Washington State Health Care Authority

Washington State Medicaid Transformation Project (MTP) demonstration

Section 1115 Waiver Quarterly Report (DY7 Q1)

Reporting quarter: 1 (January 1 to March 31, 2023)

Table of contents

Introduction 4
Vision: a healthier Washington 4
Quarterly report: January 1–March 31, 2023 5
Summary of quarter accomplishments 5
MTP-wide stakeholder engagement 5
Statewide activities and accountability 6
Value-based purchasing (VBP) 6
VBP Roadmap and Apple Health Appendix 6
Validation of financial performance measures 6
Statewide progress toward VBP targets 6
Technical support and training 6
Upcoming activities 6
VBP website section and infographics 6
Figure 1: One HCA VBP purchasing strategy 7
Figure 2: progress towards HCA's 90 percent VBP adoption goal 8
Integrated managed care (IMC) progress 8
Health information technology (Health IT) 9
Activities and successes 9
DSRIP program implementation accomplishments 11
ACH project milestone achievement 11
Pay-for-reporting (P4R) 11
Next steps 11
Annual VBP milestone achievement by ACHs 11
Financial executor (FE) portal activity 11
DSRIP measurement activities 11
Statewide results 11
DSRIP program stakeholder engagement activities 11
DSRIP stakeholder concerns 12
Upcoming DSRIP activities 12
Tribal project implementation activities 12
Tribal partner engagement timeline 12
LTSS implementation accomplishments 13
Network adequacy for MAC and TSOA 13
Assessment and systems update 13
Staff training 13
Data and reporting 13
Table 1: beneficiary enrollment by program 13
Figure 3: statewide care plan proficiency to date 14
Tribal engagement 14
Outreach and engagement 14
Table 2: number of outreach and engagement activities held by AAA 14
Quality assurance 15
Figure 4: question 1: was the client appropriately determined to be nursing facility level of care eligible for PE? 15
Figure 5: question 2a: did the client remain eligible after the PE period? 15
Figure 6: question 2b: if "No" to question #2a, why? 16
2023 quality assurance results to date 16
Figure 7: statewide proficiency to date 17
State rulemaking 17
Upcoming activities 17
LTSS stakeholder concerns 17
FCS implementation accomplishments 18
Network adequacy for FCS 18
Table 3: FCS provider network development 18

Client enrollment *18*
Table 4: FCS client enrollment 18
Table 5: FCS client risk profile 18
Table 6: FCS client risk profile continued 19
Table 7: FCS client service utilization 19
Table 8: FCS client Medicaid eligibility 19
Quality assurance and monitoring activity *20*
Other FCS program activity *20*
Upcoming activities *21*
FCS program stakeholder engagement activities *21*
Table 9: number of FCS program stakeholder engagement activities held 21
FCS stakeholder concerns *22*
SUD IMD waiver implementation accomplishments 23
Implementation plan *23*
SUD Health IT plan requirements *23*
Evaluation design *23*
Monitoring protocol *23*
Upcoming activities *23*
MHIMD waiver implementation accomplishments 24
Implementation plan *24*
MH Health IT plan requirements *24*
Evaluation design *24*
Monitoring protocol *24*
Upcoming activities *24*
Quarterly expenditures 25
Table 10: DSRIP expenditures 25
Table 11: MCO VBP expenditures 25
Table 12: LTSS and FCS service expenditures 26
Financial and budget neutrality development issues 27
Financial *27*
Table 13: member months eligible to receive services 27
Budget neutrality *29*
Designated state health programs (DSHP) *29*
Overall MTP development and issues 30
Operational/policy issues *30*
Consumer issues *30*
MTP evaluation *30*
Quantitative analysis and Medicaid data 30
Qualitative analysis of Medicaid data 30
Key findings from the latest rapid-cycle report 30
Summary of changes in Medicaid system performance 31
Upcoming IEE activities 31
Summary of additional resources, enclosures, and attachments 32
Additional resources *32*
Summary of attachments *32*
Attachment A: state contacts 33
Attachment B: Financial Executor Portal Dashboard, Q1 2023 34
Attachment C: 1115 SUD Demonstration Monitoring Workbook Part A 35
Attachment D: 1115 SUD Demonstration Monitoring Report Part B 36
Attachment E: 1115 SMI/SED Demonstration Monitoring Workbook Part A 56
Attachment F: 1115 SMI/SED Demonstration Monitoring Report Part B 57

Introduction

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

Over the MTP period, Washington will:

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

The state will accomplish these goals through these programs:

- Transformation through Accountable Communities of Health (ACHs) and Indian Health Care Providers (IHCPs)
- Long-Term Services and Supports (LTSS): Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)
- Foundational Community Supports (FCS): Community Support Services (CSS) and Supported Employment – Individual Placement and Support (IPS)
- SUD IMD waiver: treatment services, including short-term services provided in residential and inpatient treatment setting that qualify as an institution for mental disease (IMD)
- Mental health (MH) IMD waiver: treatment services, including short-term services provided in residential and inpatient treatment settings that qualify as an IMD

Vision: a healthier Washington

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

Quarterly report: January 1 – March 31, 2023

This quarterly report summarizes MTP activities from the first quarter of 2023: January 1 through March 31. It details MTP implementation, including stakeholder education and engagement, planning and implementation, and development of policies and procedures.

Summary of quarter accomplishments

- Washington State and CMS continued negotiations on the MTP 2.0 application for renewal, along with submission for the MTP amendment request on the current waiver and preparation for the public comment period.
- ACHs distributed $32,856,256 to 215 partnering providers and organizations in support of implementation activities and performance incentives. The state distributed approximately $1,766,819 in earned incentive funds to IHCPs in Q1 for achievement of IHCP-specific project milestones.
- As of March 31, 2023, more than 14,750 clients have received services and supports from the MAC and TSOA programs. New enrollees in LTSS for this reporting period include 242 MAC dyads, 1126 TSOA dyads, and 3007 TSOA individuals.
- Within FCS, the total aggregate number of people enrolled in services as of March 31, 2023, included 5,738 in IPS and 10,870 in CSS. The total unduplicated number of enrollments at the end of this reporting period was 12,883.

MTP-wide stakeholder engagement

During the reporting quarter, HCA prepared for the MTP amendment request public comment period—which will occur next quarter—from April 20 to May 22. To prepare for this, HCA renamed the "one year extension and amendment" page to "MTP amendment request." Read the announcement. The agency also updated the content on the new MTP amendment request page, which initially held content about the MTP amendment request Washington State requested in late 2021.

HCA also worked on developing and coordinating the required communications for the MTP amendment request public comment period, including a/an:

- Amendment request and its appendices
- Executive summary
- Director's letter to CMS
- Dear Tribal Leader Letter
- Washington State Register notice
- Webpage content for when public comment officially opens (April 20)
- Slide deck for the public hearings

In addition to MTP amendment request efforts, the MTP team continues to share information with agency leadership and partners about the status of MTP 2.0. HCA provides information about renewal negotiations and partnership with CMS, and the extended end date for the current MTP waiver period (June 30, 2023).

Statewide activities and accountability

Value-based purchasing (VBP)

VBP Roadmap and Apple Health Appendix

The VBP Roadmap describes HCA's VBP goals, purchasing and delivery system transformation strategies, innovation successes to date, and plans to accelerate the transition into value-based payment models. The appendix, in accordance with the STCs, describes how MTP supports providers and MCOs to move along the value-based care continuum. The roadmap establishes targets for VBP attainment and related Delivery System Reform Inventive Payment (DSRIP) incentives for MCOs and ACHs. In Q4 of 2022, HCA updated the annual roadmap and the VBP website. In Q1 of 2023, these changes were released publicly.

Validation of financial performance measures

HCA contracts with Myers and Stauffer LC (MSLC) to serve as the independent Assessor (IA) for MTP. In this role, the IA functions as the third-party assessor of financial measures data submitted by MCOs as part of their contracts with HCA. HCA's contracts with the five MCOs establish parameters for the VBP assessment process. These parameters include the financial performance measures, the timelines under which MCOs must submit data, and the review process, which includes third party validation. HCA will meet with MSLC in Q2 to begin the 2023 validation process.

Statewide progres s toward VBP targets

HCA sets annual VBP adoptions targets for MCOs and ACH regions in alignment with HCA's state-financed purchasing goals. To track progress, HCA collects financial performance measure data from MCOs by ACH region through the VBP validation process and from commercial and Medicare payers and providers through an annual survey. HCA completed the analysis of these data in Q4 of 2022 (DY6) and shared the results on our website.

Technical support and training

No activities to report in Q1 of 2023.

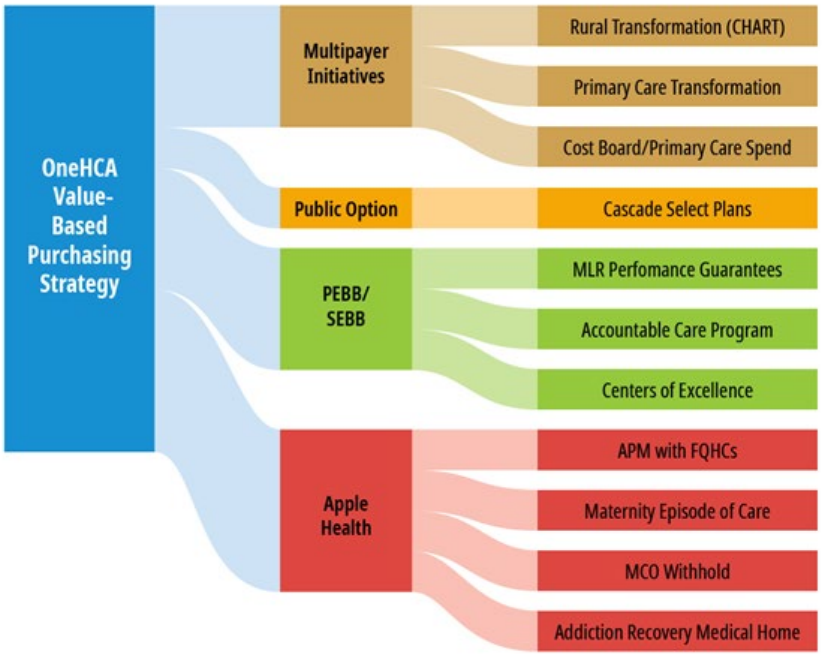
Upcoming activities

HCA will begin revising the annual Paying for Value Survey in Q2 of 2023.

VBP website section and infographics

During this reporting period, HCA began updating language for the VBP website section. This work will continue through next quarter. In addition, the agency also developed two infographics: one that illustrates OneHCA VBP purchasing strategy and another that shows progress towards HCA's 90 percent VBP adoption goal.

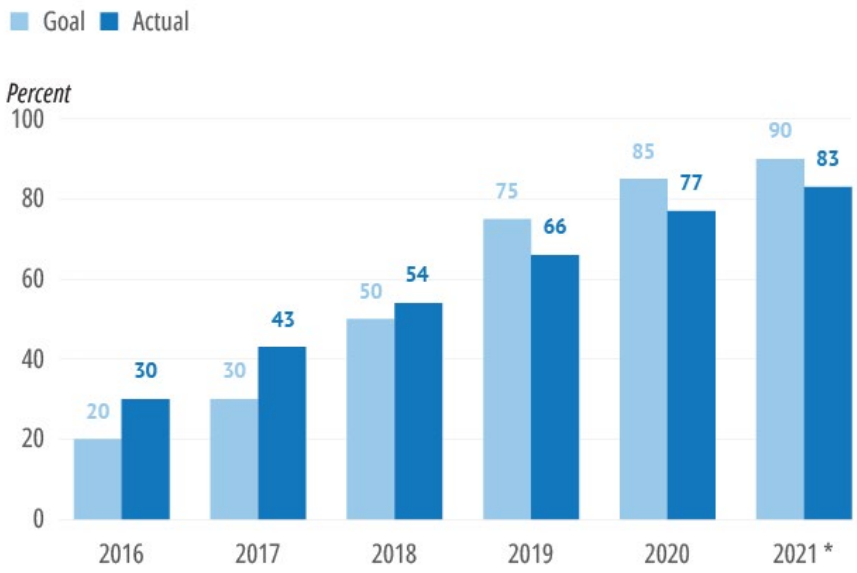
Figure 1: OneHCA VBP purchasing strategy



This figure shows how all of HCA's programs and initiatives fall under the OneHCA purchasing philosophy. An overarching blue box that says "OneHCA value-based purchasing strategy" has four branches that say "Multipayer initiatives," "Public option," "PEBB/SEBB," and "Apple Health." Each of those four branches have their own branches representing their respective programs. They are as follows:

- Multipayer initiatives: Rural transformation (CHART), primary care transformation, and Cost Board/primary care spend.
- Public option: Cascade Select plans.
- PEBB/SEBB: MLR performance guarantees, Accountable Care Program, and Centers of Excellence.
- Apple Health: APM with FQHCs, Maternity Episode of Care, MCO withhold, and addiction recovery medical home.

