measurement period.	Milestone 4	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
23	Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Percentage of beneficiaries ages 18 to 75 with a serious mental illness and diabetes (type 1 and type 2) whose most recent Hemoglobin A1c (HbA1c) level during the measurement year is >9.0%.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Medical records	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Decrease	Decrease	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
24	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	Percentage of beneficiaries age 18 and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, AND if positive, a follow-up plan is documented on the date of the positive screen.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Medical records	Year	Annually	Recommended	N								
25	Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)	Percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, AND if positive, a follow-up plan is documented on the date of the positive screen.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Electronic medical records	Year	Annually	Recommended	N								
26	Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	The percentage of Medicaid beneficiaries age 18 years or older with SMI who had an ambulatory or preventive care visit during the measurement period.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
27	Tobacco Use Screening and Follow-up for People with SMI or Alcohol or Other Drug Dependence	The percentage of patients 18 years and older with a serious mental illness or alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Two rates are reported: • Percentage of adults with SMI who received a screening for tobacco use and follow-up for those identified as a current tobacco user • Percentage of adults with AOD who received a screening for tobacco use and follow-up for those identified as a current tobacco user	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Recommended	N								
28	Alcohol Screening and Follow-up for People with SMI	The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Recommended	N								
29	Metabolic Monitoring for Children and Adolescents on Antipsychotics	The percentage of children and adolescents ages 1 to 17 who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: •Percentage of children and adolescents on antipsychotics who received blood glucose testing •Percentage of children and adolescents on antipsychotics who received cholesterol testing •Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Percentage of Medicaid beneficiaries age 18 years and older with new antipsychotic prescriptions who have completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
32	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	The sum of all Medicaid spending for mental health services not in inpatient or residential settings during the measurement period.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Consistent	Consistent	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
33	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential	The sum of all Medicaid costs for mental health services in inpatient or residential settings during the measurement period.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Consistent	Consistent	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
34	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	Per capita costs for non-inpatient, non-residential services for mental health, among beneficiaries in the demonstration population during the measurement period.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Consistent	Consistent	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
35	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential	Per capita costs for inpatient or residential services for mental health among beneficiaries in the demonstration population during the measurement period.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Consistent	Consistent	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.

Standard information on CMS-provided metrics												Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Milestone or reporting topic	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)		Baseline Reporting Period (MM/DD/YYYY--MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data source, definition, codes, target population, etc.)	State plans to phase in reporting (Y/N)	Report in which metric will be phased in (Format SMI/SED DYQ; Ex. DY1Q3)	Explanation of any plans to phase in reporting over time
36	Grievances Related to Services for SMI/SED	Number of grievances filed during the measurement period that are related to services for SMI/SED.	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y		01/01/2020 - 12/31/2020	Consistent	Consistent	N	See Attachment A for requested deviations.	Y	DY1Q3	See Attachment A for requested reporting schedule.
37	Appeals Related to Services for SMI/SED	Number of appeals filed during the measurement period that are related to services for SMI/SED.	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y		01/01/2020 - 12/31/2020	Consistent	Consistent	N	See Attachment A for requested deviations.	Y	DY1Q3	See Attachment A for requested reporting schedule.
38	Critical Incidents Related to Services for SMI/SED	Number of critical incidents filed during the measurement period that are related to services for SMI/SED.	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y		01/01/2020 - 12/31/2020	Consistent	Consistent	N	See Attachment A for requested deviations.	Y	DY1Q3	See Attachment A for requested reporting schedule.
39	Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	Total Medicaid costs for beneficiaries in the demonstration population who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y		01/01/2020 - 12/31/2020	Consistent	Consistent	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
40	Per Capita Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	Per capita Medicaid costs for beneficiaries in the demonstration population who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y		01/01/2020 - 12/31/2020	Consistent	Consistent	Y		Y	DY1Q3	See Attachment A for requested reporting schedule.
Q1	*Community Based Psychiatric Hospitals Using HIT for Discharge Summaries*	The percentage of community-based psychiatric hospitals that use Collective Medical (CM)	Health IT	State-specific	*Other annual metrics*	Survey	Year	Annually	Required	Y		01/01/2020 - 12/31/2020	Increase	Increase			Y	DY1Q3	See Attachment A for requested reporting schedule.
Q2	*Mental Health Treatment Penetration Rate*	The percentage of Medicaid beneficiaries, 6 years of age and older, with a mental health se	Health IT	State-specific	*Other annual metrics*	Claims	Year	Annually	Required	Y		01/01/2020 - 12/31/2020	Increase	Increase			Y	DY1Q3	See Attachment A for requested reporting schedule.
Q3	*Foundational Community Supports for Beneficiaries with Inpatient or Residential Mental Health Services*	Percent of Foundational Community Supports (FCS) eligible Medicaid beneficiaries, age 18 a	Health IT	State-specific	*Other annual metrics*	Claims	Year	Annually	Required	Y		01/01/2020 - 12/31/2020	Increase	Increase			Y	DY1Q3	See Attachment A for requested reporting schedule.
State-specific metrics																			
Add rows for any additional state-specific metrics																			

