Washington State Health Care Authority

Washington State Medicaid Transformation Project 2.0 (MTP 2.0) demonstration

Section 1115 Waiver Quarterly Report

DY8 reporting period 1: July 1 through September 30, 2023

Table of contents

Introduction

On June 30, 2023, the Centers for Medicare & Medicaid Services (CMS) approved Washington State's request for a Section 1115 Medicaid demonstration waiver, titled "Medicaid Transformation Project 2.0 (MTP 2.0)." 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 2.0 period, Washington will:

- Expand coverage and access to care, ensuring that people can get the care they need.
- Advance whole-person primary, preventive, and home-and community-based care.
- Accelerate care delivery and payment innovation focused on health-related social needs.

The state will accomplish these goals through these continuing or new programs:

- Long-Term Services and Supports (LTSS): Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) and Presumptive Eligibility (PE).
- 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.
- Contingency Management (CM) for SUD treatment: evidence-based intervention for SUD.
- Continuous enrollment: Continuous Apple Health enrollment for children ages 0 through 5 and Apple Health postpartum coverage expansion.
- Reentry from a carceral setting: Services to individuals beginning up to 90 days prior to their expected release and continuing into their reentry to their communities.
- Health-related social needs (HRSN) services: Evidence-based, non-medical services that address social needs that affect health. HRSN services are coordinated in part by nine Community Hubs and one statewide Native Hub.

Vision: a healthier Washington

The Washington State Health Care Authority (HCA) is the lead agency for MTP 2.0, and many other 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: July 1 – September 30, 2023

This quarterly report summarizes MTP activities from the first reporting period of MTP 2.0: July 1 through September 30, 2023. It details MTP implementation, including stakeholder education and engagement, planning and implementation, and development of policies and procedures, and continues the demonstration reporting as "demonstration year 8" (DY8).

Summary of quarter accomplishments

- Accountable Communities of Health (ACHs) continue to distribute incentive funds, including $28,319,823 to 146 partnering providers this reporting period. The state distributed approximately $5,000,000 in earned incentive funds to IHCP-specific project milestones.
- As of September 30, 2023, more than 15, 800 clients, in addition to their family caregivers, have received services and supports through the MAC and TSOA programs. New enrollees in LTSS for this reporting period include 34 MAC dyads, 222 TSOA dyads, and 380 TSOA individuals.
- Within FCS, the total aggregate number of people enrolled in services as of September 30, 2023, included 6,737 in IPS and 13,612 in CSS. The total unduplicated number of enrollments at the end of this reporting period was 17,109.
- Since the approval date in April 2023, the state has implemented a manual process to ensure continuous coverage for Medicaid children under the age of six. This includes reinstating coverage for any children under the age of six who may lose coverage under the yearly redetermination process.
- Several justice-involved re-entry implementation subgroups have been formed to advise on facility and provider readiness, system changes, care management continuity, eligibility and enrollment, and benefit design for the pre-release period.

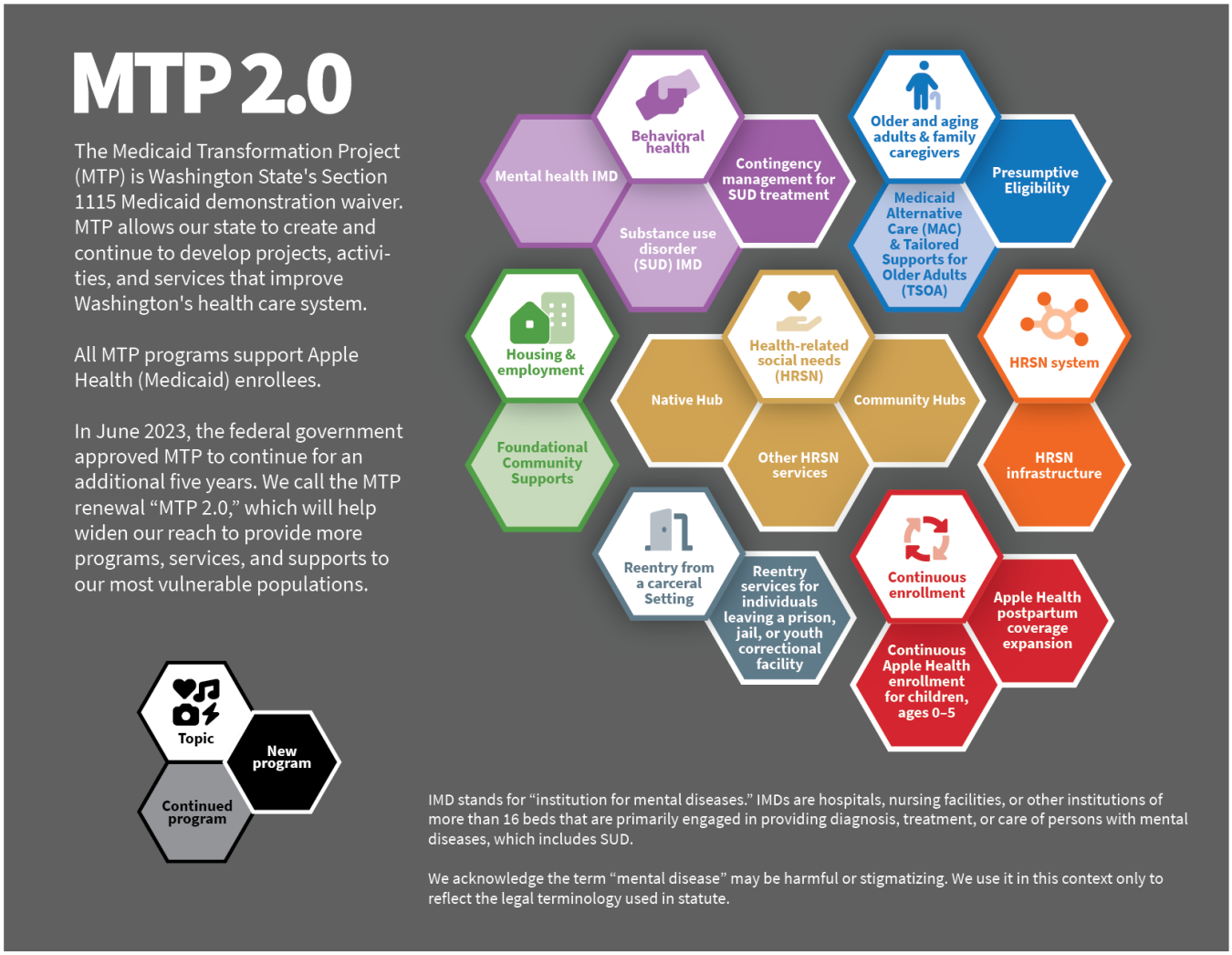
MTP 2.0-wide stakeholder engagement

During the reporting quarter, HCA continued its stakeholder engagement efforts. HCA developed a **summary document of MTP 2.0**. It shares information about MTP and MTP 2.0, the state's goals under the renewal, and additional updates. Most importantly, the summary contains a table that organizes each MTP program by topic and shares:

- Formal name of each program
- Population(s) served
- If the program is new or continuing (and how the program has expanded, if applicable)
- Additional information about each program

During Demonstration Year (DY) 8 Q1, HCA also designed and completed an infographic that illustrates each MTP 2.0 program clustered within a topic, with all clusters connecting together. There's a legend in the bottom left corner that explains the color differences between the new and continuing programs. This infographic is **available online**, and MTP team members and partners can use this in various presentations and materials.

Graphic 1: MTP 2.0



In addition, HCA began developing content for specific MTP 2.0 programs that have generated some interest from the public, stakeholders, media, and others. In September, HCA focused on the reentry program, a new program under MTP 2.0. We hope to share a new webpage and other blog and social media posts about this program in late 2023/early 2024.

In early August, HCA announced **Washington's waiver amendment request to cover former foster care youth and CHIP children**. We submitted this request to CMS in late June.

Last, HCA began planning the upcoming MTP Public Forum, which will occur in mid-December 2023. The MTP team will share:

- Updates for each program, including achievements and challenges
- What happened during 2023 (DY7), including the transition from the initial MTP waiver to MTP 2.0
- Timeline/expectations for new program implementation

During the MTP Public Forum, HCA will provide dedicated time for attendees to ask questions and share feedback.

State activities and accountability

Integrate d 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**.

There are no updates to report for DY8 Q1.

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

Activities this reporting period focused heavily on the following Health IT-related initiatives:

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

Activities and successes

The Health IT team spent much of the first quarter of MTP 2.0 continuing its focus on advancing multi-year initiatives involving Health IT.

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 Washington State's more expansive requirements for a Crisis Call Center Hub System and the BH Integrated Client Referral System (E2SHB 1477).

HCA and DOH staff completed the analyses of responses from 11 technology vendors to the Request for Information (RFI) regarding the availability of interoperable tools to support crisis call and response services. HCA and DOH staff began preparations for planned Request for Proposals (RFPs).

The HCA-initiated 988 State Affinity Workgroup (SAW) continues to convene monthly. It is now facilitated by representatives from the National Association of State Mental Health Program Directors (NASMHPD). The 988 SAW is a forum to discuss the implementation of 988, give and gain advice, discuss challenges, and learn about how other states are implementing 988 in their jurisdictions.

HCA and DOH staff are discussing options for the future 988 system's bed registry. DOH owns an existing system called WaHealth that still requires exploring, and HCA staff have analyzed systems used by other states via a 2021 NASMHPD

report. HCA staff have also spoken directly to several states about their experience and current state of bed registry, including Arizona, Georgia, Indiana, and Rhode Island.

HCA Health IT has brought on staff members from ISG to serve as Lead Project Managers on the 988 project. Other positions continue to be filled.

HCA and DOH staff have completed work with National Suicide Prevention Lifelines (NSPLs) and Regional Crisis Lines (RCLs), to map current state workflows for their encounters. The purpose of these mappings was to identify how a call flows in the current state of the center's system and identify key problems or focus areas for the future system to address. Outreach will continue into Q4 and Q1 of 2024 to ensure that future state requirements are gathered and addressed.

HCA and DOH staff met with NSPLs and RCLs about the role of RCLs in the 988 Hub future state. These meetings were convened to address centers' concerns or desires for the future state of RCLs in the 988 system. Recommendations are currently being drafted for next steps.

Electronic Consent Management (ECM)

The ECM solution will initially focus on managing consents governing 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.

In this reporting period, the contract with the solution vendor, CodeSmart Inc. (with subcontractor Midato Health), was approved by CMS, signed, and executed. This included an updated timeline, budget, and deliverables. The kickoff session with the vendor was held on September 21 and sprints began on October 3. The Independent Third Party QA/ Technical Quality Review (TQR) vendor came onboard August 14 and have posted their QA/TQR Plan and the QA/TQR Initial Assessment. HCA continues to meet with providers interested in being early system users and has confirmed a provider who will be an interoperability pilot partner. The baseline version of the electronic consent solution is scheduled to go live in May 2024.

Statewide EHR as a Service

The statewide plan for the implementation of an electronic health record system that will serve the Medicaid patient populations for HCA, Department of Corrections (DOC), and Department of Social and Health Services (DSHS) was completed and submitted for approval in September 2023. The plan was reviewed and received approval by the Office of Financial Management (OFM). The plan was submitted to the Technology Services Board (TSB) for review and approval, and we expect approval when TSB meets in late fall.

The statewide planning committee meets weekly to identify and report on the status of areas of work required to complete the pre-planning phase of this project, prior to contract execution and payment. These areas include:

- Staff the program office
- Establish governance
- Evaluate, select, and award a vendor contract
- Develop and issue of an RFP for systems integration services to support the program in implementing the selected EHR software

Department of Enterprise Services (DES) developed and released an RFP for an electronic health records convenience contract, which will allow the statewide EHR program to select an approved vendor and software. The RFP is scheduled to close at the end of November 2023, with an estimated selection of vendor/software by the EHR program in January 2024.

The Washington State's Health and Human Services Enterprise Coalition's Governance Committee (G1) approved the program office to be located within HCA, and the statewide planning committee is developing job descriptions to initiate the process of staffing the program office to oversee progress of the program and the individual agencies' projects.

Provider Directory Application Programming Interface (API)

MyHealthButton is published in the Google and Apple application stores. HCA continues to test and work through usability issues with the app development team. Another application, FlexPA connects successfully to the Fast Healthcare Interoperability Resources (FHIR)server. Next steps are to ensure successful usability testing and then send out communications around its availability to potential members. HCA is waiting for additional information from OneRecord, another interested third party entity. Once they send in the requested information, they can begin the connectivity process and testing. HCA currently has 154,000 providers listed in the provider directory as of June 30, 2023.