Figure 2: progress towards HCA's 90 percent VBP adoption goal



*The MCOs contractual targets for 2021 were adjusted to 85 percent due to COVID-19. The overall agency goal remained at 90 percent

Integrated managed care (IMC) progress

In 2021, Washington State completed its research to identify a new clinical integration assessment tool to better support the advancement of bidirectional physical and behavioral health clinical integration in the state. The tool, called the Washington Integrated Care Assessment (WA-ICA), is completed by outpatient behavioral and physical health practices. WA-ICA tracks progress toward clinical integration and serves as a roadmap for practice teams to advance integration.

Domains and subdomains (evidence-based elements of bidirectional integration) on the WA-ICA include screenings, referrals, care management, and sharing treatment information. A complete list of the domains and more information about the tool is available on the HCA website.

During Q1 of 2023, HealthierHere, the ACH that serves King County, acted as the data management entity for Cohort 1. HealthierHere compiled and analyzed data received from the completion of the WA-ICA by Cohort 1 practices. Across Washington State, 126 behavioral health (BH) and 79 primary care (PC) practices participated. HealthierHere created and distributed the first set of statewide reports. These reports included the aggregated results from the BH and PC practices across all domains and subdomains of the assessment. The data shows where practices collectively sit along the integration continuum, where there are opportunities for improvement, and where Washington State could apply technical assistance (TA) and coaching resources. In the future these reports could also guide policy and funding requests. In addition, the reports included:

- A summary of responses to supplemental questions including practice demographics
- How integration might support efforts to address health equity
- What tools providers use in screening for SDoH
- Funding sources for advancing integration
- IT and/or population health tools in use, which will also be used for targeting of TA resources

Over time, practice-level data may be shared with TA and coaching entities, among others, in accordance with data share agreements.

The reports can be found on the WA Portal, at About the Washington Integrated Care Assessment | WaPortal.org under the sections titled, "Guidance for Behavioral Sites and Guidance for Primary Care Sites".

As per the WA-ICA communication plan, webinars were conducted to present and discuss the results with Cohort 1 practices. The reports also were shared with the MCOs, ACHs, and the HCA, as well as other audiences identified for further socializing this standardized state-wide approach and for sparking interest in participation in future cohorts. Practice key informant interviews were also conducted to identify lessons learned and to inform the WA-ICA's work going forward, specifically around refinements to the tool to better support pediatric practices or those serving individuals with SUDs.

WA-ICA continued to refine the workplan and budget for TA and coaching coordinated through a centralized entity, a centralized data management entity, ACH regional coordination of TA and coaching, and WA-ICA Workgroup/Advisory group support.

Finally, the WA-ICA continued to work on the Provider/Practice Quality Improvement Resource Guide and continued working on a methodology for identifying primary care and BH outpatient practices across Washington State.

Health information technology (H ealth IT)

The Health IT Operational Plan is composed of actionable deliverables to advance the Health IT goals and vision articulated in the Health IT Strategic Roadmap. This work supports MTP in Washington State. The Health IT Roadmap and Operational Plan focuses on three phases of MTP work: design, implementation and operations, and assessment. The activities for the 2023 Health IT Operational Plan include 42 deliverables and tasks in these areas:

- State Electronic health records (EHRs)
- Crisis Call Center and Related Activities: 988/E2SHB 1477
- Electronic Consent
- MH IMD Waiver Health IT tasks

Q1 of 2023 focused heavily on planning for the following health IT-related initiatives:

- Nationally required 988 crisis call line and the related, and more expansive, state requirements for a Crisis Call Center Hub System and a BH Integrated Referral System in E2SHB 1477
- Electronic Consent Management (ECM) Solution
- MH IMD Health IT tasks

Activities and successes

The Health IT team spent much of the first quarter of 2023 continuing its focus on advancing five-year initiatives involving Health IT. During the past quarter, Washington State continued work in a variety of areas

- **2023 Health IT Operational Plan** In Q1 2023, HCA submitted the 2023 Health IT Operational Plan to CMS.
- **Community Information Exchange (CIE):** HCA continues to play a lead role in coordinating support of CIE technology among state agencies and with MTP. Initial investments in CIE technology in the ACH regions support the activities of community-based care coordination and refer Medicaid clients to local organizations that assist people with healthy behaviors or other services that help to sustain a family's health.
- **Crisis Call and Response Services:** The HCA Health IT team, in coordination with the Department of Health (DOH), continued implementation planning for the nationally required 988 crisis call system and the more expansive state requirements in E2SHB 1477 for a Crisis Call Center Hub System and the Behavioral Health Integrated Client Referral System.

  A key accomplishment in Q2 2023 was the publication of a Request for Information (RFI) from technology vendors regarding interoperable tools that could support the functionality needed for the Washington State enhanced Crisis Call and Response and Integrated Client Referral System required under E2SHB 1477. Responses to the RFI are due in Q2 2023.

- **ECM** The ECM solution will initially focus on facilitating the exchange of SUD information, subject to 42 CFR Part 2, and will ultimately be a generalized consent solution to address many future use cases. The health IT project team released a Request for Proposal (RFP) and selected an Apparent Successful Bidder (ASB),

CodeSmart/Midato Health. A review team encompassing subject matters experts across various domains (management, technical, functional/operations) were involved in the selection. Follow-up discussions are underway with CodeSmart/Midato Health regarding the updated timeline, budget, and deliverables. After CMS approval of the HCA planning document and the vendor contract, kickoff for implementation of the ECM solution is scheduled for July 2023. HCA continues to closely monitor the 42 CFR Part 2 Notice of Proposed Rulemaking (NPRM) published in November 2022. HCA submitted an agency wide coordinated response to CMS.

- **EHR**: HCA is working in collaboration with the Office of the Chief Information Officer (OCIO), WaTech (the lead state agency for this work), the Department of Corrections (DOC), and Department of Social and Health Services (DSHS) to develop, by June 30, 2023, a plan for procuring and implementing a state EHR. State funding has been authorized by the Washington State Legislature effective July 1, 2023. HCA will continue to work with the Washington State Department of Enterprise Services (DES) to develop, with a target of August 30, 2023, the procurement strategy for the state EHR.
- **Provider Directory Application Programming Interface (API)**: MyHealthButton App was published in the Google and Apple application stores. HCA continues to work through usability issues. HCA has also been working on bringing in other third-party applications to connect to our FHIR server. HCA completed the checklist process for Flexpa, and they are currently working with CNSI to connect to the test and production FHIR servers. Washington State is waiting on OneRecord. They have submitted their patient access checklist and completed a walk-through demonstration with the workgroup, but there area few outstanding questions from them before they will be ready to connect. Washington State currently has 145,437 providers listed in the provider directory. Washington State also recently submitted the endpoint directory for the state for the CMS endpoint directory.
- **WA-ICA**: The WA-ICA Initiative involves behavioral health and primary care practices completing a practice self-assessment of their level of bidirectional clinical integration and supports to increase their level of clinical integration. As practices advance along the continuum of integration, the assessment references the use of technology tools to support clinical integration. As part of the WA-ICA Initiative, the workgroup continued to focus on activities to advance clinical integration pending CMS approval of the WA-ICA Initiative included in Washington State's waiver application.

DSRIP program implementation accomplishments

ACH project milestone achievement

Pay-for-reporting (P4R)

ACHs report on their MTP activities, project implementation, and progress on required milestones. This is outlined in the Project Toolkit. P4R reports are submitted every six months. ACH P4R report was submitted on October 7, 2022.

Next steps

HCA and ACHs continue to partner on the transition from DSRIP to the programs proposed under MTP 2.0 that introduce strategies to address health equity through community-based care coordination (Community Hub model) and implementation of health-related social needs (HRSN) services. HCA continues to convene a task force that includes representatives from MCOs, ACHs, the Washington State DOH, DSHS, and HCA to discuss roles and partnership opportunities to support the Community Hub model and HRSN services implementation. Conversations in Q2 of 2023 will focus on HRSN services implementation planning, including alignment between FFS and managed care delivery systems, timeline for service phase-in, and the role of the Community Hubs to support administration of HRSN services.

Annual VBP milestone achievement by ACHs

ACHs help assess and support provider VBP readiness and practice transformation by connecting providers to training and resources. ACH support for the transition to VBP has narrowed in DY6 and DY7 based on significant VBP progress to-date and a shifting focus with DSRIP closeout on the horizon.

Five of the nine ACH regions achieved the VBP adoption target for 2021 of 85 percent (pending CMS approval of the target adjustment). 2021 represents the final year of VBP pay-for-performance (P4P) for ACHs under DSRIP.

Financial executor (FE) portal activity

ACHs continue to distribute incentive funds to partnering providers through the FE portal. During the reporting quarter, ACHs distributed more than **$32,856,256 to 215** partnering providers and organizations in support of project planning and implementation activities. The state distributed approximately **$1,766,819** in earned incentive funds to IHCPs in Q1 for achievement of IHCP-specific project milestones.

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

DSRIP measurement activities

DY5 regional and statewide VBP results are finalized pending CMS approval of the target adjustment from 90 percent to 85 percent. DY5 P4P and high-performance pool (HPP) baseline and performance rates were presented to ACHs. TA regarding performance results and analysis was offered to ACHs in anticipation of final approval and release of payment.

Statewide results

HCA submitted the DY5 statewide accountability report to CMS on December 28, 2022. The report includes both quality improvement and VBP adoption outcomes. Washington State's DY5 VBP adoption score improved from 49.7 percent to 84.7 percent from DY1 to DY5.

DSRIP program stakeholder engagement activities

HCA continues to share pertinent information with ACHs on an ad-hoc basis. The agency shares information via email about training, grant opportunities, and events, and requests that ACHs share with their networks and community.

No stakeholder concerns were reported during Q1, 2023.

DSRIP stakeholder concerns

No stakeholder concerns were reported during Q1, 2023.

Upcoming DSRIP activities

Following CMS approval of the statewide accountability report, HCA will account for any withheld funds unearned and adjust ACH P4P and HPP incentives accordingly. ACH incentives are anticipated to be distributed in June 2023. This impacts the following:

- DY5 regional and statewide VBP results have been assessed by the IA. Results will be presented in Q2, 2023 to ACHs. HCA is waiting for a decision from CMS regarding the VBP target adjustment from 90 percent to 85 percent.
- DY5 P4P and HPP achievement values calculations are calculated and will be provided to the ACHs in Q2, 2023.

Tribal project implementation activities

Primary milestone: Distributed $1,766,819 to IHCPs for milestone completion.

Tribal partner engagement timeline

- January 3: Met with Southwest ACH (SWACH) to discuss MTP 1.0, MTP 2.0, tribal relationships and community-based care coordination
- January 6: Hosted the first ACH Tribal Liaison call since before the COVID-19 pandemic
- January 17: Met with HCA Equity Investment team and Better Health Together (BHT) staff to discuss alignment with current work and discuss alignment for future work
- January 18: Attended the North Sound ACH partner convening
- February 1: Visited the Jamestown S'Klallam Tribe
- February 24: Hosted the ACH Tribal Liaison call
- February 27: Participated in the North Sound Accountable Community of Health (NSACH) Tribal Alignment Committee
- March 17: Hosted the ACH Tribal Liaison call

LTSS implementation accomplishments

This section summarizes LTSS program development and implementation activities from January 1 through March 31, 2023. Key accomplishments for this quarter include:

- As of March 31, 2023, more than 14,750 clients, in addition to their unpaid family caregivers, have received services and supports through the MAC and TSOA programs. The average statewide caseload for the quarter was 4,028 clients.
- The Aging and Long-term Support Administration (ALTSA) began their annual quality assurance cycle in January.