Medicaid Section 1115 SMI/SED Demonstrations Monitoring Protocol (Part A) - SMI/SED Definitions (Version 2.0)

State	*Washington*
Demonstration Name	*Washington State Medicaid Transformation Project (MTP) Demonstration*

Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Definitions

Narrative description of the SMI/SED demonstration population

See Attachment A

	Serious Mental Illness (SMI)	Serious Emotional Disturbance (SED)
Narrative description of how the state defines the population for purposes of monitoring (including age range, diagnosis groups, and associated service use requirements)	*See Attachment A*	*See Attachment A*
Codes used to identify population[b] *States may use ICD-10 diagnosis codes or state-specific treatment, diagnosis, or other types of codes to identify the population. When applicable, states should supplement ICD-10 codes with state-specific codes.*	*See Attachment A*	*See Attachment A*
Procedure (e.g., CPT, HCPCS) or revenue codes used to identify/define service requirements[b] *If the state is not using procedure or revenue codes, the state should include the data source(s) (e.g., state-specific codes) used to identify/define service requirements.*	*Per agreement with CMS, state definition of SMI/SED is still under development.*	*Per agreement with CMS, state definition of SMI/SED is still under development.*

[a]The examples are based on a definition of SMI from the National Committee for Quality Assurance (NCQA). The examples provided are intended to be illustrative only. The example codes provided are not comprehensive.

[b]States may choose to include codes as separate tabs in this workbook.

Medicaid Section 1115 SMI/SED Demonstrations Monitoring Protocol (Part A) - Planned subpopulations (Version 2.0)
State *Washington*
Demonstration Name *Washington State Medicaid Transformation Project (MTP) Demonstration*

Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Planned Subpopulations

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)	If the planned reporting of subpopulations does not match (i.e., column G = "N"), list the subpopulations state plans to report (Format: comma separated)	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), list the metrics for which state plans to report for each subpopulation category (Format: metric number, comma separated)
EXAMPLE: Age group ***(Do not delete or edit this row)***	*EXAMPLE: Children (Age<16), Transition-age youth (Age 16-24), Adults (Age 25–64), Older adults (Age 65+)*	*EXAMPLE: Required*	*EXAMPLE: Metrics #11, 12, #13, 14, 15, 16, 17, 18, 21, 22*	*EXAMPLE: CMS-provided*	*EXAMPLE: Y*	*EXAMPLE: N*	*EXAMPLE: Children/Young adults (ages 12-21), Adults (ages 21-65)*	*EXAMPLE: Y*	*EXAMPLE:*
Standardized definition of SMI	Individuals who meet the standardized definition of SMI	Required	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	Y			Y	
State-specific definition of SMI	Individuals who meet the state-specific definition of SMI	Required	Metrics #13, 14, 15, 16, 17, 18, 21, 22	State-specific	Y			Y	
Age group	Children (Age<16), Transition-age youth (Age 16-24), Adults (Age 25–64), Older adults (Age 65+)	Required	Metrics #11, 12, 13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	Y	Y		Y	
Dual–eligible status	Dual-eligible (Medicare-Medicaid eligible), Medicaid only	Required	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	Y	Y		Y	
Disability	Eligible for Medicaid on the basis of disability, Not eligible for Medicaid on the basis of disability	Recommended	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	N				
Criminal justice status	Criminally involved, Not criminally involved	Recommended	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	N				
Co-occurring SUD	Individuals with co-occurring SUD	Recommended	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	N				
Co-occurring physical health conditions	Individuals with co-occurring physical health conditions	Recommended	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	N				
[Insert row(s) for any state-specific subpopulation(s)]									

Medicaid Section 1115 SMI/SED Demonstrations Monitoring Protocol (Part A) - SMI/SED Reporting schedule
State *Washington*
Demonstration Name *Washington State Medicaid Transformation Project (MTP) Demonstration*

Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Reporting Schedule

Instructions:

(1) In the reporting periods input table (Table 1), use the prompt in column A to enter the requested information in the corresponding row of column B. All report
(2) Review the state's reporting schedule in the SMI/SED demonstration reporting schedule table (Table 2). For each of the reporting categories listed in column E,

Table 1. Reporting Periods Input Table

	Demonstration reporting periods/dates
Dates of first SMI/SED reporting quarter:	
(Format SMI/SED DYQ; Ex. DY1Q1)	DY1Q1
Start date (MM/DD/YYYY)[a]	01/01/2021
End date (MM/DD/YYYY)	03/01/2021
Broader section 1115 demonstration reporting period corresponding with the first SMI/SED reporting quarter, if applicable. If there is no broader demonstration, fill in the first SMI/SED reporting period. (Format DYQ; Ex. DY3Q1)	DY5Q1
First SMI/SED report due date (per STCs) (MM/DD/YYYY)	06/02/2021
First SMI/SED report in which the state plans to report annual metrics that are established quality measures (EQMs):	
Baseline period for EQMs (Format CY; Ex. CY2019)	CY2020
associated with report (Format SMI/SED DYQ; Ex. DY1Q1)	DY2Q2
Start date (MM/DD/YYYY)	04/01/2022
End date (MM/DD/YYYY)	06/30/2022
Dates of last SMI/SED reporting quarter:	
Start date (MM/DD/YYYY)	10/01/2022
End date (MM/DD/YYYY)	12/31/2022