Master Person Index (MPI) project

The Health and Human Service Coalition (Coalition) MPI initiative has established the MPI solution, created its operational governance structure, and connected two Coalition systems. The MPI has identified 16 additional Coalition systems that are expected to connect by June 2025. Additionally, the MPI initiative is developing enhancements to the MPI to support future use cases, including enhanced reporting and notifying connected systems when new demographic information is available.

Integrated Care Assessment Initiative (WA-ICA)

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 Q2 of 2023, HCA staff and MCO colleagues presented at the Integrated Care Conference, sponsored by the University of Washington. WA-ICA workgroup members further refined the requirements for both a lead data entity and statewide coordinating entity.

During Q3 of 2023, the workgroup began to research and discuss a new approach for advancing integration due to changes in funding streams. Extensive provider materials were reviewed and prepared for transfer from the WA Portal to the HCA website. Healthier Here ACH also prepared data management pieces to be transferred to HCA. The writing of a final report for this phase of work began, which will inform the implementation plan going forward.

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. The final **ACH P4R report** was submitted on October 7, 2022.

Pay for performance (P4P)

HCA and the Independent Assessor are actively working on P4P results, achievement values, and the statewide accountability report. Because of the at-risk DSRIP funding, the statewide accountability report must be approved by CMS prior to the Independent Assessor finalizing regional P4P results.

Next steps

HCA will submit the statewide accountability report to CMS in Q4 of 2023 while continuing to work with the Independent Assessor on regional results in anticipation of CMS approval of the statewide accountability results.

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 the Community Hubs and implementation of health-related social needs (HRSN) services. HCA continues to convene a task force that includes representatives from managed care organizations (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 Q4 of 2023 will focus on an assessment of the current community-based organization (CBO) and community-based workforce network, along with implementation standards for the nine Community Hubs and the community-based workforce.

Annual value-based purchasing (VBP) milestone achievement by ACHs

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

There are no updates to report for the first reporting period of DY8 and VBP will be phased out with the sunsetting of DSRIP performance accountability.

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 **$28,319,823 to 146** partnering providers and organizations in support of project planning and implementation activities. The state distributed approximately **$5,000,000** in earned incentive funds to IHCPs in DY8 for achievement of DY6 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.

Tribal project implementation activities

This section summarizes the tribal project implementation activities for this quarter:

- The American Indian Health Commission, as the Tribal Coordinating Entity, submitted the final report for MTP 1.0, drawing down the final payment for IHCPs.

- Attended the National Tribal Opioid Summit, as the opioid epidemic is disproportionately impacting Indian Country.

LTSS implementation accomplishments

This section summarizes LTSS program development and implementation activities for MAC and TSOA programs from July 1 through September 30, 2023. Key accomplishments for this quarter include:

- As of September 30, 2023, more than 15, 800 individuals, in addition to their family caregivers, have received services and supports through the MAC and TSOA programs. The average caseload for the quarter was 3,919 clients.
- The Aging and Long-Term Support Administration (ALTSA) continued with their annual quality assurance cycle.
- Expansion under 1115 demonstration waiver renewal, MTP 2.0, to further develop innovative projects, activities, and services for MTP participants implementation is under way.
    - Expansion Highlights:
        - Effective July 1, income limit for TSOA eligibility increased to 400 percent of the federal benefit rate. This allowed for 18 new participants this quarter to access TSOA services.
        - Effective July 1, the resource standard was updated to reflect six months of the current private nursing facility rate. This resulted in one (1) additional participant being able to access TSOA services this quarter.
        - Policy and procedure development, as well as system configurations, have occurred for the expansion of the four additional services in both MAC and TSOA programs: nurse delegation, pest eradication, specialized deep cleaning, and community choice guide services.

Network adequacy for MAC and TSOA

Due to the continued shortage of paid in-home care providers for respite and personal care services, at both the national and state level, further innovation around service delivery is occurring. The Area Agencies on Aging (AAAs) continue to engage with a variety of new providers to serve as a bridge when personal care or respite workers are in short supply.

Other services in the MTP service benefits package to meet participants' needs are also being utilized, including, but not limited to, home delivered meals, personal emergency response systems, adult day care, and environmental modifications. AAAs have also been working on onboarding providers for support group services and behavior support specialists that offer MTP counseling, challenging behavior consultation, transitional behavioral health, and technical assistance to better support MAC and TSOA participants. Additionally, the AAAs continue to maintain and monitor existing service contracts.

Progress continues with Consumer Directed Employer (CDE) implementation. Consumer Direct of Washington (CDWA) is the contracted CDE provider for Washington state. CDWA implementation will expand personal or respite care provider options for MAC and TSOA participants.

Assessment and systems update

Tailored Caregiver Assessment and Referral (TCARE 5.0) evidence-based caregiver assessment tool was released in February 2023 and continues to release periodic upgrades for system compatibility with GetCare, the MAC and TSOA case management system.

RTZ Systems, GetCare' s administrator, will build an interface between the GetCare case management system and CDWA's provider management system. This interface will allow case managers to send and receive required documents to CDWA which are necessary so MAC and TSOA participants can utilize individual providers who will deliver personal care and respite services.

GetCare enhanced visibility of race and ethnicity values for PE and Nursing Facility Level of Care (NFLOC) confirmations were updated in the CARE data exchange to GetCare.

System configurations in both ProviderOne and GetCare have been initiated in preparation for the implementation of the new MTP 2.0 services (nurse delegation, pest eradication, specialized deep cleaning, and community choice guide services).

Staff training

MAC and TSOA program managers for Home and Community Services are committed to providing monthly statewide training webinars on requested and needed topics. Below are the webinar trainings that occurred during the first two reporting periods of DY8:

- **July**: Open Office Hours – Question and Answers
- **August**: Nurse Delegation Staff Training and Open Office Hours
- **September**: What's Lost, What's Gained; Resource Eligibility and After Public Health Emergency Financial Review/Discussion
- **October**: Open Office Hours including New Services Overview
- **November**: Open Office Hours including End of the Year Highlights and Getting to Know the CDWA Provider