Network adequacy for MAC and TSOA

A shortage of paid in-home care providers for respite and personal care services continues to be a statewide issue. The Area Agencies on Aging (AAAs) work diligently with enrollees to utilize other available services to support the unpaid family caregivers and TSOA individuals without family caregivers. This includes services such as home delivered meals, personal emergency response systems, adult day care, and environmental modifications.

Assessment and systems update

There have been no changes to the assessments used for MAC and TSOA this quarter.

The Comprehensive Assessment Reporting Evaluation (CARE) system used by ALTSA intake staff completing Presumptive Eligibility assessments was moved to a web-based platform during the first quarter of 2023. This has been a multi-year project.

Staff training

MAC and TSOA program managers for Home and Community Services committed to providing monthly statewide training webinars on requested and needed topics during 2023. These webinar trainings occurred this quarter:

- January: Overview of Quality Performance Measures and the State's Quality Assurance Process
- February: Caregiver Programs Learning Collaborative – Family Caregiving for Someone with Alzheimer's or Other Dementia
- March: MTP Office Hours – Q&A for January webinar; Updates to the GetCare system Desk Manual; Open Q&A

Upcoming webinars in Q2 include:

- May: Overview of Estate Recovery
- June: Caregiver Programs Learning Collaborative – Understanding How Scoring Stresses and Burdens Is Used to Determine Strategies and Goals for the Unpaid Family Caregiver

Data and reporting

Table 1: beneficiary enrollment by program

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of March 31, 2023	242	1226	3007
Number of new enrollees in quarter by program	48	212	336
Number of new person-centered service plans in quarter by program	22	78	148
Number of new enrollees do not require a care plan because they are still in the care planning phase and services have yet to be authorized	26	129	187
Number of beneficiaries self-directing services under employer authority*	0	0	0

*The state will begin using individual providers after the Consumer Directed Employer is fully implemented for the 1915c and 1915k programs.

Figure 3: statewide care plan proficiency to date

The 86 percent line represents the CMS proficiency expectation

The AAA's compliance with timely completion of care plans for enrollees continues to excel

Tribal engagement

The following Tribal engagement activities occurred during the Q1 2023:

- January: Presented MAC and TSOA information to Tribes at IPAC subcommittee. A reminder was also provided regarding the need for volunteers for the MTP video project.
- February: Tribal Affairs met with Jamestown S'klallam to discuss MAC and TSOA programs, the Tribal initiative grant, and health homes. Program information was provided as requested by the Tribe.
- March 2: MAC and TSOA information was presented and request for Tribal interview video was shared at Spring 2023 Summit
- March 30: Dear Tribal Leader Letter (DTLL) sent out to request for video participation for MAC/TSOA video project.

Tribal nations have begun to meet in person and the newly formed ALTSA Tribal Affairs unit will be sharing MAC and TSOA information as part of Tribal LTSS Roadshow this year.

Outreach and engagement

ALTSA's MAC/TSOA program manager continues to seek indigenous volunteers to participate in interviews for the Caregivers Program video. One Tribal member from the Yakama Nation has agreed to be interviewed for the video.

Table 2: number of outreach and engagement activities held by AAA

	January	February	March
Community presentations and information sharing	61	100	106

The volume and type of outreach activities are beginning to increase as communities stabilize following the end of the PHE (public health emergency).

Quality assurance

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

Figure 4: question 1: was the client appropriately determined to be nursing facility level of care eligible for PE?

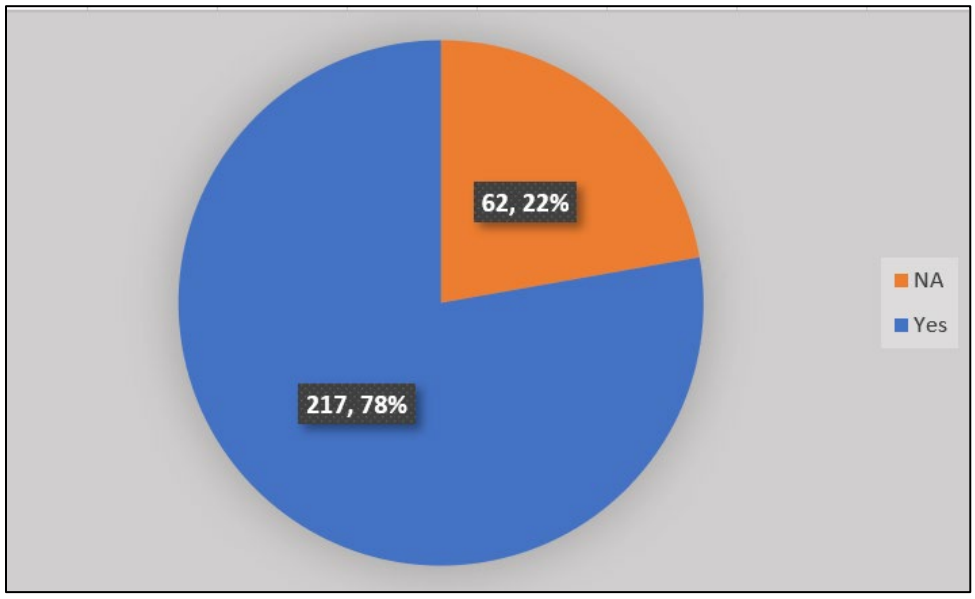


Figure 5: question 2a: did the client remain eligible after the PE period ?

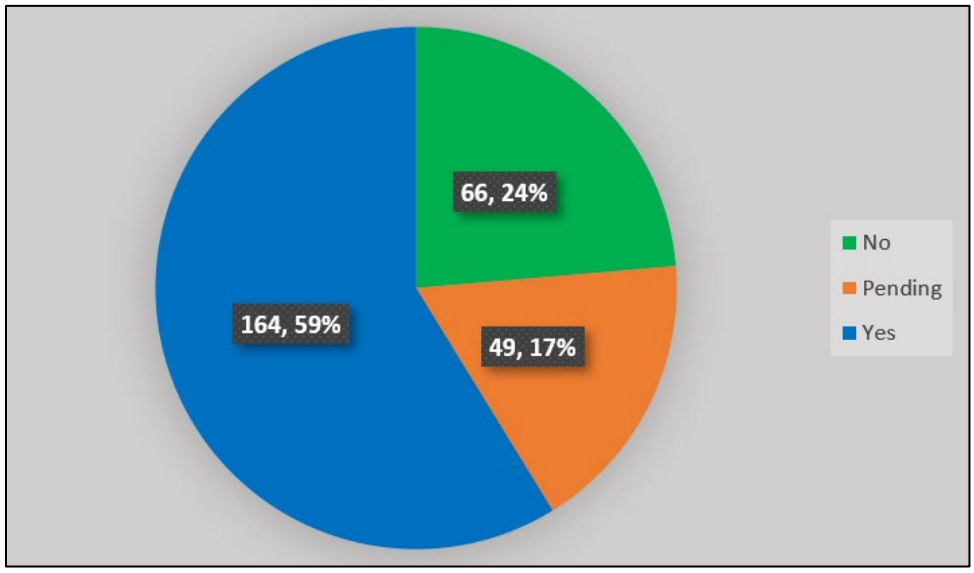
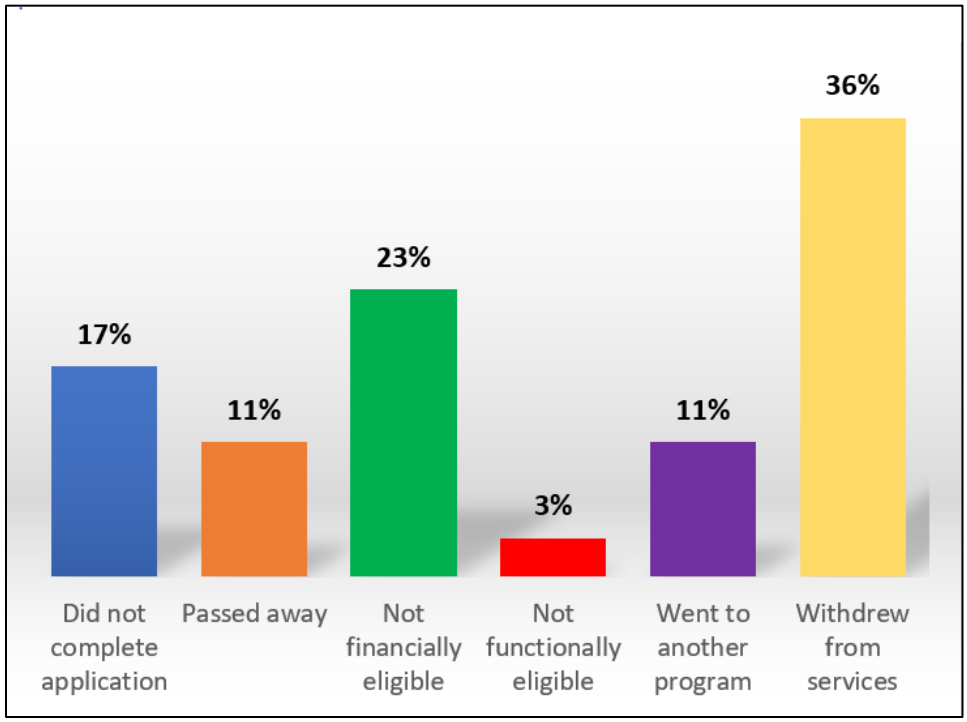


Figure 6: question 2b: if “No” to question #2a, why?

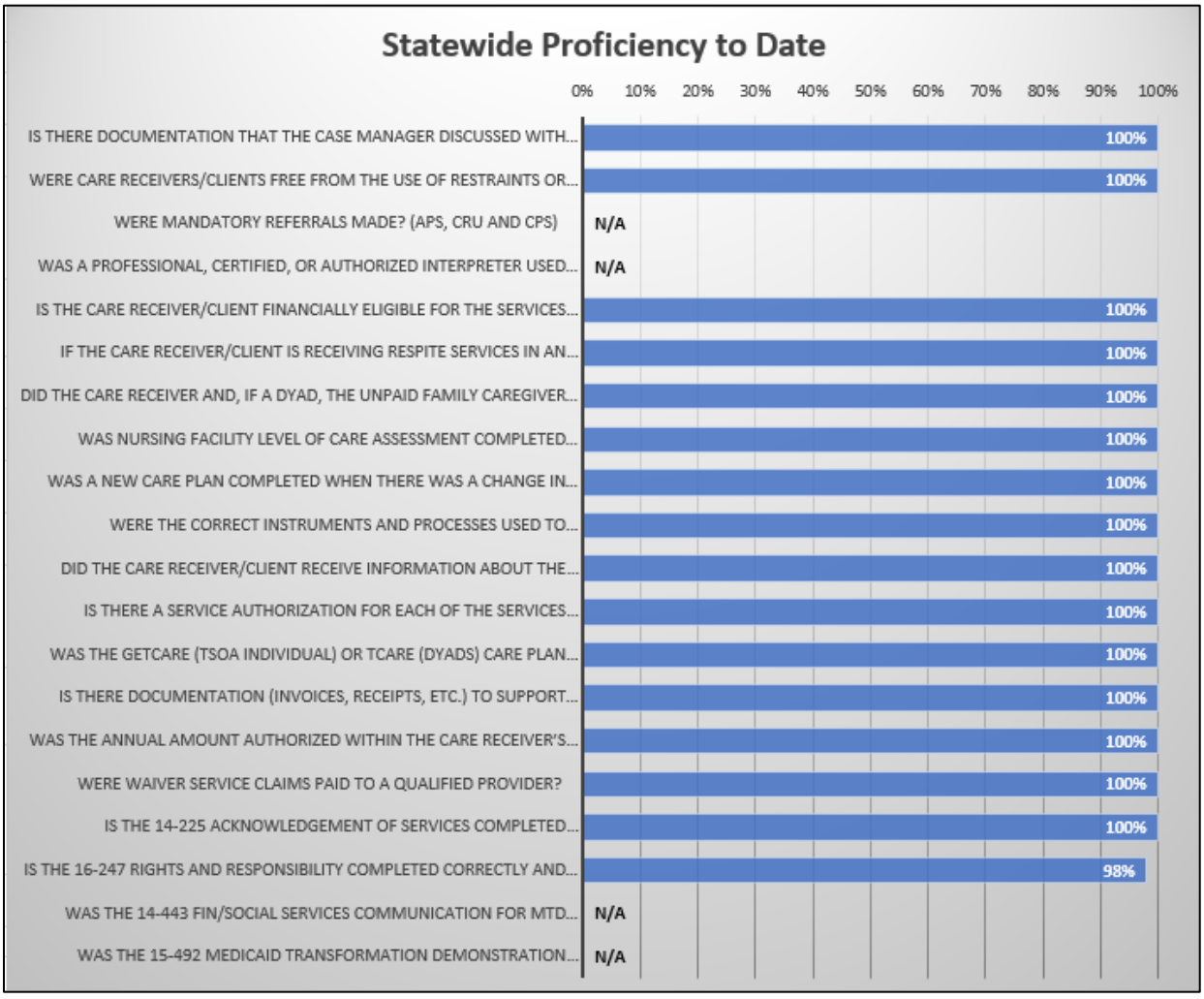


2023 quality assurance results to date

HCS’ Quality Assurance unit began the 2023 audit cycle in January and is expected to conclude in November. The statewide compliance review of the twenty MAC and TSOA performance measures is conducted with all 13 AAAs. An identical review process is applied in each AAA Planning and Service Area (PSA), using the same quality assurance tool and the same performance measures.