Table 2. SMI/SED Demonstration Reporting Schedule

Dates of SMI/SED reporting quarter (MM/DD/YYYY - MM/DD/YYYY) Start date	End date	Report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DYQ; Ex. DY1Q3)[b] SMI/SED	Deviation from standard reporting schedule (Y/N)	Explanation for deviations (if column G="Y")	Proposed deviations from standard reporting schedule (Format DYQ; Ex. DY1Q3)
01/01/2021	03/01/2021	06/02/2021	DY5Q1	Narrative information	DY1Q1	N		
				Grievances and appeals	DY1Q1	Y	See Attachment A	None
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
04/01/2021	06/30/2021	08/29/2021	DY5Q2	Narrative information	DY1Q2	N		
				Grievances and appeals	DY1Q2	Y	See Attachment A	None
				Other monthly and quarterly metrics	DY1Q1	Y	See Attachment A	None
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
07/01/2021	09/30/2021	11/29/2021	DY5Q3	Narrative information	DY1Q3	N		
				Grievances and appeals	DY1Q3	Y	See Attachment A Will report from January 2020 - March 2021	DY1Q1
				Other monthly and quarterly metrics	DY1Q2	Y	See Attachment A Will report from January 2020 - March 2021	DY1Q1
				Annual availability assessment				
				Annual metrics that are established quality measures		Y	Will report baseline annual metrics (January - December 2020) with this report)	CY2020
				Other annual metrics		Y	Will report baseline annual metrics (January - December 2020) with this report)	
10/01/2021	12/31/2021	03/01/2022	DY5Q4	Narrative information	DY1Q4	N		
				Grievances and appeals	DY1Q4	Y	See Attachment A	DY1Q2
				Other monthly and quarterly metrics	DY1Q3	Y	See Attachment A	DY1Q2
				Annual availability assessment	AA1			
				Annual metrics that are established quality measures				
				Other annual metrics				
01/01/2022	03/31/2022	06/29/2022	DY6Q1	Narrative information	DY2Q1	N		
				Grievances and appeals	DY2Q1	Y	See Attachment A	DY1Q3
				Other monthly and quarterly metrics	DY1Q4	Y	See Attachment A	DY1Q3
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics	DY1	Y	State proposed reporting other annual metrics for the measurement period of Oct 2020 – Sept 2021	
04/01/2022	06/30/2022	08/29/2022	DY6Q2	Narrative information	DY2Q2	N		
				Grievances and appeals	DY2Q2	Y	See Attachment A	DY1Q4
				Other monthly and quarterly metrics	DY2Q1	Y	See Attachment A	DY1Q4
				Annual availability assessment				
				Annual metrics that are established quality measures	CY2021	N		
				Other annual metrics				
07/01/2022	09/30/2022	11/29/2022	DY6Q3	Narrative information	DY2Q3	N		
				Grievances and appeals	DY2Q3	Y	See Attachment A	DY2Q1
				Other monthly and quarterly metrics	DY2Q2	Y	See Attachment A	DY2Q1
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
10/01/2022	12/31/2022	03/01/2023	DY6Q4	Narrative information	DY2Q4	N		
				Grievances and appeals	DY2Q4	Y	See Attachment A	DY2Q2
				Other monthly and quarterly metrics	DY2Q3	Y	See Attachment A	DY2Q2
				Annual availability assessment	AA2			
				Annual metrics that are established quality measures				
				Other annual metrics				
				Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				

01/01/2023	03/31/2023	06/29/2023	DY7Q1	Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
04/01/2023	06/30/2023	08/29/2023	DY7Q2	Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
07/01/2023	09/30/2023	11/29/2023	DY7Q3	Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
10/01/2023	12/31/2023	02/29/2024	DY7Q4	Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
01/01/2024	03/31/2024	06/29/2024	DY8Q1	Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
04/01/2024	06/30/2024	08/29/2024	DY8Q2	Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
07/01/2024	09/30/2024	11/29/2024	DY8Q3	Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
10/01/2024	12/31/2024	03/01/2025	DY8Q4	Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
01/01/2025	03/31/2025	06/29/2025	DY9Q1	Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
04/01/2025	06/30/2025	08/29/2025	DY9Q2	Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
07/01/2025	09/30/2025	11/29/2025	DY9Q3	Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
10/01/2025	12/31/2025	03/01/2026	DY9Q4	Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				

Add rows for all additional demonstration reporting quarters

Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations Monitoring Protocol Template

Note: PRA Disclosure Statement to be added here

1. **Title page for the state's serious mental illness and serious emotional disturbance (SMI/SED) demonstration or the SMI/SED component of the broader demonstration**

The state should complete this title page as part of its SMI/SED monitoring protocol. This form should be submitted as the title page for all monitoring reports. The content of this table should stay consistent over time. Definitions for certain rows are below the table.