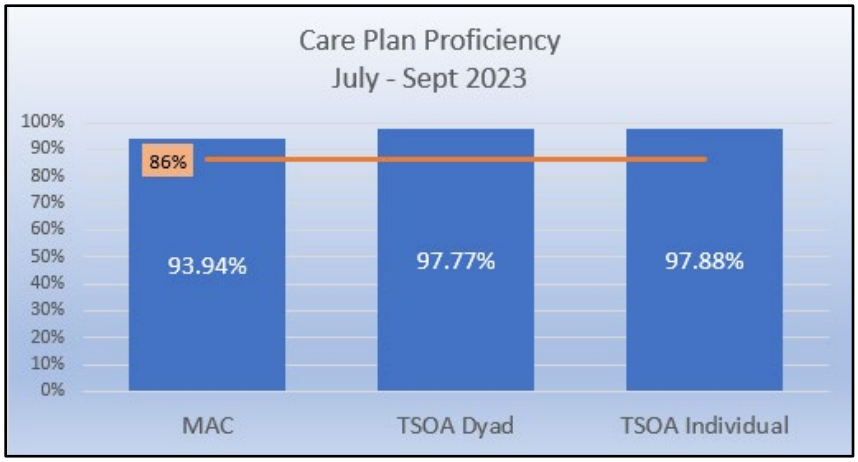
Data and reporting

Table 1: beneficiary enrollment by program

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of September 30, 2023	223	1245	2,846
Number of new enrollees in quarter by program	34	222	380
Number of new person-centered service plans in quarter by program	12	86	140
Number of new enrollees who do not require a care plan because they are still in the care planning phase and services have yet to be authorized	20	131	232
Number of beneficiaries self-directing services under employer authority*	0	0	0

*The state has successfully implemented the CDE for the 1915c and 1915k programs. Therefore, the MAC and TSOA programs, have started the system enhancements and interfaces needed for CDE implementation.

Figure 1: statewide care plan proficiency to date



Note: The 86 percent line represents the CMS proficiency expectation.

The AAAs compliance with timely completion of care plans for enrollees continues to be remarkable.

Tribal engagement

ALTSA met with a number of tribes to discuss Medicaid services, MAC, TSOA, and FCS from **July 1st-September 30th**.

- **July**: Tribal Affairs attended Swinomish Brain Health event and shared information about the MAC and TSOA programs with Tribal Elders. This information received positive feedback and stories from Elders who have utilized MAC and TSOA services.
- **August:** Tribal Affairs shared MAC and TSOA program information with the Muckleshoot Tribe during Savvy Caregiver in Indian Country. Many unpaid caregivers in the room were interested in learning about the program.
- **September**: Tribal Affairs visited Skokomish, Hoh, and Quileute and shared information with Tribal program managers who partner with unpaid caregivers to share information about MAC and TSOA.

MAC, TSOA, and other programs for unpaid caregivers will be presented at the upcoming 2023 Tribal Fall Summit scheduled for the first week in October.

Tribal Affairs has been building relationships with Tribal Nations while sharing services supported by Money Follows the Person Tribal Initiative (MFPTI) including MAC and TSOA programs. The MFPTI project manager is currently compiling all resources and information that pertain to the utilization of the grant and the services that it supports to present to unpaid caregivers in Tribal communities.

Outreach and engagement

ALTSA's MAC and TSOA program manager is still seeking indigenous volunteers to participate in interviews for the Caregivers Program video. A few Tribes have indicated interest in participating.

ALTSA headquarters staff have been collaborating with the AAAs on updating outreach materials and brainstorming ideas for new publications to engage potential MAC and TSOA community members. Some AAAs have indicated they may start utilizing the Wilder ads "You Call It…." campaign materials to increase community engagement.

Table 2: number of outreach and engagement activities held by Area Agencies on Aging

	July	August	September
Community presentations and information sharing	50	125	67

Though the volume and type of outreach activities continued to fluctuate, this quarter presented an overall increase.

Quality assurance

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

Figure 2: Question 1: was the client appropriately determined to be nursing facility level of care eligible for PE?

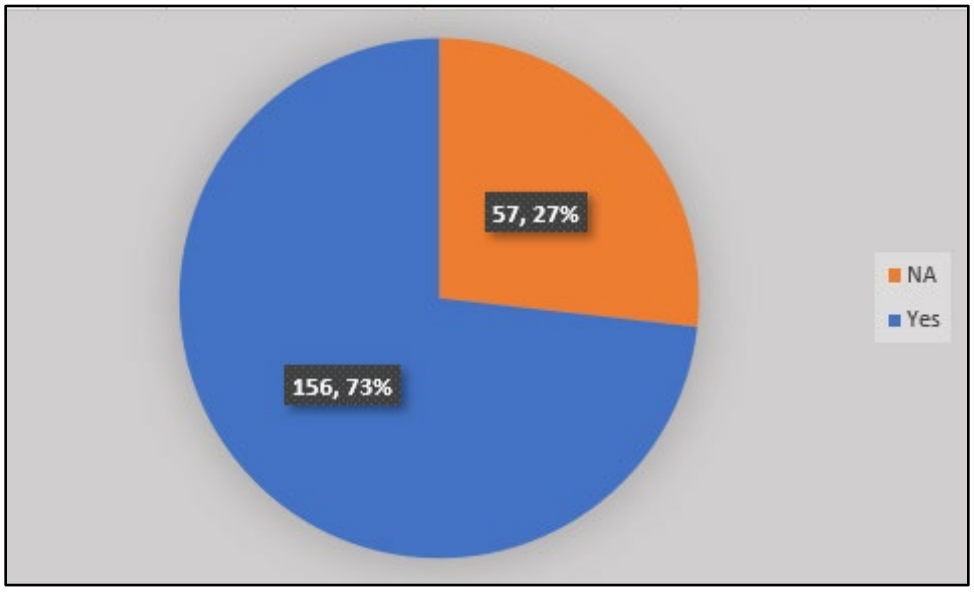


Figure 3: Question 2a: did the client remain eligible after the PE period?