The Quality Assurance team reviews a statistically valid sample of case records. The sample size in 2023 is 353 cases. The methodology used is the same for the state’s 1915(c) waivers and meets the CMS requirements for sampling. Each AAA’s sample was determined by multiplying the percent of the total program population in that area by the sample size.

Figure 7: statewide proficiency to date



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

State rulemaking

The rule making process continued this quarter in anticipation of the proposed definition of transportation being approved. The public comment period and public hearing will occur during the next quarter.

Upcoming activities

- The 1115 waiver amendment to modify the transportation service definition to include accessing community resources is anticipated to be approved by CMS in April.
- A rulemaking public hearing will be held May 23, 2023.
- The state anticipates CMS approval of the MTP 2.0 renewal application by the end of the second quarter.

LTSS stakeholder concerns

No stakeholder concerns were noted this quarter.

FCS implementation accomplishments

Initiative 3 provides evidence-based supportive housing and supported employment services to eligible Medicaid clients. This section summarizes the FCS program development and implementation activities from January 1 through March 31, 2023. Key accomplishments for the quarter include:

Total aggregate number of people enrolled in FCS services at the end of Q1 of 2023:

- CSS: 10,870
- IPS: 5,738

There were 190 providers under contract with Amerigroup at the end of Q1 of 2023, representing 519 sites throughout the state.

Note: CSS and IPS enrollment totals include 2,725 participants enrolled in both programs. The total unduplicated number of enrollments at the end of this reporting period was 12,883

Network adequacy for FCS

Table 3: FCS provider network development

	January		February		March	
FCS service type	Contracts	Service locations	Contracts	Service locations	Contracts	Service locations
Supported Employment–Individual Placement Support (IPS)	35	76	35	76	25	76
Community Support Services (CSS)	22	57	22	57	23	58
CSS and IPS	128	369	128	369	132	385
Total	**185**	**502**	**185**	**502**	**190**	**519**

Client enrollment

Table 4: FCS client enrollment

	January	February	March
Supported Employment–Individual Placement and Support (IPS)	2,741	2,775	3,013
Community Support Services (CSS)	7,014	7,397	8,145
CSS and IPS	2,498	2,494	2,725
Total aggregate enrollment	**12,253**	**12,666**	**13,883**

Data source: RDA administrative reports

Table 5: FCS client risk profile

		Met HUD homeless criteria	Avg. PRISM risk score	Serious mental illness
January	IPS	603 (12%)	.93	3,328 (64%)
	CSS	2,010 (21%)	1.16	5,513 (58%)

February	IPS	613 (12%)	.9	3,301 (63%)
	CSS	2,086 (21%)	1.11	5,547 (56%)
March	IPS	684 (12%)	.95	3,251 (57%)
	CSS	2,322 (21%)	1.18	5,537 (51%)

HUD= Housing and Urban Development

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

Table 6: FCS client risk profile continued

		Medicaid only enrollees*	MH treatment need	SUD treatment need	Co-occurring MH + SUD treatment needs flags
January	IPS	4,413	4,056 (92%)	2,697 (61%)	2,533 (57%)
	CSS	7,957	7,114 (89%)	5,794 (73%)	5,310 (67%)
February	IPS	4,422	4,047 (92%)	2,661 (60%)	2,491 (56%)
	CSS	8,281	7,341 (89%)	6,001 (72%)	5,464 (66%)
March	IPS	4,815	4,375 (91%)	2,873 (60%)	2,674 (56%)
	CSS	9,105	8,005 (88%)	6,545 (72%)	5,920 (65%)

Data source: RDA administrative reports

*Does not include individuals who are dual enrolled.

Table 7: FCS client service utilizatio n

		Medicaid only enrollees*	Long-term Services and Supports	Mental health services	SUD services (received in last 12 months)	Care + MH or SUD services
January	IPS	4,413	504 (11%)	3,213 (73%)	1,672 (38%)	440 (10%)
	CSS	7,957	762 (10%)	5,075(64%)	3,484 (44%)	634 (8%)
February	IPS	4,422	508 (11%)	3,166 (72%)	1,621 (37%)	431 (10%)
	CSS	8,281	786 (9%)	5,174 (62%)	3,601 (43%)	656 (8%)
March	IPS	4,815	556 (12%)	3,339 (69%)	1,723 (36%)	460 (10%)
	CSS	9,105	859 (9%)	5,445 (60%)	3,842 (42%)	706(8%)

(Aging CARE assessment in last 15 months)

*Does not include individuals who are dual enrolled.

Data source: RDA administrative reports

Table 8: FCS client Medicaid eligibility

		CN blind/disabled (Medicaid only & full dual eligible)	CN aged (Medicaid only & full dual eligible)	CN family & pregnant woman	ACA expansion adults (nonadults presumptive)	Adults (nonadults presumptive) ACA expansion adults (SSI presumptive)	CN & CHIP children
January	IPS	1,526 (29%)	118 (2%)	549 (10%)	2,268 (43%)	623 (12%)	155 (3%)
	CSS	2,879 (30%)	478 (5%)	1,146 (12%)	3,309 (35%)	1,604 (17%)	96 (1%)
February	IPS	1,562 (30%)	114 (2%)	572 (11%)	2,239 (42%)	627 (12%)	155 (3%)
	CSS	2,978 (30%)	488 (5%)	1,203 (12%)	3,474 (35%)	1,644 (17%)	104 (1%)

March	IPS	1,684 (29%)	134 (2%)	633 (11%)	2,491 (43%)	627 (11%)	169 (3%)
	CSS	3,233 (30%)	555 (5%)	1,316 (12%)	3,971 (37%)	1,683 (15%)	112 (1%)

ACA= Affordable Care Act

CHIP= Children's Health Insurance Program

CN= categorically needy

Data source: RDA administrative reports

Quality assurance and monitoring activity

FCS staff continued to work with the TPA to monitor the implementation of FCS during Q1. No major concerns or issues were identified, and the TPA reported no grievances or appeals during the quarter. The cumulative enrollment increased month-over-month in each program, after seeing slight decreases at the end of DY6.

A good portion of work focused on identifying processes to reconnect enrollees due to changes in coverage. Because FCS is not an entitlement benefit, enrollment in the program is a manual process requiring weekly workflows to enroll and re-enroll (or "reconnect") eligible individuals to the program. Reconnecting involves a historical eligibility screening to identify gaps in coverage caused by changes in Medicaid type, incarceration, and other changes in the ProviderOne database that automatically disconnects an individual from FCS. Due to the unwinding of the PHE and Medicaid enrollments resuming normal operations at the end of Q1, Washington State is anticipating an increase in Q2 of reconnections and changes to the number of enrolled participants. While the manual process is time consuming, Washington State is able to increase insight into specific FCS providers and monitor for any inconsistencies or data misalignment.

FCS training staff completed several fidelity reviews of contracted FCS providers. These reviews were completed virtually or hybrid over two or more days with a review team of HCA staff and other FCS providers. The FCS training staff are also bringing on fidelity reviewers from other state agencies such as the Division of Vocational Rehabilitation to facilitate more cross-system collaboration. Fidelity reviews will remain consistent and frequent in Q2.

FCS staff also held two two-part fidelity reviewers training events, one for supported employment and one for supportive housing, that teach FCS providers and prospective reviewers the evidence-based practices that support the respective services provided. This training is offered to prepare agency staff for participation on review panels and help them understand how fidelity is measured. These fidelity reviews use a learning collaborative approach and FCS providers can receive incentives through Substance Abuse and Mental Health Services Administration (SAMHSA) block grant funds to become reviewers or host a review.

Lastly, FCS hosted the first inaugural Permanent Supportive Housing (PSH) Fidelity Certification training. The learning environment was provided by an FCS agency, Pioneer Human Services. The content was presented by one of the national technical assistance organizations that supports the work of FCS, Advocates for Human Potential. Both supportive housing trainer staff were present assisting with overall support and providing community specific examples of PSH implementation. Eleven staff graduated from the course with the essential knowledge of PSH fidelity and will be assisting the FCS training staff with an expansion of reviews across Washington State.

Other FCS program activity

HCA continues to convene a monthly workgroup with DSHS-ALTSA and Research and Data Analysis (RDA) staff to develop, discuss, and decide on key policies and practices necessary for the ongoing operation, improvement, and sustainability of the FCS program. The group also continued its bimonthly meeting series with CSS providers organized by King County, the most populous county in Washington State. This meeting offers housing providers in that county the opportunity to discuss implementation and learn from fellow providers on best practices when running an FCS benefit.

In partnership with DSHS Division of Vocational Rehabilitation (DVR), HCA participates in a quarterly workgroup to improve consistency, collaboration, and employment outcomes for DVR customers with a BH condition receiving supported employment services from DVR Supported Employment program and FCS.

In late 2022, FCS offered a funding opportunity that agencies could apply for that directly increases access to housing and/or employment services for eligible participants. In Q1 of 2023, a series of required trainings began and will continue into Q2. This funding was awarded using federal block grants from SAMSHA to ten agencies throughout Washington State. Each agency will add staffing to serve individuals who, at minimum, experience challenges with substance use.

Upcoming activities

- Medicaid Academy: The first of two seven-week Medicaid Academies will be offered to potential and current FCS providers in Q2 and will be again in Q3. These Academies are targeted to executive leads, fiscal/finance leads, programmatic leads, and quality improvement leads within their agencies. The information presented will primarily benefit support agencies who are not yet set up as Medicaid billing providers, who have been having issues with billing to Medicaid, and those who are interested in billing Medicaid for CSS and IPS services.
- Supportive Housing Academy: Based on direct provider feedback, a series of nine training courses aimed at increasing tenant engagement, clarifying roles and responsibilities, and increasing housing inventory began and will continue to be offered into Q2.
- FCS staff continue to meet regularly with the Department of Commerce on the planning and development of two programs:
    - Apple Health and Homes, a partnership among the Department of Commerce, DSHS, and the HCA focused on creating permanent supportive housing units for CSS-eligible individuals.
    - The expansion of the Housing and Essential Needs (HEN) program to create a bridge period of up to nine months of additional rental support for IPS-enrolled individuals. Roughly 30 percent of IPS enrollees have a referral for and receive assistance from the HEN program.

FCS program stakeholder engagement activities

HCA continues to receive inquiries from other states and entities regarding the FCS program. HCA responds readily to these inquiries, usually by teleconference. During the reporting quarter, staff from HCA, ALTSA, and Amerigroup supported a variety of stakeholder engagement activities.

Table 9: number of FCS program stakeholder engagement activities held

	January	February	March
Training and assistance provided to individual organizations	96	109	128
Community and regional presentations and training events	5	11	8
Informational webinars	7	8	9
Stakeholder engagement meetings	25	18	17
Total activities	**97**	**114**	**118**

Training and assistance activities to individual organizations continued to increase this quarter. Webinars are intended to inform, educate, and coordinate resources for FCS providers serving people who need housing and employment services, resources, and supports.