State	*Washington State.*
Demonstration name	*Washington State Medicaid Transformation Project No. 11-W-00304/0*
Approval period for section 1115 demonstration	*January 9, 2017-December 31, 2021).*
SMI/SED demonstration start date[a]	*Enter the start date for the section 1115 SMI/SED demonstration or SMI/SED component if part of a broader demonstration (11/06/2020).*
Implementation date of SMI/SED demonstration, if different from SMI/SED demonstration start date[b]	*01/01/2021.*
SMI/SED (or if broader demonstration, then SMI/SED - related) demonstration goals and objectives	*The intent of this demonstration is to support systemic changes to improve the lives of Washington Medicaid enrollees with SMI/SED service needs by: improving access, quality, oversight, crisis services and service coordination consistent milestones of the November 13th, 2018 SMDL letter*

[a] **SMI/SED demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at time of SMI/SED demonstration approval. For example, if the state's STCs at the time of SMI/SED demonstration approval note that the SMI/SED demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the SMI/SED demonstration. Note that the effective date is considered to be the first day the state may begin its SMI/SED demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on 12/15/2020, with an effective date of 1/1/2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

[b] **Implementation date of SMI/SED demonstration:** The date the state began claiming federal financial participation for services provided to individuals in institutions of mental disease.

2. Acknowledgement of narrative reporting requirements

☒ The state has reviewed the narrative questions in the Monitoring Report Template provided by CMS and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested narrative information (with no modifications).

3. Annual Assessment of the Availability of Mental Health Services reporting

☒ The state will use data as of the following month and day of each calendar year to conduct its Annual Assessment of the Availability of Mental Health Services:

December 31

4. Acknowledgement of budget neutrality reporting requirements

☒ The state has reviewed the Budget Neutrality Workbook provided by the CMS demonstration team and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (with no modifications).

5. Retrospective reporting

The state is not expected to submit metrics data until after monitoring protocol approval, to ensure that data reflects the monitoring plans agreed upon by CMS and the state. Prior to monitoring protocol approval, the state should submit quarterly and annual monitoring reports with narrative updates on implementation progress and other information that may be applicable, according to the requirements in its STCs.

For a state that has monitoring protocols approved after one or more initial quarterly monitoring report submissions, it should report metrics data to CMS retrospectively for any prior quarters of the section 1115 SMI/SED demonstration that precede the monitoring protocol approval date. A state is expected to submit retrospective metrics data—provided there is adequate time for preparation of these data—in its second monitoring report submission that contains metrics. The retrospective report for a state with a first SMI/SED DY of less than 12 months should include data for any baseline period quarters preceding the demonstration, as described in Part A of the state's monitoring protocol (see Appendix B of the instructions for further guidance determining baseline periods for first SMI/SED DYs that are less than 12 months). If a state needs additional time for preparation of these data, it should propose an alternative plan (i.e., specify the monitoring report that would capture the data) for reporting retrospectively on its SMI/SED demonstration.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of its demonstration through the end of the current reporting period. The state should report this information in Part B of its report submission (Section 3. Narrative information on implementation, by milestone and reporting topic). This general assessment is not intended to be a comprehensive description of every trend observed in metrics data. Unlike other

monitoring report submissions, for instance, the state is not required to describe all metrics changes (+ or - greater than 2 percent). Rather, the assessment is an opportunity for the state to provide context for its retrospective metrics data, to support CMS's review and interpretation of these data. For example, consider a state that submits data showing an increase in the utilization of telehealth services for mental health (Metric #15) over the course of the retrospective reporting period. The state may decide to highlight this trend to CMS in Part B of its monitoring report (under Milestone 3) by briefly summarizing the trend and providing context that during this period, the state implemented a grant to improve access to mental health treatment in rural areas through the use of telemedicine.

For further information on how to compile and submit a retrospective report, the state should review Section B of the Monitoring Report Instructions document.

☒ The state will report retrospectively for any quarters prior to monitoring protocol approval as described above, in the state's second monitoring report submission that contains metrics after monitoring protocol approval.

☐ The state proposes an alternative plan to report retrospectively for any quarters prior to monitoring protocol approval: *Insert narrative description of proposed changes to retrospective reporting. The state should provide justification for its proposed alternative plan.*

Attachment A: Monitoring Metric Supplemental Information

Medicaid Section 1115 SMI/SED Demonstration Monitoring Protocol – Additional Information to Support Monitoring Metric Specifications

Submitted March 1, 2022

Background and Introduction

The State will be leveraging multiple analytic teams to produce the required metric reporting. These analytic teams include the Health Care Authority's Analytics, Research, and Measurement team, the Health Care Authority's Finance and Medicaid Program Office of Integrity, and the Department of Social and Health Services Research and Data Analysis Division. Between the analytic teams, the State has an extensive existing data infrastructure that the State intends to leverage for the CMS reporting requirements. This existing infrastructure currently completes reporting for various entities, including the Adult and Child Common Measure Set and mental health related Substance Abuse Mental Health Services Administration (SAMHSA) reporting. This analytic infrastructure also supports a number of ongoing activities in the realm of health care transformation. These include, but are not limited to, Washington's movement towards the integration of behavioral and physical health care and all three initiatives of the initial Medicaid Transformation Project (Transformation through Accountable Communities of Health, Long-Term Services and Supports of the Aging Population, and Foundational Community Support Services).