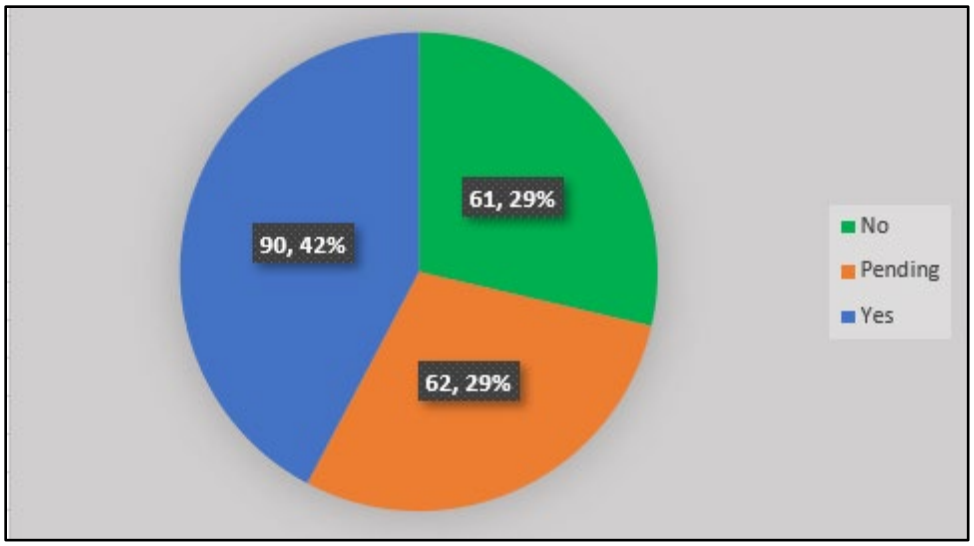
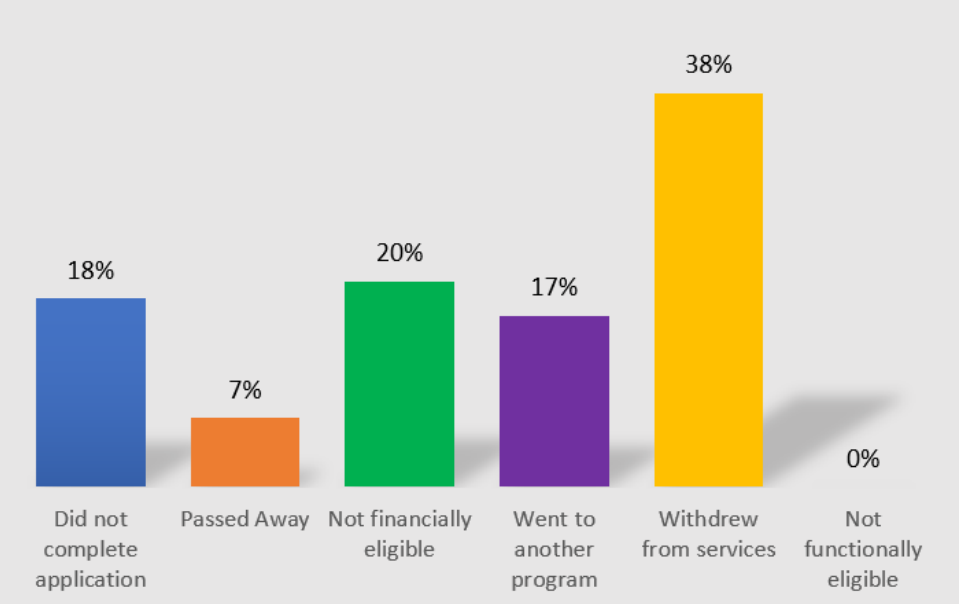


Figure 4: Question 2b: if "No" to question #2a, why?

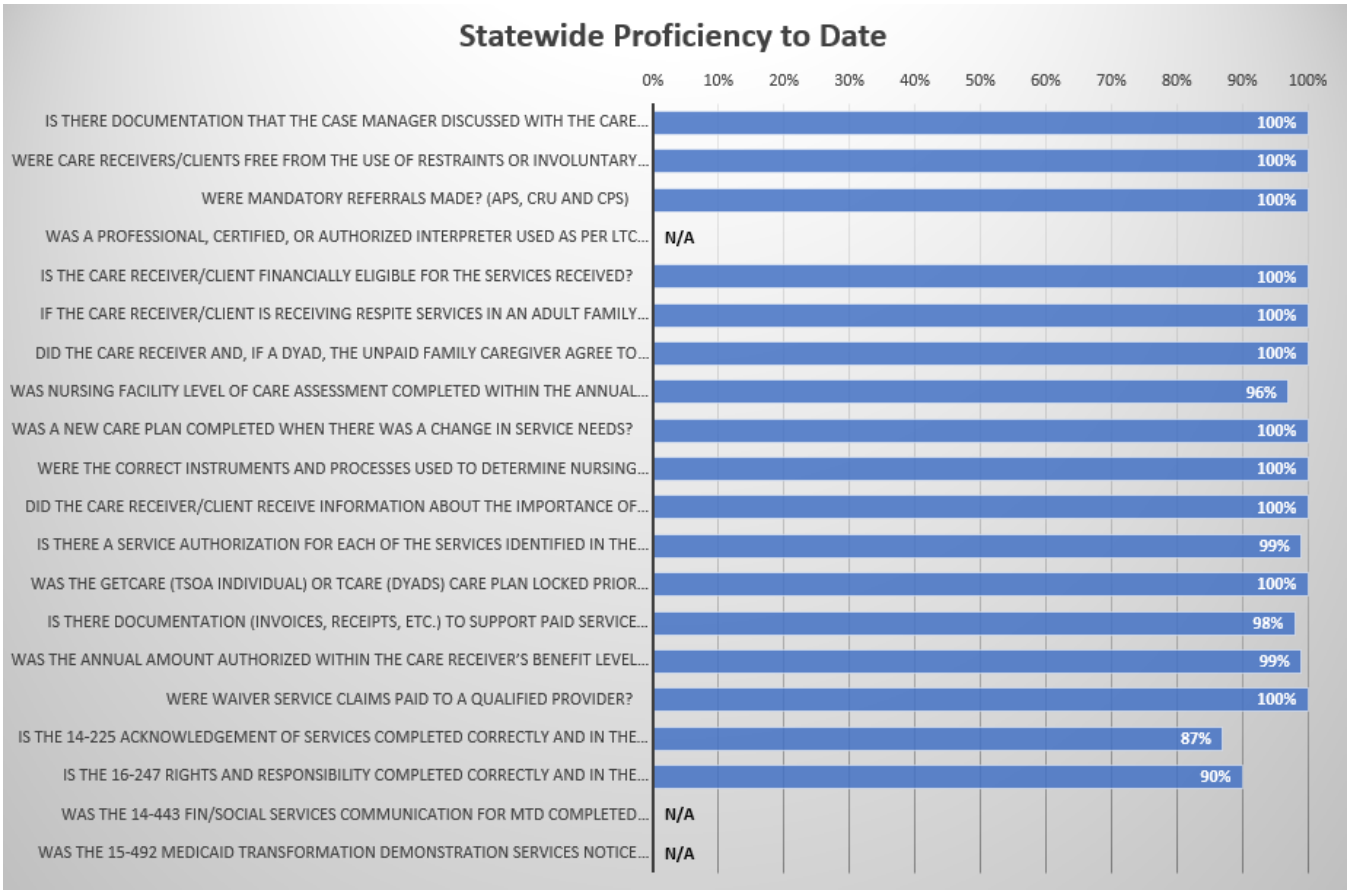


2023 quality assurance results to date

HCS's 2023 Quality Assurance cycle began in January, and it is projected to conclude in November 2023. 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 5: statewide proficiency to date



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

State rulemaking

The modified Washington Administrative Code (WAC) related to new MAC and TSOA services requested in the 1115 waiver renewal (MTP 2.0), as well as the expanded definition for transportation to include accessing community resources (requested in the January 2021 amendment), became permanent during this quarter.