Q1 topics included:

- Braiding resources to collaboratively develop and strengthen housing and services
- SMART recovery
- Career profile: not just a form
- Mapping Washington State's housing system and supports
- PSH as an evidence-based practice
- Preparing for Initial Interactions and Introductions with employers
- Policing mental illness and homelessness

- Understanding the SDoH in the Context of Supportive Housing Services
- Trauma Informed Design: Project based buildings
- Apprenticeship 101
- Benefit planning basics and resources

FCS stakeholder concerns

- The FCS team continues to receive feedback regarding challenges with submitting claims, most specifically from providers who are new to billing Medicaid. HCA supports providers through additional technical assistance on billing best practices and alignment with other Medicaid billing processes. The Medicaid Academy has a specific session on billing and documentation.
- FCS stakeholders have asked questions regarding the status of the waiver renewal and the plans for the continuation of the services. This is particularly prevalent among new providers interested in developing FCS services and programs within their agencies.
- FCS agencies have continued to provide feedback and perspective on the integration of FCS services and Apple Health and Homes initiatives. The FCS team provides updates and opportunities during the Advisory Council that occurs quarterly as well as host specific webinars to provide updated information to constituents.

SUD IMD waiver impleme ntation accomplishments

In July 2018, Washington State received approval of its 1115 waiver amendment to receive federal financial participation for SUD treatment services. This includes short-term residential services provided in residential and inpatient treatment settings that qualify as an IMD. An IMD is a facility with more than 16 beds where at least 51 percent of the patients receive MH or substance use treatment.

This section summarizes SUD IMD waiver development and implementation activities from January 1 through March 31, 2023. Primary implementation and support activities during Q1 related to the 2023 legislative session and the number of bills and legislative inquiries related to SUD. Accomplishments for the quarter include:

- This year's legislative session commenced this quarter, with calls for using State v. McKessen Corp settlement dollars for supporting delivering parents with SUD needs, Public Education, Prescriber Education, Fentanyl technical assistance, consultation and discharge planning for emergency departments, scholarships to increase BIPOC providers, and expanded prevention and harm reduction activities.
- The governor's budget also calls expand substance use disorder prevention and to connect all Department of Children Youth and Family involved families with SUD supports aimed at reducing child placements. (Parental substance use is a risk factor for a child being placed out of home, contributing to 71% of infant removal cases statewide.)
- The Governor's budget also calls for further expansion of 988/Crisis services aimed at expanding mobile crisis services, crisis stabilization services, and additional training for the crisis response workforce.

Implementation plan

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

SUD Health IT plan requirements

During Q1 2023, Health IT advanced crisis call and response services (see the **health information technology activities and successes** section of this report), as well as tele-behavioral health. HCA continued to support the use of tele-behavioral health through its contract with the BHI. HCA awarded funds to BHI to host the 2023 Tele-Behavioral Health Summit.

Evaluation design

No changes to evaluation design for this quarter

Monitoring protocol

No changes to monitoring protocol for this quarter.

Upcoming activities

- Conclusion of the 2023-2025 legislative session in April, including responding to ongoing legislative inquiries and final passage of legislation.
- State Tribal Opioid, Fentanyl Summit in May

MHIMD waiver implementation accomplishments

In November 2020, the state received approval of its 1115 waiver amendment to receive federal financial participation for serious mental illness (SMI)/serious emotional disturbance (SED) treatment services with a start date of January 1, 2021. This includes acute inpatient services provided in residential and inpatient treatment settings that qualify as an IMD.

This section summarizes MH IMD waiver development and implementation activities from January 1 through March 31, 2023.

- January marks the beginning of Washington's full legislative session. Several bills are anticipated relating to MH care including:
    - Expansion of mobile crisis services, crisis stabilization services, and additional training to support the crisis response workforce. The statewide 988 behavioral health crisis response and suicide prevention line tax to fund
    - Plans to increase funding to assist Medicaid patients transition from acute care hospitals, state hospitals, and community psychiatric hospitals into community settings.
    - Further rate increases
    - Expanded services to prevent unnecessary hospitalization of clients with developmental disabilities.
    - Additional funding for community-based facilities.

Implementation plan

No changes to implementation plan this quarter.

MH Health IT plan requirements

During Q1 2023, HCA identified the need for and is pursing contracts related to Health IT tasks in the MH IMD Waiver:

- Telehealth: In Q1 2023, HCA engaged the Behavioral Health Institute (BHI) to host the 2023 Tele-Behavioral Health Summit that will provide training on use of tele-behavioral health.
- Health IT Project Management: HCA identified the need to acquire the services of a Project Manager to develop a strategic plan to guide HCA/DBHR health IT project planning related to the MH IMD Waiver and other health IT activities.

Evaluation design

No changes to evaluation design for this quarter.

Monitoring protocol

No changes to monitoring protocol for this quarter.

Upcoming activities

- Conclusion of the 2023-2025 legislative session in April.
- First in-person Behavioral Health Conference since the pandemic will occur in June 2023.

Quarterly expenditures

The following table reflects quarterly expenditures for DSRIP, LTSS, and FCS during DY7 (2023). In the first quarter there were no incentives paid out to ACH's or MCO's.

Table 10: DSRIP expenditures

	Q1 (January 1– March 31)	Q2 (April 1– June 30)	Q3 (July 1– September 30)	Q4 (October 1– December 31)	DY7 Total (January 1– December 31)	Funding source: Federal financial participation
Better Health Together	$0				$0	
Cascade Pacific Action Alliance	$0				$0	
Elevate Health	$0				$0	
Greater Health Now (formerly Greater Columbia)	$0				$0	
HealthierHere	$0				$0	
Thriving Together North Central Washington (formerly North Central)	$0				$0	
North Sound	$0				$0	
Olympic Community of Health	$0				$0	
SWACH	$0				$0	
Indian Health Care Providers	$0				$0	

Table 11: MCO-VBP expenditures

MCO-VBP	Q1 (January 1– March 31)	Q2 (April 1– June 30)	Q3 (July 1– September 30)	Q4 (October 1 – December 31)	DY7 Total (January 1– December 31)
Amerigroup WA	$0				$0
CHPW	$0				$0
CCW	$0				$0
Molina	$0				$0
United Healthcare	$0				$0

Table 12: LTSS and FCS service expenditures

	Q1 (January 1–March 31)	Q2 (April 1–June 30)	Q3 (July 1–September 30)	Q4 (October 1–December 31)	DY6 Total (January 1–December 31)
Tailored Supports for Older Adults (TSOA)	$5,171,456				$5,171,456
Medicaid Alternative Care (MAC)	$159,264				$159,264
MAC and TSOA not eligible	$259.28				$259.28
FCS	$7,950,523				$7,950,523

Financial and budget neutrality development issues

Financial

Below are the counts of member months eligible to receive services under MTP. Member months for non-expansion adults are updated retrospectively, based on the current caseload forecast council (CFC) medical caseload data.

Table 13: member months eligible to receive services

Calendar month	Non-expansion adults only	SUD Medicaid disabled	SUD Medicaid non-disabled	SUD newly eligible	SUD AI/AN	SMI Medicaid Disabled IMD	SMI Medicaid non-disabled IMD	SMI Newly eligible IMD	SMI AI/AN
Jan-17	376,299	0	0	0	0	0	0	0	0
Feb-17	375,195	0	0	0	0	0	0	0	0
Mar-17	374,723	0	0	0	0	0	0	0	0
Apr-17	373,574	0	0	0	0	0	0	0	0
May-17	373,119	0	0	0	0	0	0	0	0
Jun-17	373,022	0	0	0	0	0	0	0	0
Jul-17	372,109	0	0	0	0	0	0	0	0
Aug-17	371,843	0	0	0	0	0	0	0	0
Sep-17	370,577	0	0	0	0	0	0	0	0
Oct-17	370,383	0	0	0	0	0	0	0	0
Nov-17	370,213	0	0	0	0	0	0	0	0
Dec-17	370,239	0	0	0	0	0	0	0	0
Jan-18	370,278	0	0	0	0	0	0	0	0
Feb-18	368,902	0	0	0	0	0	0	0	0
Mar-18	368,709	0	0	0	0	0	0	0	0
Apr-18	367,449	0	0	0	0	0	0	0	0
May-18	367,812	0	0	0	0	0	0	0	0
Jun-18	367,090	0	0	0	0	0	0	0	0
Jul-18	366,833	5	19	91	10	0	0	0	0
Aug-18	366,234	8	17	95	44	0	0	0	0
Sept-18	365,237	4	19	80	44	0	0	0	0
Oct-18	365,235	4	22	93	47	0	0	0	0
Nov-18	364,767	3	27	93	34	0	0	0	0
Dec-18	364,217	4	17	96	23	0	0	0	0
Jan-19	364,142	34	133	411	37	0	0	0	0
Feb-19	362,461	31	115	391	40	0	0	0	0
Mar-19	362,113	42	144	398	45	0	0	0	0
Apr-19	361,644	56	136	473	38	0	0	0	0
May-19	361,125	43	125	483	49	0	0	0	0
June-19	360,366	65	150	573	54	0	0	0	0

Jul-19	360,793	65	197	676	55	0	0	0	0
Aug-19	360,367	66	243	744	49	0	0	0	0
Sep-19	359,922	75	214	779	44	0	0	0	0
Oct-19	359,409	73	237	884	36	0	0	0	0
Nov-19	358,545	81	190	812	44	0	0	0	0
Dec-19	358,870	58	213	940	51	0	0	0	0
Jan-20	359,316	32	129	531	44	0	0	0	0
Feb-20	359,322	24	125	478	44	0	0	0	0
Mar-20	361,014	33	133	484	45	0	0	0	0
Apr-20	364,507	42	109	383	21	0	0	0	0
May-20	366,952	25	97	376	29	0	0	0	0
Jun-20	369,749	46	157	553	46	0	0	0	0
Jul-20	372,413	25	84	335	32	0	0	0	0
Aug-20	375,214	51	218	711	38	0	0	0	0
Sep-20	377,400	65	208	680	46	0	0	0	0
Oct-20	379,393	26	93	373	43	0	0	0	0
Nov-20	380,268	54	185	762	27	0	0	0	0
Dec-20	381,715	66	192	827	26	89	58	264	5
Jan-21	382,859	41	131	563	31	242	170	799	17
Feb-21	382,879	25	89	298	18	275	196	876	11
Mar-21	384,165	21	85	318	25	293	239	952	15
Apr-21	385,454	25	97	369	15	267	234	844	18
May-21	386,608	31	85	313	26	278	263	871	16
Jun-21	387,628	17	32	157	21	305	227	878	16
Jul-21	389,227	25	104	368	20	272	179	605	17
Aug-21	391,255	19	91	322	20	250	176	564	14
Sep-21	392,688	16	86	326	15	241	177	604	14
Oct-21	394,029	16	81	273	11	256	199	620	18
Nov-21	395,958	14	77	301	14	248	226	608	27
Dec-21	396,580	7	45	221	13	237	221	625	15
Jan-22	398,190	1	15	66	7	238	237	625	22
Feb-22	399,480	15	97	367	8	221	250	599	24
Mar-22	401,039	18	116	409	3	236	240	672	23
April-22	403,219	22	105	358	20	198	169	459	16
May-22	404,663	3	13	62	11	285	263	691	17
Jun-22	406,907	30	110	401	26	282	218	654	12
Jul-22	408,973	21	91	367	17	239	128	506	9
Aug-22	411,735	24	117	484	16	255	219	685	8
Sep-22	413,132	4	28	152	13	236	199	576	10
Oct-22	415,090	0	12	34	16	77	46	192	6
Nov-22	417,399	26	105	355	15	279	227	694	5

Dec-22	420,007	8	34	168	3	236	173	591	3
Jan-23	422,038					73	30	150	0
Feb-23	424,224								
Mar-23	427,559								
Total	28,494,064	1,635	5,794	21,657	1,569	6,108	4,964	16,204	358

Budget neutrality

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

Designated state health programs (DSHP)

HCA has continued to contract with MSLC to perform an independent audit based on agreed-upon procedures to validate the accuracy of DSHP claims reported on the CMS-64 for CY2021. Expected completion of the review is June 30, 2023.