The State analytic teams have reviewed the CMS provided specifications and reporting procedures. Per the instructions in the Monitoring Protocol, the State will explain any deviations from the CMS-provided specifications that are needed to match the health care context and data infrastructure within Washington State. The State created this attachment to minimize duplication of explanation of requested modifications which apply to multiple metrics, and to provide details on state-specified metrics that would not fit within the given metric workbook template.

The State thanks CMS for the opportunity to align the specifications with the State's health care context, data infrastructure, and existing 1115(a) demonstration. We welcome any questions or concerns from CMS regarding these requests.

Overview of 1115 SMI Demonstration Monitoring Metrics

This section describes the data sources the State will be drawing on, how the State will align the Serious Mental Illness (SMI) measurement periods with the State's broader 1115(a) demonstration reporting cycle, and will note the reporting level for all metrics.

Description of Data Sources

Integrated Client Databases and ProviderOne (MMIS). SMI demonstration monitoring metric production will leverage the integrated administrative data maintained in the Department of Social and Health Services Integrated Client Databases (ICDB) and ProviderOne (the state's Medicaid Management Information System). The ICDB was explicitly designed to support quasi-experimental evaluation of health and social service interventions in Washington State, and has been widely used in evaluation

studies published in peer-reviewed journals[1] and for the production of performance and monitoring measures. The underlying reporting arrays are regularly updated to align with State requirements. The State has analyzed completion factors based on the historical encounter data submitted to the State's MMIS by contracted MCOs responsible for SMI services. This completion factor analysis indicates that fewer than 90% of ultimately accepted encounters are uploaded and successfully accepted into the MMIS by five months from the month the service was provided to the client. Reporting with a 90-day lag would result in an even greater systematic undercount of services provided in the most recent reporting period. The State believes that reporting information that is known to be undercounted will negatively impact the IMD waiver program. The State requests a 6-month reporting lag to allow for reporting of information that is more complete. Even with the proposed 6-month reporting lag, we recommend provisions for updating information previously reported with more complete data when it becomes available.

The State also requests the ability to calculate the monthly metrics once per quarter. Per CMS' technical assistance document Reporting 1115 SMI Demonstration Monitoring Metrics "…if a state submits data on a quarterly basis, the submission should contain three monthly values for each monthly metric, each produced at the same time relative to their measurement periods." However, the underlying production schedule for the State's analytic environment is quarterly. The State is unable to change the global production cycle and fundamental infrastructure to accommodate this monitoring expectation. In addition, some of the data necessary for the monthly metrics is updated quarterly and would not be up to date for two months of each quarter. The State understands that part of CMS' reasoning for producing the monthly metrics at the same time relative to their measurement periods is due to the dynamic nature of Medicaid data. Observing a 6-month reporting lag mitigates this impact.

Measurement Period

Per CMS's instructions and in alignment with the Special Terms and Conditions (Schedule of State Deliverables for the Demonstration Period (XV), Washington will align the reporting cycles for the SMI Demonstration Amendment with the broader section 1115(a) demonstration quarterly and annual reporting cycles. Table 1 shows the current reporting cycle to the broader section 1115(a) demonstration.

Aligning to this reporting cycle will require a modification to the measurement periods in the technical specification document. The effective date of the Washington SMI demonstration is December 23, 2020. However, to align with this reporting structure, we will use January 1, 2021 as the start date for the measurement periods. This does not change the effective date of the demonstration. Washington is in favor of this modification, as it closely aligns with our current data infrastructure and reporting processes. For example, Medicaid enrollment is verified monthly in Washington, and thus all eligibility requirements will need to be based around calendar months. It would be impracticable for the State to make the substantial modifications to our current infrastructure that would be required to report on a different quarterly cycle.

[1] For a recent example, see Jingping Xing, Candace Goehring and David Mancuso. Care Coordination Program For Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs Care Coordination Program For Washington State. Health Affairs, 34, no.4 (2015):653-661.

TABLE 1.

Washington's 1115(a) Waiver Quarterly and Annual Reporting Cycle

Quarter/Annual Report Cycle	MTP Reporting Period	Report Due Date
DY4 Q4 (Annual Report DY4)	Jan 2020 – Dec 2020	03/01/2021
DY5 Q1	Jan 2021 – March 2021	06/01/2021
DY5 Q2	April 2021 – June 2021	09/01/2021
DY5 Q3	July 2021 – Sept 2021	12/01/2021
Final Report	Jan 2021 – Dec 2021	06/30/2022
DY5 Q4 (Annual Report DY5)	Jan 2021 – Dec 2021	03/01/2021
DY6 Q1	Jan 2022 – March 2022	06/01/2022
DY6 Q2	April 2022 – June 2022	09/01/2022
DY6 Q3	July 2022 – Sept 2022	12/01/2022
Final Report*	Jan 2022 – Dec 2022	06/30/2022

*The State will be submitting an 1115 renewal request. Should the request be approved, the additional quarterly and annual reporting cycles will be added.