Upcoming activit ies

- Full implementation and utilization of the new services approved under MTP 2.0.
- Application and utilization of the expanded transportation definition.
- Continuation of infrastructure development and staff training regarding Consumer Direct Employer implementation.

LTSS stakeholder concerns

No stakeholder concerns were noted during this quarter.

LTSS Presumptive Eligibility

The LTSS Presumptive Eligibility Program was approved June 30, 2023, as part of the MTP 2.0 renewal. This section summarizes LTSS program development and implementation activities for LTSS Presumptive Eligibility program from July 1 through September 30, 2023. Key accomplishments for this quarter include:

- Completion of Washington Administrative Code (WAC)

- Stakeholder engagement activities
- Finalizing staff training materials and conducting training with financial and social service staff
- Releasing CARE system updates such as PE assessment, client approval and denial letters and PE care plans
- Development of tracking and reporting metrics
- Completion of ProviderOne configuration changes for PE provider authorizations
- Development of communication tools for internal and external partners

Upcoming activities in the next quarter include:

- Launch of LTSS PE Phase 1 in December 2023
- Continued coordination with the Washington State Hospital Association related to LTSS PE referrals
- Continued development and refinement of tracking and reporting metrics

FCS implementation accomplishments

Foundational Community Supports (FCS) provides evidence-based supportive housing and supported employment services to eligible Medicaid clients. This section summarizes the FCS program development and implementation activities from July 1 through September 30, 2023. Key accomplishments for the quarter include:

Total aggregate number of people enrolled in FCS services at the end of DY8 reporting period 1:

- CSS: 13,612
- IPS: 6,737

There were 209 providers under contract with Amerigroup at the end of DY8 reporting period 1, representing 553 sites throughout the state.

Note: CSS and IPS enrollment totals include 3,240 participants enrolled in both programs. The total unduplicated number of enrollments at the end of this reporting period was 17,109.

Network adequacy for FCS

Table 3: FCS provider network development

	July		August		September	
FCS service type	Contracts	Service locations	Contracts	Service locations	Contracts	Service locations
Supported Employment – Individual Placement Support (IPS)	37	76	37	76	37	76
Community Support Services (CSS)	25	61	26	62	26	62
CSS and IPS	143	409	146	415	146	146
Total	**205**	**546**	**209**	**553**	**209**	**553**

Client enrollment

Table 4: FCS client enrollment

	July	August	September
Supported Employment – Individual Placement and Support (IPS)	3,239	3,382	3,497
Community Support Services (CSS)	9,573	10,144	10,372
CSS and IPS	2,965	3,162	3,240
Total aggregate enrollment	**15,777**	**16,688**	**17,109**

Data source: RDA administrative reports

Table 5: FCS client risk profile

		Met HUD homeless criteria	Avg. PRISM risk score	Serious mental illness
July	IPS	710 (11%)	.97	4,205 (68%)

August	CSS	2,560 (20%)	1.17	7,620 (61%)
	IPS	744 (11%)	1.05	4,497 (69%)
September	CSS	2,684 (20%)	1.29	8,381 (63%)
	IPS	752 (11%)	1.05	4,591 (68%)
	CSS	2,738 (20%)	1.28	8,535 (63%)

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
July	IPS	5,229	4,752 (91%)	3,160 (60%)	2,952 (56%)
	CSS	10,671	9,448 (89%)	7,600 (71%)	6,959 (65%)
August	IPS	5,531	4,980 (90%)	3,303 (60%)	3,071 (56%)
	CSS	11,365	9,989 (88%)	7,972 (70%)	7,260 (64%)
September	IPS	5,696	5,076 (89%)	3,349 (59%)	3,090 (54%)
	CSS	11,638	10,130 (87%)	8,083 (69%)	7,321 (63%)

Data source: RDA administrative reports

*Does not include individuals who are dual enrolled.

Table 7: FCS client service utilization

(Aging CARE assessment in last 15 months)

		Medicaid only enrollees*	Long-term Services and Supports	Mental health services	SUD services (received in last 12 months)	Care + MH or SUD services
July	IPS	5,229	632 (12%)	3,608 (69%)	1,959 (37%)	508 (10%)
	CSS	10,671	995 (9%)	6,508 (61%)	4,650 (44%)	812 (8%)
August	IPS	5,531	683 (12%)	3,662 (66%)	2,019 (37%)	534 (10%)
	CSS	11,365	1,033 (9%)	6,681 (59%)	4,821 (42%)	829 (7%)
September	IPS	5,696	717 (13%)	3,668 (64%)	2,014 (35%)	553 (10%)
	CSS	11,638	1,050 (9%)	6,616 (57%)	4,833 (42%)	823 (7%)

(Aging CARE assessment in last 15 months)

Data source: RDA administrative reports

*Does not include individuals who are dual-enrolled.

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
July	IPS	1,814 (29%)	150 (2%)	702 (11%)	2691 (43%)	679 (11%)	164 (3%)
	CSS	3,584 (29%)	643 (5%)	1,650 (13%)	4586 (37%)	1,947 (16%)	111 (1%)
August	IPS	1,903 (29%)	164 (3%)	738 (11%)	2863 (44%)	709 (11%)	161 (2%)
	CSS	3,763 (28%)	698 (5%)	1,781 (13%)	4893 (37%)	2,047 (15%)	105 (1%)
September	IPS	1,956 (29%)	177 (3%)	752 (11%)	2930 (43%)	753 (11%)	163 (2%)
	CSS	3,854 (28%)	718 (5%)	1,827 (13%)	4990 (37%)	2,107 (15%)	100 (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 collaborated with the Third Party Administrator (TPA) to oversee FCS. No significant concerns or problems were identified, and the TPA has confirmed the absence of any grievances or appeals throughout this period.

FCS staff continued work to identify processes to decrease the need for reconnecting enrollees who experience changes in their Medicaid coverage. FCS is not an entitlement benefit, and enrollment is accomplished through a manual process requiring weekly workflows to enroll and reenroll (or "reconnect") eligible individuals to the program. The reconnection process necessitates conducting a historical eligibility screening to identify gaps in coverage that may have occurred due to changes in Medicaid type, incarceration, or other modifications in the ProviderOne database that automatically disconnect an individual from FCS.