Overall MTP development and issues

Operational/policy issues

No operational or policy issues were identified in Q1 2023. Washington State continued to work with the legislature on many bills and budget provisos in support of MTP 2.0 programs and goals. MTP 2.0 expenditure authority is anticipated in the final state budget to be approved in Q2 2023.

Consumer issues

Washington State has not experienced any major consumer issues for DSRIP, FCS, LTSS, or the SUD IMD waiver during this reporting quarter, other than general inquiries about benefits available through MTP. Other questions have focused on the status of the MTP 2.0 renewal application, including ongoing discussions between the state and CMS.

MTP evaluation

The MTP independent external evaluator (IEE) submitted their quarterly rapid-cycle report on March 10, 2023. Their report covers January 1 through March 31, 2023, and presents findings on Washington State's Medicaid system performance through December 2021.

The IEE report also includes key performance indicators in 10 measurement domains as well as an examination of equity and disparities among specific populations within measurement domains. The report is available on the HCA website.

Quantitative analysis and Medicaid data

The quantitative team obtained and analyzed administrative data, including Medicaid enrollment, encounters, and claims through December 2021.

Qualitative analysis of Medicaid data

The qualitative team is:

- Continuing to analyze previously collected qualitative data; these ongoing analyses will be documented in the final evaluation report.
- Actively coding and analyzing data from the final round of ACH interviews and is assisting in preparing materials for an IRB amendment for Initiative 5 by developing a qualitative data collection tool.
- Actively sampling for and recruiting behavioral health provider organization interviewees, tailoring interview guides, developing a codebook, and conducting interviews concurrently with data analysis.
- Meeting weekly to listen to audio recordings, analyze transcripts, and refine the codebook.

Key findings from the latest rapid-cycle report

This is the fourth measurement period falling entirely after the statewide stay-at-home order was issued in Washington. Rates of well-child visits for children over the age of three and well-care visits for members under 21 improved substantially compared with the previous year, gaining much of the ground lost following the beginning of the PHE. Rates of periodontal exams for adults show a similar pattern, with substantial increases during this reporting period, following sharp declines during the first year of the PHE.

However, we also observed persistently lower rates for several outcome metrics that declined during the early months of the PHE. Most notably, adults' access to primary care and rates of cancer screenings remain low, showing further declines during this reporting period compared with the previous year. Although well-child visit rates have improved, immunization rates for children have declined.

We previously reported a dramatic downward trend in rates of care received in emergency departments and acute hospital settings. We are now seeing a reversal in that trend, with the rate of care received in Emergency Departments now higher than the previous year.

Finally, we continue to note disparities in health care access and quality among subpopulations examined in this report. Asian and Black members continue to receive lower rates of follow-up care after an emergency department visit for alcohol or other drug use and have less access to substance use disorder treatment than other groups. American Indian and Alaska Native members experienced markedly worse access to well-child visits, cancer screenings, mental health care, and care related to chronic conditions, alongside higher rates of emergency department utilization and acute hospitalization. Members living with a chronic health condition or a serious mental illness were more likely to experience homelessness and higher rates of arrest.

Summary of changes in Medicaid system performance

Better

- Access to well-care visits for members ages 3 to 21 and well-child visits for children ages 3 to 11 improved over the previous year. Decreases in this type of care represented some of the most notable impacts of the PHE but have nearly rebounded to pre-PHE levels in this reporting period.
- The IEE saw improvements in access to mental health care, particularly access to antidepressants for adults at both 12 weeks and 6 months post-diagnosis.
- Statewide access to periodontal exams improved 11 percentage points over the previous year, with Hispanic members experiencing notably better access than the state average.

Mixed

- Although the IEE saw improvements to well-care visits, other metrics of access to primary and preventive care and prevention and wellness declined during this period, with rates of breast cancer screening falling by 2.9 percentage points and immunizations for children falling 4.1 percentage points compared with the previous year.
- Most care for people with chronic conditions remained relatively flat during this reporting period, with the exception of controller medication for asthma which improved. However, disparities in this domain persist for American Indian and Alaska Natives who had less access to diabetes care, controller medication for asthma, and statin medication for cardiovascular disease.
- While care received in acute hospital settings fell statewide, rates of emergency department visits increased over this period for the first time since the onset of the PHE.

Worse

- Disparities in quality and access to care persisted during this reporting period, with American Indian, Alaska Native, and Black members experiencing worse access to mental health care and notably higher rates of utilization in emergency departments and acute hospital settings compared with statewide averages.
- American Indian and Alaska Native members experienced worse access to well-care visits for members ages 3-21. Hawaiian and Pacific Islander members experienced worse rates of well care across all ages measured.
- Asian, Black, Native Hawaiian and Pacific Islander, and Hispanic members also experienced less access to care for substance use disorders than in the state overall. Notably, Black members needing OUD treatment experienced that care at a rate that was 10.2 percent less than the state average.

Upcoming IEE activities

The IEE qualitative team will continue recruiting, conducting interviews, and meeting weekly to analyze data for behavioral health provider organization interviews. The IEE will report the findings from these interviews in the final evaluation report.

Summary of additional resou rces, enclosures, and attachments

Additional resources

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

Summary of attachments

- Attachment A: state contacts
- Attachment B: Financial Executor Portal Dashboard, Q1 2023
- Attachment C: 1115 SUD Demonstration Monitoring Workbook – Part A
- Attachment D: 1115 SUD Demonstration Monitoring Report – Part B
- Attachment E: 1115 SMI/SED Demonstration Monitoring Workbook – Part A
- Attachment F: 1115 SMI/SED Demonstration Monitoring Report – Part B

Attachment A: state contacts

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

Area	Name	Title	Phone
MTP and quarterly reports	Chase Napier	MTP Director, HCA	360-725-0868
DSRIP program	Chase Napier	MTP Director, HCA	360-725-0868
LTSS program	Debbie Johnson	Initiative 2 Program Manager, DSHS	360-725-2531
FCS program	Matthew Christie	Program Administrator, Foundational Community Supports, HCA	360-489-2021
SUD IMD waiver	David Johnson	Federal Programs manager, HCA	360-725-9404
MH IMD waiver	David Johnson	Federal Programs manager, HCA	360-725-9404

For mail delivery, use the following address:

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

Attachment B: Financial Executor Portal Dashboard, Q1 2023

View this table on the HCA website, which shows all funds earned and distributed through the FE portal through March 31, 2023.

Attachment C: 1115 SUD Demonstration Monitoring Workbook – Part A

A public workbook (which does not contain the full workbook) is available on the HCA website.

Attachment D: 1115 SUD Demonstration Monitoring Report – Part B

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

State	Washington State
Demonstration name	Washington State Medicaid Transformation Project No. 11-W-00304/0
Approval date for demonstration	January 9, 2017
Approval period for SUD	July 1, 2018-June 30, 2023
Approval date for SUD, if different from above	July 17, 2018
Implementation date of SUD, if different from above	July 1, 2018
SUD (or if broader demonstration, then SUD-related) demonstration goals and objectives	Under Washington's 1115 demonstration waiver, the SUD program allows th state to receive Federal Financial Participation (FFP) for Medicaid recipients residing in institutions for mental disease (IMDs) under the terms of this demonstration for coverage of medical assistance including opioid use disorder (OUD)/substance use disorder (SUD) benefits that would otherwise be matchable if the beneficiary were not residing in an IMD. Under this demonstration, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medica supervised withdrawal management to ongoing chronic care for these conditions in cost-effective settings while also improving care coordination an care for comorbid physical and mental health conditions. Expenditure authority will allow the state to improve existing SUD services and ensure the appropriate level of treatment is provided, increase the availability of medication assisted treatment (MAT), and enhance coordination between levels of care. The state will continue offering a full range of SUD treatment options using the American Society for Addiction Medicine (ASAM) criteria fo assessment and treatment decision making. Medical assistance including opioid use disorder (OUD)/substance use disorder (SUD) benefits that would

	otherwise be matchable if the beneficiary were not residing in an IMD.

2. Executive Summary

This quarter's report covers a period (07/01/2022-09/30/2022) where this initiative of the demonstration waiver has matured but is still within the COVID-19 pandemic. Please note, the impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.

Metrics reported this period indicated a slight rise in the number of Medicaid beneficiaries with an SUD diagnosis, and the number of Medicaid beneficiaries with an SUD diagnosis who received any treatment. It also notes a slight decrease in early intervention services, but increases in outpatient services and residential services. There was a slight decrease in the number of persons receiving withdrawal management, however, the number of Medicaid beneficiaries receiving medication assisted treatment increased by 240. The annual number of adults with pharmacotherapy for opiate use disorder who have at least 180 days of continuous treatment increased by almost 7 percentage points since the prior year's measurement period.

This year's legislative session commenced this quarter, with calls for using State v. McKessen Corp settlement dollars for supporting delivering parents with SUD needs, Public Education, Prescriber Education, Fentanyl technical assistance, consultation and discharge planning for emergency departments, scholarships to increase BIPOC providers, and expanded prevention and harm reduction activities.

The governor's budget also calls expand substance use disorder prevention and to connect Department of Children Youth and Family involved families with SUD supports aimed at reducing child placements. (Parental substance use is a risk factor for a child being placed out of home, contributing to 71% of infant removal cases statewide.)

The governor's budget also calls for further expansion of 988/Crisis services aimed at expanding mobile crisis services, crisis stabilization services, and additional training for the crisis response workforce.

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

Prompt	State response	Measurement period first reported (MM/DD/YYYY-MM/DD/YYYY)	Related metric (if any)
1.2 Assessment of Need and Qualification for SUD Services			
1.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or-) greater than 2 percent related to assessment of need and qualification for SUD services.	The monthly number of Medicaid beneficiaries with a SUD diagnosis trended upward during the 07/01/2022-09/30/2022 measurement period, showing an overall increase of 561 between July and September 2022. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#3: Medicaid beneficiaries with SUD diagnosis (monthly)
☒ The state has no metrics trends to report for this reporting topic.	The state has no metrics trends to report for this reporting topic this quarter. This topic is not due for reporting for this reporting period.	07/01/2018 – 06/30/2019	#4: Medicaid beneficiaries with SUD diagnosis (annual)

	The state has no metrics trends to report for this reporting topi this quarter. This topic is not due for reporting for this reporting period.	07/01/2018–06/30/2019	#5: Medicaid beneficiaries treated in an IMD for SUD
1.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐i) The target population(s) of the demonstration. ☐ii) The clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the dem onstration.			
☒ The state has no implementation update to report for this reporting topic.			
☐The state expects to make other program changes that may affect metrics related to assessment of need and qualification for SUD services.			
☒ The state has no implementation update to report for this reporting topic.			
2.2 Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)			
2.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or-) greater than 2 percent related to Milestone 1.	The monthly number of Medicaid beneficiaries with a SUD diagnosis who received any SUD treatment fluctuated slightly during the 07/01/2022-09/30/2022 measurement period, with an overall increase of 246 between July and September 2022. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these	04/01/2019 – 06/30/2019	#6: Any SUD Treatment

	services is unknown. Any changes in trends should be interpreted with caution.		
	The monthly number of Medicaid beneficiaries with a SUD diagnosis who received early intervention (i.e., SBIRT) fluctuated slightly during the 07/01/2022–09/30/2022 measurement period, with an overall decrease of 8 between July and September 2022. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019–06/30/2019	#7: Early Intervention
	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received outpatient SUD treatment fluctuated slightly during the 07/01/2022–09/30/2022 measurement period, with an overall increase of 342 between July and September 2022. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019–06/30/2019	#8: Outpatient Services
	The monthly number of Medicaid beneficiaries with a SUD diagnosis who received residential and inpatient SUD treatment fluctuated slightly during the 07/01/2022–09/30/2022 measurement period, with an overall increase of 6 between July and September 2022. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019–06/30/2019	#10: Residential and Inpatient Services
	The monthly number of Medicaid beneficiaries with a SUD diagnosis who received withdrawal management SUD treatment fluctuated slightly during the 07/01/2022–09/30/2022	04/01/2019–06/30/2019	#11: Withdrawal

	measurement period, with an overall decrease of 18 between July and September 2022. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.		Management
	The monthly number of Medicaid beneficiaries with a SUD diagnosis who received MAT SUD treatment fluctuated slightly during the 07/01/2022–09/30/2022 measurement period, with an overall increase of 240 between July and September 2022. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019–06/30/2019	#12: Medication Assisted Treatment
☒ **The state has no metrics trends to report for this reporting topic.**	The state has no metrics trends to report for this reporting topic this quarter. This topic is not due for reporting for this reporting period.	07/01/2018 – 06/30/2019	#36: Average Length of Stay in IMDs
2.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐i) Planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g., outpatient services, intensive outpatient services, medication assisted treatment, services in intensive residential and inpatient settings, medically supervised withdrawal management).**			