In addition, this also aligns with reporting cycles for other related SMI projects and the Washington State fiscal year. The modified measurement periods for the monthly, quarterly, and annual metrics are described next and in the table below.

- For metrics with a monthly measurement period, the first monthly measurement period is the month the SMI demonstration began – January 1, 2021 to January 31, 2021. The second month is February 1, 2021 to February 28, 2021, and so forth.
- For metrics with a quarterly measurement period, the first quarter of the demonstration is the first three months of the demonstration – January 1, 2021 to March 31, 2021.
- For the CMS-constructed metrics with an annual measurement period, the first annual measurement period is the first twelve months of the demonstration – January 1, 2021 to December 31, 2021.
- For the established quality measures, the first annual measurement period is the calendar year in which the demonstration began – January 1, 2021 to December 31, 2021.

As previously discussed with CMS and consistent with the monitoring protocol for the SUD IMD waiver, the State believes setting the baseline to the year prior to the change in authorizing expenditure authority is needed to appropriately set demonstration targets, annual goals, and to ultimately respond to the demonstration hypothesis specific to the SMI amendment (STC 118). Thus, the State requests to define the baseline year as January 1, 2020 to December 31, 2020 for the CMS-constructed metrics (monthly, quarterly, and annual) and January 1, 2020 to December 31, 2020 for the established quality measures.

The State will begin reporting after a monitoring protocol has been agreed upon by the State and CMS, and sufficient time is provided to implement the metric specifications as stated in the agreed upon monitoring protocol. The requested reporting schedule in Table 2 below may change depending on when the monitoring protocol is approved. The reporting schedule also specifies a baseline reporting period of January 1, 2020 to December 31, 2020 for CMS constructed metrics and January 1, 2020 to December 31, 2020 for established quality measures. In addition, Table 2 employs the 6-month reporting lag that is necessary for the State to submit data that does not substantially undercount the

number of services provide. The proposed reporting schedule also aligns with the SMI/SED Demonstration Reporting Schedule in the Monitoring Protocol Workbook.

TABLE 2.
Proposed Reporting Schedule for Washington Metrics for SMI Demonstration

Dates of reporting quarter	WA's SMI DY: Jan - Dec	WA's broader 1115 DY: Jan 1 – Dec 31 (type of report)	Report due (per STCs schedule)	SMI metrics included in report	Reporting period of SMI metrics
Oct – Dec 2020	*waiver approved 12/23/2020*	DY4 Q4 (annual)	3/1/2021	N/A	N/A
Jan – Mar 2021	DY1 Q1	DY5 Q1 (quarterly)	6/2/2021	No SMI metrics reported. Monitoring protocol under development.	N/A
Apr – Jun 2021	DY1 Q2	DY5 Q2 (quarterly)	9/1/2021	No SMI metrics reported. Monitoring protocol under development.	N/A
Jul – Sept 2021	DY1 Q3	DY5 Q3 (quarterly)	12/1/2021	No SMI metrics reported. Monitoring protocol under development.	N/A
Oct – Dec 2021	DY1 Q4	DY5 Q4 (annual)	3/1/2022	No SMI metrics reported. Monitoring protocol under development.	N/A
Jan – Mar 2022	DY2 Q1	DY6 Q1 (quarterly)	6/2/2022	(1) Monthly metrics (2) Quarterly metrics (3) Established quality metrics (4) Other annual metrics	(1) Jan 2020 – Sept 2021 (2) Jan 2020 – Sept 2021 (3) January – December 2020 (4) January – December 2020
Apr – Jun 2022	DY2 Q2	DY6 Q2 (quarterly)	9/1/2022	(1) Monthly metrics (2) Quarterly metrics (3) Established quality metrics (4) Other annual metrics	(1) October – December 2021 (2) October – December 2021 (3) January – December 2021 (4) January – December 2021
Jul – Sept 2022	DY2 Q3	DY6 Q3 (quarterly)	12/1/2022	(1) Monthly metrics (2) Quarterly metrics	(1) January – March 2022 (2) January – March 2022
Oct – Dec 2022*	DY2 Q4	DY6 Q4 (annual)	3/1/2023	(1) Monthly metrics (2) Quarterly metrics	(1) April – June 2022 (2) April – June 2022

** Currently the SMI Demonstration ends on December 31, 2022. Data from July 1, 2022 to December 31, 2022 will not be available before the final annual report is due to CMS.*

Reporting Level

For each metric, the demonstration population is defined as the whole state. In addition, the State's SMI amendment is not focused on a particular geographic area or a specific subpopulation of Medicaid beneficiaries. Thus, per previous conversations with CMS, the State will not be reporting a separate model population.

Reporting 1115 SMI Demonstration Monitoring Metrics Defined by CMS

This section defines the subpopulations for metric reporting and provides additional information about the State's approach to metric calculation and reporting.

Subpopulation Definitions

- Standardized definition of SMI: Per the 1115_SMI_TechSpecsManualV2.pdf, Table B.1 for applicable value sets and Appendix E: Standardized Definition of SMI, the standardized definition of SMI will align with the NCQA definition.