FCS Supported Employment training staff have successfully conducted several fidelity reviews of contracted FCS providers. These reviews were performed virtually or in a hybrid format over a period of two or more days, with review teams consisting of HCA staff and other FCS providers. To foster greater collaboration across systems, FCS training staff also engage fidelity reviewers from other state agencies, such as the DSHS Division of Vocational Rehabilitation.

The FCS team conducted two virtual comprehensive fidelity reviewer trainings, each divided into two sessions. One session centered on supported employment, while the other session was dedicated to supportive housing. The purpose of the training events was to equip FCS providers and potential reviewers with knowledge about the evidence-based practices; ultimately, enhancing the quality of the services they offer. The training aimed to prepare agency staff for their active participation in review panels while also raising their knowledge of fidelity measurement. It is worth noting that the fidelity reviews adopt a collaborative learning approach. Additionally, FCS providers can receive incentives through Substance Abuse and Mental Health Services Administration (SAMHSA) block grant funds if they choose to become reviewers or host a review.

Additionally, FCS Supportive Housing trainer staff hosted the second inaugural Permanent Supportive Housing (PSH) Fidelity Certification. The content was once again delivered by a national technical assistance organization that actively

supports the work of FCS, Advocates for Human Potential. The training was facilitated by both the supportive housing trainers, who offered comprehensive assistance and shared community-specific examples of successful PSH implementation. All together the FCS team successfully graduated 24 staff members who acquired vital PSH fidelity knowledge and are now actively contributing to the expansion of reviews throughout Washington.

Other FCS program activity

On August 14, 2023, FCS Program Administrator Scott Tankersley participated in a panel discussion titled Keeping Pace with Basic Needs: Cross-Agency Approaches to Align Health and Housing Systems at the 36th annual National Academy for State Health Policy (NASHP) conference in Boston, Massachusetts.

During the panel discussion, Tankersley provided an overview of FCS services while highlighting new opportunities for FCS under Washington's recently approved Medicaid Transformation Project 2.0 waiver proposal. After, the FCS team joined other states at NASHP's annual Health and Housing Institute meeting to discuss accomplishments, plan next steps, and address emerging opportunities and future directions for state health and housing initiatives.

HCA continues to maintain an ongoing monthly workgroup with the ALTSA team and Research and Data (RDA) staff. The workgroup meets to develop, discuss, and adopt key policies and practices necessary for the continued operation, improvement, and long-term success of the FCS program.

Additionally, the group continues to hold bi-monthly meetings with CSS providers, coordinated by King County, the most populous county in Washington state. These meetings offer housing providers in the county the opportunity to share experiences, exchange ideas, and learn from one another about effective practices when administering FCS benefits.

Furthermore, in partnership with the DSHS Division of Vocational Rehabilitation (DVR), HCA actively engages in a quarterly workgroup. This workgroup's primary goal is to improve consistency, foster collaboration, and optimize employment outcomes for DVR customers with behavioral health conditions who are receiving supported employment services through the DVR Supported Employment program and FCS.

FCS provided a funding opportunity, referred to as Glidepath, intended to provide formal benefit planning and employment services. Multiple agencies were awarded contracts and will support identified regions. These funds are intended to partner with Housing and Essential Needs (HEN) program to provide up to nine months of additional rental assistance as a bridge period for IPS-enrolled individuals who would otherwise be financially unsupported due to increasing income through employment.

Upcoming activities

Medicaid Academy: FCS will be offering a budgeting series related to the new FCS Budget Tool in addition to individual agency technical assistance provided by the Corporation for Supportive Housing. These courses are specifically designed for prospective and current FCS providers. The target audience includes executive leads, fiscal/finance leads, programmatic leads, and quality improvement leads within respective agencies.

Supportive Housing Institute: Based on provider feedback, a series of nine training courses aiming to increase tenant engagement, clarify roles and responsibilities, and increase the state's housing inventory will be offered in 2024 in addition to the FCS team's traditional Supportive Housing Institute in 2025.

The FCS team will continue to maintain regular meetings with the Department of Commerce to discuss the planning and development of two programs. These programs include the collaboration of the Department of Commerce, DSHS, and the HCA to establish permanent supportive housing units for CSS-eligible individuals under the name "Apple Health and Homes." Within the next quarter the FCS team hopes to finalize prioritization requirements and begin to officially launch the rental assistance aspect of the program.

FCS program stakeholder engagement activ ities

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

	July	August	September
Training and assistance provided to individual organizations	86	120	103
Community and regional presentations and training events	8	5	7
Informational webinars	7	7	7
Stakeholder engagement meetings	4	8	10
Total activities	**105**	**140**	**127**

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.

This reporting period's topics included:

- Bending but not breaking: Healthy grieving and building resilience
- Dementia: Promoting Stigma Reduction, Early Diagnosis, and Effective Communication
- Maintaining Optimism in a Challenging Housing Market
- Supplemental Security Income Overview
- Supporting Your Supervisees' Wellness with Restorative Supervision
- Using Permanent Supportive Housing Interventions in Transitional Housing Settings
- Utilizing Motivational Interviewing in Supported Employment: Listening for Change Talk
- Words are Powerful: Incorporating Strengths-Based Language into Career Services

FCS stakeholder concerns

The FCS team has been receiving feedback about the challenges faced by providers who are new to billing Medicaid when submitting claims. In response, HCA is offering additional one-on-one technical assistance and a series of budget webinars to support providers in adopting best practices and aligning with other Medicaid billing processes.

FCS agencies have been actively providing feedback and insights on FCS services. Providers share feedback during the quarterly Advisory Council meeting, in addition to other venues. Some of the issues that were raised were the need to increase understanding about systems used to verify eligibility of enrollees, examining reasons for application denials, and decreasing confusion through updating provider facing documents. To keep constituents informed, the FCS team regularly provides updates and opportunities during the quarterly Advisory Council meetings, as well as hosts webinars with specific and relevant information.

SUD IMD waiver implementation 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 mental health or substance use treatment.

SUD IMD waiver development and implementation accomplishments for this reporting period include:

- Hosted CMS visit in September, including site visits to facilities in Western Washington.
- Publicized international overdose awareness day and the ongoing "Friends for Life" statewide fentanyl education campaign that was launched earlier this year. This campaign seeks to inform teens and young adults in Washington about the risks of fentanyl and the power of naloxone to reverse opioid overdoses. The Washington Department of Health has a similar campaign for adults "Prevent Overdose WA."
- Legislation clarifying that Fentanyl testing strips are not considered illegal drug paraphernalia took effect on July 1. Washington's Department of Health will be distributing roughly 75,000 test strips to needle exchanges and other groups working with people with substance use disorders.