☐ii) SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and medication assisted treatment services provided to individuals in IMDs.			
☒ The state has no implementation update to report for this reporting topic.			
☐The state expects to make other program changes that may affect metrics related to Milestone 1.			
☒ The state has no implementation update to report for this reporting topic.			
3.2 Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)			
3.2.1 Metric Trends			
☐The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 2.			
☒ The state has no trends to report for this reporting topic.			
☐The state is not reporting metrics related to Milestone 2.			
3.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐i) Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria			

☐ii) Implementation of a utilization management approach to ensure (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, or (c) use of independent process for reviewing placement in residential trea tment settings.			
☒ The state has no implementation update to report for this reporting topic.			
☐The state expects to make other program changes that may affect metrics related to Milestone 2.			
☒ The state has no implementation update to report for this reporting topic.			
☐The state is not reporting metrics related to Milestone 2.			
4.2 Use of Nationally Recognized SUD-Specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)			
4.2.1 Metric Trends			
☐The state reports the following metric trends, including all changes (+ or-) greater than 2 percent related to Milestone 3.			
☒ The state has no trends to report for this reporting topic.			
☐The state is not reporting metrics related to Milestone 3.			
4.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to:			

☐i) Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards. ☐ii) State review process for residential treatment providers' compliance with qualifications standards. ☐iii) Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site.			
☒ The state has no implementation update to report for this reporting topic.			
☐The state expects to make other program changes that may affect metrics related to Milestone 3.			
☒ The state has no implementation update to report for this reporting topic.			
☐The state is not reporting metrics related to Milestone 3.			
5.2 Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)			
5.2.1 Metric Trends			
☐The state reports the following metric trends, including all changes (+ or-) greater than 2 percent related to Milestone 4.			
☒ The state has no trends to report for this reporting topic.			
5.2.2 Implementation Update			

Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐Planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care.**			
☒ The state has no implementation update to report for this reporting topic.			
☐The state expects to make other program changes that may affect metrics related to Milestone 4.			
☒ The state has no implementation update to report for this reporting topic.			
6.2 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)			
6.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or-) greater than 2 percent related to Milestone 5.	The annual number of adults with pharmacotherapy for OUD who have at least 180 days of continuous treatment increased by 6.97 percentage points since the year prior to the 01/01/2021-12/31/2021 measurement period. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2018 – 12/31/2018	#22: Continuity of Pharmacotherapy for Opioid Use Disorder (modified by State)
☐The state has no trends to report for this reporting topic.			
6.2.2 Implementation Update			

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

inpatient facilities to community -based services and supports.			
☒ The state has no implementation update to report for this reporting topic.			
☐The state expects to make other program changes that may affect metrics related to Milestone 6.			
☒ The state has no implementation update to report for this reporting topic.			
8.2 SUD Health Information Technology (Health IT)			
8.2.1 Metric Trends			
☐The state reports the following metric trends, including all changes (+ or-) greater than 2 percent related to its Health IT metrics.			
☒ The state has no trends to report for this reporting topic.			
8.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐i) How health IT is being used to slow down the rate of growth of individuals identified with SUD. ☐ii) How health IT is being used to treat effectively individuals identified with SUD. ☐iii) How health IT is being used to effectively monitor "recovery" su pports and services for individuals identified with SUD.			

☐iv) Other aspects of the state's plan to develop the health IT infrastructure/capabilities at the state, delivery system, health plan/MCO, and individual provider levels. ☐v) Other aspects of thestate's health IT implementation milestones. ☐vi) The timeline for achieving health IT implementation milestones. ☐vii) Planned activities to increase use and functionality of the state's prescription drug monitoring program.			
☒ The state has no implementation update to report for this reporting topic.			
☐The state expects to make other program changes that may affect metrics related to Health IT.			
☒ The state has no implementation update to report for this reporting topic.			
9.2 Other SUD-Related Metrics			
9.2.1 Metric Trends			
☐The state reports the following metric trends, including all changes (+ or-) greater than 2 percent related to other SUD-related metrics.			
☒ The state has no trends to report for this reporting topic.			

9.2.2 Implementation Update			
☐The state expects to make other program changes that may affect metrics related to other SUD-related metrics.			
☒ The state has no implementation update to report for this reporting topic.			
10.2 Budget Neutrality			
10.2.1 Current status and analysis			
☐If the SUD component is part of a broader demonstration, the state should provide an analysis of the SUD-related budget neutrality and an analysis of budget neutrality. Describe the status of budget neutrality and an analysis of the budget neutrality to date.			
10.2.2 Implementation Update			
☐The state expects to make other program changes that may affect budget neutrality			
☒ The state has no implementation update to report for this reporting topic.			
11.1 SUD-Related Demonstration Operations and Policy			
11.1.1 Considerations			
☐States should highlight significant SUD (or if broader demonstration, then SUD-related) demonstration operations or policy considerations that could positively or negatively affect beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or			

impediments in achieving the SUD demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.			
☒ The state has no related considerations to report for this reporting topic.			
11.1.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐i) How the delivery system operates under the demonstration (e.g., through the managed care system or fee for service). ☐ii) Delivery models affecting demonstration participants (e.g., Accountable Care Organizations, Patient Centered Medical Homes). ☐iii) Partners involved in service delivery.			
☒ The state has no implementation update to report for this reporting topic.			
☐The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities.			
☒ The state has no implementation update to report for this reporting topic.			

☐The state is working on other initiatives related to SUD or OUD.			
☒ The state has no implementation update to report for this reporting topic.			
☐The initiatives described above are related to the SUD or OUD demonstration (States should note similarities and differences from the SUD demonstration).			
☒ The state has no implementation update to report for this reporting topic.			
12. SUD Demonstration Evaluation Update			
12.1. Narrative Information			
☐Provide updates on SUD evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. See report template instructions for more details.			
☒ The state has no SUD demonstration evaluation update to report for this reporting topic.			
☐Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.			
☒ The state has no SUD demonstration evaluation update to report for this reporting topic.			

☐List anticipated evaluation -related deliverables related to this demonstration and their due dates.			
☒ The state has no SUD demonstration evaluation update to report for this reporting topic.			
13.1 Other Demonstration Reporting			
13.1.1 General Reporting Requirements			
☐The state reports changes in its implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol.			
☒ The state has no updates on general requirements to report for this reporting topic.			
☐The state anticipates the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes .			
☒ The state has no updates on general requirements to report for this reporting topic.			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐i) The schedule for completing and submitting monitoring reports. ☐ii) The content or completeness of submitted reports and/or future reports.			
☒ The state has no updates on general requirements to report for this reporting topic.			

☐The state identified real or anticipated issues submitting timely post -approval demonstration deliverables, including a plan for remediation			
☐The state has no updates on general requirements to report for this reporting topic.			
13.1.2 Post-Award Public Forum			
☐If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual report.			
☒ No post-award public forum was held during this reporting period and this is not an annual report, so the state has no post-award public forum update to report for this topic.			
14.1 Notable State Achievements and/or Innovations			
14.1 Narrative Information			
☐Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD (or if broader demonstration, then SUD related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the			

achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.			
☒ The state has no notable achievements or innovations to report for this reporting topic.			

Note: Licensee and states must prominently display the following notice on any display of Measure rates:

The IET-AD, FUA-AD, FUM-AD, and AAP measures (metrics #15, 17 (1), and 17 (2), and 32) are Healthcare Effectiveness Data and Information Set ("HEDIS®") measures that are owned and copyrighted by the National Committee for Quality Assurance ("NCQA"). NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA is not liable to anyone who relies on such measures or specifications.

The measure specification methodology used by CMS is different from NCQA's methodology. NCQA has not validated the adjusted measure specifications that CMS has granted CMS permission to adjust. Calculated measure results, based on adjusted HEDIS specifications, may be called only "Uncertified, Unaudited HEDIS rates."

Certain non-NCQA measures in the CMS 1115 Substance Use Disorder Demonstration contain HEDIS Value Sets (VS) developed by and included with permission of the NCQA. Proprietary coding is contained in the VS. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of the VS with non-NCQA measures and any coding contained in the VS.

Attachment E: 1115 SMI/SED Demonstration Monitoring Workbook – Part A

A public workbook (which does not contain the full workbook) is available on the HCA website.

Attachment F: 1115 SMI/SED Demonstration Monitoring Report – Part B

1. 1115-SMI/SED Demonstration-Monitoring -Report Trend Narrative Reporting

State		Washington
Demonstration name		Washington State Medicaid Transformation Project No. 11-W-00304/0
Approval date for demonstration		January 9, 2017
Approval period for SMI/SED		November 6, 2020-June 30, 2023
Approval date for SMI/SED, if different from above		November 6. 2020
Implementation date of SMI/SED, if different from above		December 23, 2020
SMI/SED (or if broader demonstration, then SMI/SED-related) demonstration goals and objectives		This demonstration amendment will provide authority for the state to receive FFP for delivering treatment to Medicaid beneficiaries diagnosed with SMI while they are short-term residents in settings that qualify as IMDs, primarily to receive treatment for SMI. The goal of this amendment is for the state to maintain and enhance access to mental health services, and continue delivery system improvements to provide more coordinated and comprehensive treatment for beneficiaries with SMI. With this approval, beneficiaries will have access to a continuum of services at new settings that, absent this amendment, would be ineligible for payment for most Medicaid enrollees.

2. Executive Summary

The quarterly metrics in this measurement relate to services occurring between 07/01/2022 to 09/30/2022. This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown, any changes in trends should be interpreted with caution.

Slight fluctuations were noted in the number of Medicaid beneficiaries who used mental health related inpatient, intensive outpatient, outpatient, emerge department, and telehealth.

The count of beneficiaries was little changed, as with last quarter, no grievances were reported, however there was a small number of appeals and critical incidents.

This quarter marks the start of the 2023 long legislative session. The Governor's budget includes several requests for investments in mental health care. The request focuses on items including:

- Expansion of mobile crisis services, crisis stabilization services, and additional training to support the crisis response workforce. The statewide 988 behavioral health crisis response and suicide prevention line tax to fund
- Plans to increase funding to assist Medicaid patients transition from acute care hospitals, state hospitals, and community psychiatric hospitals into community settings.
- Additional provider rate increases
- Expanded services to prevent unnecessary hospitalization of clients with developmental disabilities.
- Additional investments for community-based facilities.