  - Age (children <16, transition age youth 16-24, adults 25-64, and older adults 65+): Age will be determined as of the first day of the measurement period. This is consistent with CMS provided instructions. Age breakouts will be reported for the cohort of beneficiaries that meet the CMS definition of SMI.
  - Dual-eligible status (Medicaid only or Medicare-Medicaid eligible): Dual eligibility will be determined as of the first day of the measurement period. This is consistent with CMS provided instructions. Dual-eligible status breakouts will be reported for the cohort of beneficiaries that meet the CMS definition of SMI.
- State-specific definition of SMI: Per agreement with CMS, the state-specific definition of SMI/SED is under development.

Metric Calculation and Reporting

As CMS noted, Medicaid data is dynamic prior to reaching a data maturity threshold. For Washington State, that threshold is six-months. Observing a six-month data lag allows the State to represent the most complete data set for the measurement period. Any data lag less than six-months will result in potentially incomplete data and misrepresentative metric results. In addition, the six-month data lag allows for the inclusion of up to date information from data sources that are updated on a quarterly cadence, such as the Washington State Identification System arrest database, which the State will be using to define the “criminally involved” subpopulation as noted above.

Using a six-month data lag also allows the State to leverage the existing quarterly performance measurement processes to calculate the required metrics. Thus, required monthly reporting will be calculated at the same time once per quarter. All the data will be, at a minimum, matured to six-months thus minimizing the likelihood of any variability due to data completeness. This is consistent with the CMS approved monitoring protocol for the state’s SUD IMD waiver.

Metric Specifications

This section provides additional detail on a subset of metric specifications. Other metric specification modifications are noted in the Monitoring Protocol 1115 SMI Metrics Workbook.

Metric # 36: Grievances Related to Services for SMI/SED

The State is requesting two modifications to Metric #36 to reflect the state-level process of reviewing grievances and existing reporting infrastructure. This metric will be restricted to Medicaid beneficiaries who are enrolled with a Managed Care Organization and will exclude fee for service Medicaid beneficiaries. All mental health service related grievances (includes both outpatient and inpatient related grievances) will be included in the metric. The State does not differentiate between SMI/SED and non-SMI/SED related grievances.

Metric #37: Appeals Related to Services for SMI/SED

Consistent with Metric #36, the State is requesting two modifications to Metric #37 to reflect the state-level process of reviewing appeals and existing reporting infrastructure. This metric will be restricted to Medicaid beneficiaries who are enrolled with a Managed Care Organization and will exclude fee for service Medicaid beneficiaries. All mental health service related appeals (includes both outpatient and inpatient related appeals) will be included in the metric. The State does not differentiate between SMI/SED and non-SMI/SED related appeals.

Metric #38: Critical Incidents Related to Services for SMI/SED

Consistent with Metric #36 and Metric #37, the State is requesting two modifications to Metric #38 to reflect the state-level process of the critical incident reporting infrastructure. This metric will be restricted to Medicaid beneficiaries who are enrolled with a Managed Care Organization and will exclude fee for service Medicaid beneficiaries. All critical incidents for Medicaid beneficiaries with a recent history of mental health treatment will be included. The State does not differentiate between SMI/SED and non-SMI/SED mental health related critical incidents.

HIT Metric Specifications

Q1: Community Based Psychiatric Hospitals Using HIT for Discharge Summaries. After reviewing the list of sample metrics provided by CMS, the State is proposing a process metric that will identify the percent of Medicaid participating community based psychiatric hospitals with access to technology tools to create and send discharge summaries.

Metric Description: This metric will report the percentage of community-based psychiatric hospitals that use Collective Medical (CM) technology tools for the creation and exchange of interoperable discharge summaries on behalf of individuals being discharged from the psychiatric hospital/psychiatric unit to the community based providers (e.g., primary care providers). The discharge summary would be created and exchanged using the Admission, Discharge, and Transfers (ADT) standard.

Data Source: Annual survey of psychiatric hospitals/psychiatric units.

Identification Window: Measurement year (January 1 – December 31)

Denominator: Total number of community-based psychiatric hospitals/psychiatric units that participate in Medicaid.

Numerator: Number of community-based psychiatric hospitals/psychiatric units that participate in a Medicaid that uses the CM system to create and send ADTs to the receiving community-based providers.

Q2: Mental Health Treatment Penetration Rate. After reviewing the list of sample metrics provided by CMS, the State was concerned about the limitations and uncertainties in technology adoption by providers treating individuals with SMI/SED. Thus, the State is proposing a metric that relies on the use of electronic claims/encounter data to identify individuals with a mental health treatment need who received a qualifying mental health service. This also aligns with HIT metric #2 in the state's SUD IMD waiver monitoring protocol (SUD treatment penetration rate). This metric includes mental health treatment services that are delivered via telehealth and allows the state to track the overall treatment penetration rate across service modalities. The state expects that improvements to information technology infrastructure for providers and recipients of telehealth mental health treatment will be reflected in this metric.

Metric Description: The percentage of Medicaid beneficiaries, 6 years of age and older, with a mental health service need identified within the past two years, who received at least one qualifying service during the measurement year.

Data Source: Administrative data.