3. Narrative information on implementation, by milestone and reporting topic

Prompt	State response	Measurement period first reported (MM/DD/YYYY-MM/DD/YYYY)	Related metric (if any)
1.2 Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings (Milestone 1)			
1.2.1 Metric Trends			
☐The state reports the following metric trends, including all changes (+ or-) greater than 2 percent related to Milestone 1.			
☒ The state has no metrics trends to report for this reporting topic.			
1.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐i) The licensure or accreditation processes for participating hospitals and residential settings ☐ii) The oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements ☐iii) The utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay			

☐iv) The program integrity requirements and compliance assurance process ☐v) The state requirement that psychiatric hospitals and residential settings screen beneficiaries for comorbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions ☐vi) Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settin gs			
☒ The state has no implementation update to report for this reporting topic.			
☐The state expects to make the following program changes that may affect metrics related to Milestone 1.			
☒ The state has no implementation update to report for this reporting topic.			
2.2 Improving Care Coordination and Transitions to Community-Based Care (Milestone 2)			
2.2.1 Metric Trends			
☐The state reports the following metric trends, including all changes (+ or-) greater than 2 percent related to Milestone 2.			
☒ The state has no metrics trends to report for this reporting topic.			
2.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐i) Actions to ensure that psychiatric hospitals and residential treatment settings carry out			

intensive predischarge planning, and include community -based providers in care transitions ☐ii) Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers ☐iii) State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community -based providers within 72 hours post discharge ☐iv) Strategies to prevent or decrease the lengths of stay in EDs among beneficiaries with SMI or SED (e.g., through the use of peers and psychiatric consultants in EDs to help with discharge and referral to treatment providers) ☐v) Other State requirements/policies to improve care coordination and connections to community based care			
☒ The state has no implementation update to report for this reporting topic.			
☐The state expects to make other program changes that may affect metrics related to Milestone 2.			
☒ The state has no implementation update to report for this reporting topic.			
3.2 Access to Continuum of Care, Including Crisis Stabilization (Milestone 3)			
3.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or-) greater than 2 percent related to Milestone 3.	The monthly number of Medicaid beneficiaries who used inpatient services related to mental health fluctuated slightly during the 07/01/202209/30/2022 measurement period, with ar overall decrease of 8 between July and September 2022.	04/01/2021-06/01/2021	Mental Health Services

	Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.		Utilization - Inpatient
	The monthly number of Medicaid beneficiaries who used intensive outpatient and/or partial hospitalization services related to mental health fluctuated slightly during the 07/01/2022-09/30/2022 measurement period, with an overall increase of 38 between July and September 2022. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2021-06/01/2021	Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization
	The monthly number of Medicaid beneficiaries who used outpatient services related to mental health fluctuated slightly during the 07/01/2022-09/30/2022 measurement period, with an overall decrease of 13 between July and September 2022. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2021-06/01/2021	Mental Health Services Utilization - Outpatient
	The monthly number of Medicaid beneficiaries who use emergency department services for mental health fluctuated slightly during the 07/01/2022-09/30/2022 measurement period, with an overall increase of 4 between July and September 202 Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2021-06/01/2021	Mental Health Services Utilization - ED
	The monthly number of Medicaid beneficiaries who used telehealth services related to mental health fluctuated slightly	01/01/2020-12/31/2020	Mental Health Services

	during the 07/01/2022-09/30/2022 measurement period, with an overall decrease of 125 between July and September 2022. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.		Utilization - Telehealth
	The monthly number of Medicaid beneficiaries who used any services related to mental health fluctuated slightly during the 07/01/2022-09/30/2022 measurement period, with an overall decrease of 184 between July and September 2022. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2020-12/31/2020	Mental Health Services Utilization - Any Services
☐ The state has no trends to report for this reporting topic.			
3.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) State requirement that providers use an evidenced-based, publicly available patient assessment tool to determine appropriate level of care and length of stay ☐ ii) Other state requirements/policies to improve access to a full continuum of care including crisis stabilization			
☒ The state has no implementation update to report for this reporting topic.			

☐The state expects to makeother program changes that may affect metrics related to Milestone 3.			
☒ The state has no implementation update to report for this reporting topic.			
4.2 Earlier Identification and Engagement in Treatment, Including Through Increased Integration (Milestone 4)			
4.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or-) greater than 2 percent related to Milestone 4.	The monthly number of Medicaid beneficiaries with a SMI/SED diagnosis fluctuated slightly during the 07/01/2022-09/30/2022 measurement period, with an overall decrease of 8 between July and September 2022. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2022-06/30/22	Count of Beneficiaries With SMI/SED (monthly)
	The baseline percentage rate for diabetes care for patients with SMI is 96.69% for the 01/01/2020-12/31/2020 measurement period. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2020-12/31/2020	Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMHAD)
☐The state has no trends to report for this reporting topic.			
4.2.2 Implementation Update			

Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐i) Strategies for identifying and engaging beneficiaries in treatment sooner (e.g., with supported education and employment) ☐ii) Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment ☐iii) Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED ☐iv) Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people			
☒ The state has no implementation update to report for this reporting topic.			
☐The state expects to make other program changes that may affect metrics related to Milestone 4.			
☒ The state has no implementation update to report for this reporting topic.			
5.2 SMI/SED Health Information Technology (Health IT)			
5.2.1 Metric Trends			
☐The state reports the following metric trends, including all changes (+ or-) greater than 2 percent related to its health IT metrics.			
☒ The state has no trends to report for this reporting topic.			

5.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐i) The three statements of assurance made in the state's health IT plan ☐ii) Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider and/or physician/mental health provider to community based supports ☐iii) Electronic care plans and medical records ☐iv) Individual consent being electronically captured and made accessible to patients and all members of the care team ☐v) Intake, assessment and screening tools being part of a structured data capture process so that this information is interoperable with the rest of the health IT ecosystem ☐vi) Telehealth technologies supporting collaborative care by facilitating broa der availability of integrated mental health care and primary care ☐vii) Alerting/analytics ☐viii) Identity management			
☒ The state has no implementation update to report for this reporting topic.			

☐ The state expects to make the following program changes that may affect metrics related to health IT.			
☒ The state has no implementation update to report for this reporting topic.			
6.2 Other SMI/SED-Related Metrics			
6.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than two 2 percent related to other SMI/SED-related metrics.	The number of grievances related to services for SMI/SED is a for the 07/01/2022-09/30/2022 measurement period. This is a continuing trend, as there were also none reported from prior quarter measurement period, a considerable drop from the spike in late 2021/early 2022. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	07/01/2022- 09/30/2022	Grievances Related to Services for SMI/SED
	The number of appeals related to services for SMI/SED increased by 8 between the 04/01/2022-06/30/2022 and 07/01/2022-09/30/2022 measurement periods. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	07/01/2022- 09/30/2022	Appeals Related to Services for SMI/SED
	The number of critical incidents related to services for SMI/SE increased by 4 between the 04/01/2022-06/30/2022 and 07/01/2022-09/30/2022 measurement periods. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2022- 06/30/2022	Critical Incidents Related to Services for SMI/SED
☐ The state has no trends to report for this reporting topic.			

6.2.2 Implementation Update			
☐The state expects to make the following program changes that may affect other SMI/SED-related metrics.			
☒ The state has no implementation update to report for this reporting topic.			
7.1 Annual Assessment of the Availability of Mental Health Providers			
7.1.1 Description Of Changes To Baseline Conditions And Practices			
☐Describe and explain any changes in the mental health service needs (for example, prevalence and distribution of SMI/SED) of Medicaid beneficiaries with SMI/SED compared to those described in the Initial Assessment of Availability of Mental Health Services. Recommended word count is 500 words or less.			
☒ This is not an annual report, therefore the state has no update to report for this reporting topic.			
☐Describe and explain any changes to the organization of the state's Medicaid behavioral health service delivery system compared to those described in the Initial Assessment of Availability of Mental Health Services. Recommended word count is 500 words or less.			
☒ This is not an annual report, therefore the state has no update to report for this reporting topic.			
☐Describe and explain any changes in the availability of mental health services for Medicaid beneficiaries with SMI/SED in the state compared to those described in the Initial Assessment of Availability of Mental Health Services. At minimum, explain any changes across the state in the availability of the following services: inpatient mental health			

services; outpatient and community -based services; crisis behavioral health services; and care coordination and care transition planning. Recommended word count is 500 words or less.			
☒ This is not an annual report, therefore the state has no update to report for this reporting topic.			
☐Describe and explain any changes in gaps the state identified in the availability of mental health services or service capacity while completing the Availability Assessment compared to those described in the Initial Assessment of Availability of Mental Health Services. Recommended word count is 500 words or less.			
☒This is not an annual report, therefore the state has no update to report for this reporting topic.			
7.1.2 Implementation Update			
☐Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐i) The state's strategy to conduct annual assessments of the availability of mental health providers across the state and updates on steps taken to increase availability ☐ii) Strategies to improve state tracking of availability of inpatient and crisis stabilization beds			
☒ The state has no implementation update to report for this reporting topic.			
8.1 SMI/SED Financing Plan			
8.1.1 Implementation Update			

Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐i) Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, and observation/assessment centers, with a coordinated community crisis response that involves law enforcement and other first responders ☐ii) Increase availability of on-going community-based services, e.g., outpatient, community 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			
☒ The state has no implementation update to report for this reporting topic.			
9.2 Budget Neutrality			
9.2.1 Current Status and Analysis			
☐If the SMI/SED component is part of a broader demonstration, the state should provide an analysis of the SMI/SED-related budget neutrality and an analysis of budget neutrality as a whole. Describe the current status of budget neutrality and an analysis of the budget neutrality to date.			
9.2.2 Implementation Update			

☐The state expects to make the following program changes that may affect budget neutrality.			
☒ The state has no implementation update to report for this reporting topic.			
10.1 SMI/SED-Related Demonstration Operations and Policy			
10.1.1 Considerations			
☐States should highlight significant SMI/SED (or if broader demonstration, then SMI/SED-related) demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SMI/SED demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.			
☒The state has no related considerations to report for this topic.			
10.1.2 Implementation Update			
☐The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities.			
☒ The state has no implementation update to report for this reporting topic.			

☐The state is working on other initiatives related to SMI/SED.			
☒The state has no implementation update to report for this reporting topic.			
☐The initiatives described above are related to the SMI/SED demonstration as described (States should note similarities and differences from the SMI/SED demonstration).			
☒The state has no implementation update to report for this reporting topic.			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐i) How the delivery system operates under the demonstration (e.g. through the managed care system or fee for service) ☐ii) Delivery models affecting demonstration participants (e.g. Accountable Care Organizations, Patient Centered Medical Homes) ☐iii) Partners involved in service delivery ☐iv) The state Medicaid agency's Memorandum of Understanding (MOU) or other agreement with its mental health services agency			
☒The state has no implementation update to report for this reporting topic.			
11 SMI/SED Demonstration Evaluation Update			
11.1. Narrative Information			
☐Provide updates on SMI/SED evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and			

the timing for the demonstration. See report template instructions for more details.			
☒ The state has no SMI/SED demonstration evaluation update to report.			
☐Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.			
☒The state has no SMI/SED demonstration evaluation update to report.			
☐List anticipated evaluation -related deliverables related to this demonstration and their due dates.			
☒The state has no SMI/SED demonstration evaluation update to report.			
12.1 Other Demonstration Reporting			
12.1.1 General Reporting Requirements			
☐The state reports changes in its implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol.			
☒ The state has no updates on general requirements to report for this topic.			
☐The state anticipates the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes.			
☒ The state has no updates on general requirements to report for this topic.			

☐The state identified real or anticipated issues submitting timely post -approval demonstration deliverables, including a plan for remediation.			
☒ The state has no updateson general requirements to report for this topic.			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐i) The schedule for completing and submitting monitoring reports ☐ii) The content or completeness of submitted reports and/or future reports			
☒ The state has no updates on general requirements to report for this topic.			
12.1.2 Post-Award Public Forum			
☐If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual report.			
☒ No post-award public forum was held during this reporting period, and this is not an annual report, so the state has no post -award public forum update to report for this topic.			
13.1 Notable State Achievements and/or Innovations			
13.1 Narrative Information			
☐Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SMI/SED (or if broader			

demonstration, then SMI/SED related) demonstration or th at served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.			
☒ The state has no notable achievements or innovations to report for this topic.			

Note: Licensee and states must prominently display the following notice on any display of Measure rates:

The MPT, FUH, FUH-AD, FUA-AD, FUM-AD, AAP, APM, and APC measures (metrics #13, 14, 15, 16, 17, 18, 7, 8, 9, 10, 26, 29, 31) are Healthcare Effectiveness and Information Set

("HEDIS®") measures that are owned and copyrighted by the National Committee for Quality Assurance ("NCQA"). NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications.

The measure specification methodology used by CMS is different from NCQA's methodology. NCQA has not validated the adjusted specifications but has granted CMS permission to adjust.

Calculated measure results, based on the adjusted HEDIS specifications, may be called only "Uncertified, Unaudited HEDIS rates."

Certain non-NCQA measures in the CMS 1115 Serious Mental Illness/Serious Emotional Disturbance Demonstration contain HEDIS Value Sets (VS) developed by and included with the permission of the NCQA. Proprietary coding is contained in the VS. Users of the proprietary code sets in the VS must obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of the VS and any NCQA measures and any coding contained in the VS.