Identification Window: Measurement year and the year prior to the measurement year.

Eligible Population	
Age	6 years and older. Age is as of the last day of the measurement year.
Gender	N/A
Minimum Medicaid enrollment	Measurement year. Enrollment must be continuous.
Allowable gap in Medicaid enrollment	One gap of one month during the measurement year.
Medicaid enrollment anchor date	Last day of measurement year.
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid and beneficiaries with primary insurance other than Medicaid.

Denominator: Medicaid beneficiaries, aged 6 and older on the last day of the measurement year, with a mental health service need identified in either the measurement year or the year prior to the measurement year.

Mental health service need is identified by the occurrence of any of the following conditions:

- Receipt of any mental health service encounter meeting the numerator service criteria in the 24-month identification window
- Any diagnosis of mental illness (not restricted to primary) in the MI-Diagnosis code set in the 24-month identification window
- Receipt of any psychotropic medication listed in the Psychotropic-NDC code set in the 24-month identification window

Value sets required for denominator.

Name	Value Set
MI-Diagnosis code set	All value sets are available upon request.
Psychotropic-NDC code set	
MH-Proc1 value set	
MH-Taxonomy value set	
MH-Proc2 value set	
MH-Proc3 value set	
MI-Diagnosis	
MH-Proc4	
MH-Proc5	

Numerator: Beneficiaries must qualify for inclusion in the denominator to be eligible for inclusion in the numerator. Members receiving at least one mental health service meeting at least one of the following criteria, applied by claim line, in the 12-month measurement year:

- Receipt of an outpatient service with a procedure code in the MH-Proc1 value set (MCG 261) **OR**
- Receipt of an outpatient service with:
  - Servicing provider taxonomy code in the MH-Taxonomy value set (MCG262) AND
  - Procedure code in MH-Proc2 value set (MCG 4947) OR MH-Proc3 value set (MCG 3117) AND
  - Primary diagnosis code in the MI-Diagnosis value set

  OR
- Receipt of an outpatient service with:
  - Procedure code in MH-Proc4 value set (MCG 4491) AND
  - Any diagnosis code in the MI-Diagnosis value set

  OR
- Receipt of an outpatient service with:
  - Servicing provider taxonomy code in the MH-Taxonomy value set (MCG262) AND
  - Procedure code in MH-Proc5 value set (MCG 4948) AND
  - Any diagnosis code in the MI-Diagnosis value set

  OR
- Receipt of an outpatient service with:
  - Procedure code in MH-Proc3-MCG3117 AND
  - Primary diagnosis code in the MI-Diagnosis value set

Value sets required for numerator.

Name	Value Set
MI-Diagnosis code set	All value sets are available upon request.
Psychotropic-NDC code set	
MH-Proc1 value set	
MH-Taxonomy value set	
MH-Proc2 value set	
MH-Proc3 value set	
MI-Diagnosis	
MH-Proc4	
MH-Proc5	

Q3: Foundational Community Supports Beneficiaries with Inpatient or Residential Mental health Service. After reviewing the list of sample metrics provided by CMS, the State was concerned about the limitations and uncertainties in technology adoption by providers treating individuals with SMI (e.g., lack of use of shared care plans, lack of connectivity between correctional health systems and community-based providers, limitations and variations in provider/resource directories). Thus, the State focused on developing a metric that links delivery of recovery supports provided through the Foundational

Community Supports (FCS) program (implemented as part of the Medicaid Transformation Program) to persons who had received mental health services in an inpatient or residential treatment facility. The metric relies on the use of electronic eligibility and claims/encounter data. This metric also aligns with the Q3 metric for the SUD IMD waiver monitoring protocol.

Metric Description: Percent of Foundational Community Supports (FCS) eligible Medicaid beneficiaries, age 18 and older, with a mental health related inpatient or residential treatment stay within the past two years, who enrolled in at least one FCS service during the measurement year.

Data Source: Administrative data.

Identification Window: Measurement year and the year prior to the measurement year.

Eligible Population	
Age	Age 18 and older. Age is as of the last day of the measurement year.
Gender	N/A
Minimum Medicaid enrollment	Measurement year. Enrollment must be continuous.
Allowable gap in Medicaid enrollment	One gap of one month during the measurement year.
Medicaid enrollment anchor date	Last day of measurement year.
Medicaid benefit and eligibility	Beneficiaries who qualify for Medicaid in any of the following categories: Categorically Needy Blind/Disabled, Categorically Needy Aged, Categorically Needy Apple Health for Workers with Disabilities (HWD), Categorically Needy Pregnant Women, Affordable Care Act Expansion Adults, Categorically Needy Family Medical, Categorically Needy Children, Children's Health Insurance Program (CHIP), Categorically Needy Children- Foster Care between 18 to 26 Years of Age

Denominator: Medicaid beneficiaries, who meet the eligibility requirements as stated above, with a mental health related inpatient or residential treatment stay within the measurement year or the year prior to the measurement year.

Numerator: Beneficiaries must qualify for inclusion in the denominator to be eligible for inclusion in the numerator. Include in the numerator all individuals who ever enrolled in at least one FCS service during the measurement year.