Implementation plan

In accordance with the amended STCs, the 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 met a number of these milestones in its provision of SUD services. Where the state did not meet the milestones, CMS was engaged to confirm appropriate adjustments.

SUD Health IT plan requirements

See these subheadings listed in the **Health IT activities and successes section:**

- Crisis Call and Response Services
- Electronic Consent Management
- MH IMD Waiver HIT Requirements

Evaluation design

There are no updates to report for this reporting period.

Monitoring protocol

There are no updates to report for this reporting period.

Upcoming activities

Expecting approval of state plan amendment for implementation of mobile crisis shortly.

MH IMD 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 July 1 through September 30, 2023.

- Hosted CMS visit with Washington State and local providers of IMD and community services.
- OHSU completed Midpoint assessment.

Implementation plan

There are no updates to report for this reporting period.

MH Health IT plan requirements

See these subheadings listed in the **Health IT activities and successes section:**

- Crisis Call and Response Services
- Electronic Consent Management
- MH IMD Waiver HIT Requirements

Evaluation design

During DY8 reporting period 1, there are no updates to report for this quarter.

Monitoring protocol

During DY8 reporting period 1, there are no updates to report for this quarter.

Upcoming activities

Upcoming activities found under the SUD IMD section.

Contingency Management for SUD treatment implementation accomplishments

On July 1, 2023, Washington State received approval of its 1115 waiver (MTP 2.0) for new programs. Contingency Management is an evidence-based behavioral intervention for stimulant use disorder. It provides incentives to individuals contingent upon objective evidence of the target behavior, such as a negative urine drug test, in order to increase the likelihood of these behaviors, which are essential components and outcomes of effective treatment. This section summarizes the Contingency Management program development and implementation activities from July 1 through September 30, 2023.

Implementation progress

Since approval of the waiver, the state has engaged in initial discussion and planning activities to outline implementation steps. The following activities were completed during the reporting period:

- Formed a project team, identified key stakeholders, and established a draft project timeline
- Began the process of gathering essential information, data, and resources required for implementation
- Created a project charter and identified key roles
- Gathered relevant Contingency Management policies, guidelines, and best practices

Upcoming activities

The state is starting the process of identifying sites that are interested in becoming an eligible site.

Continuous Enrollment implementation accomplishments

On July 1, 2023, Washington State received approval of its 1115 waiver (MTP 2.0) for new programs:

- The **Continuous Apple Health enrollment for children, ages 0 through 5,** program provides continued benefits for eligible children, from birth through the end of the month in which they turn six years old.
- The **Apple Health Postpartum coverage expansion** program provides continued benefits for individuals from the end of pregnancy through 12 months postpartum.

This section summarizes the Continuous Enrollment programs development and implementation activities from July 1 through September 30, 2023.

Continuous Apple Health enrollment for children, ages 0 through 5

Implementation progress

Since the approval date in April 2023, the state has implemented a manual process to ensure continuous coverage for Medicaid children under the age of six. This includes reinstating coverage for any children under the age of six who may lose coverage under the yearly redetermination process.

The state has also conducted outreach and training to families, providers, staff, and navigators across the state about this expanded benefit and manual process.

Upcoming activities

The state is planning to have full system support by March 2024 and will continue outreach to families in the meantime.

Apple Health Postpartum coverage expansion

Implementation progress

The state implemented postpartum coverage in June 2022 under American Rescue Plan Act (ARPA) and covered this group with state-only funding prior to waiver approval.

Upcoming activities

Since waiver implementation, the state is working towards adding this coverage group into managed care by July 2024 to be consistent with all federally funded programs in Washington.

Reentry from a carceral setting implementation accomplishments

On July 1, 2023, Washington State received approval of its 1115 waiver (MTP 2.0) for new programs. The reentry from a carceral setting program provides Medicaid eligible individuals pre-release services up to 90 days prior to the expected date of release to their communities. This section summarizes the program development and implementation activities from July 1 through September 30, 2023.

Implementation progress

HCA continues to convene the Re-entry Advisory Workgroup (RAW), a legislatively directed workgroup to advise on design and implementation of the reentry program under MTP 2.0. The workgroup includes several state agencies, carceral facilities, associations, and other leaders in justice-involved policies and operations.

In addition, several implementation subgroups have been formed to advise on facility and provider readiness, system changes, care management continuity pre-release and post-release, eligibility and enrollment, and benefit design for the pre-release period.

HCA staff developed a comprehensive implementation plan to capture activities, decision points, and dependencies across the reentry project. The state has completed several initial milestones, including the following:

- Engaged CMS to review preliminary results from the state's reinvestment plan analysis
- Coordinated with CMS to verify expenditure authority to support early reentry planning and implementation capacity investments to help facilities prepare for pre-release service implementation
- Completed informational interviews with facilities to inform the current state assessment
- Completed preliminary analysis of potential Third-Party Administrator functions to support pre-release services and continuity post-release

Upcoming activities

HCA will continue to work on several priority planning efforts in the second reporting period, including the following:

- Re-investment plan submission
- Continued discussions and information gathering regarding a potential TPA role to support administrative and/or care management functions
- Care management design, including pre-release and immediate post-release continuity of care
- Planning and implementation funding design, including parameters for funding amounts, phases of distribution, and the potential role of a lead entity to support the application and funds distribution process
- Benefit design for mandatory and secondary services, including parameters for progression from mandatory to secondary services by facility
- Enrollment and plan assignment pre-release and post-release, including implications on the potential TPA role and Medicaid billing

Health-related social needs (HRSN) implementation accomplishments

On July 1, 2023, Washington State received approval of its 1115 waiver (MTP 2.0) for new programs.

- The **Community Hubs** focus on community-based care coordination, including screening individuals, determining health-related social needs (HRSN), connecting individuals to community organizations that can provide services to meet those needs.
- The **Native Hub** is a statewide network of Indian health care providers, tribal social service divisions, and Native-led, Native-serving organizations focused on whole-person care coordination.
- **HRSN services** include nutrition, housing, rental subsidies, transportation, and other non-medical HRSN services that help a person live their healthiest life.
- **HRSN Infrastructure** provides infrastructure investments to support the readiness for HRSN service delivery. Investments include technology, planning, workforce development, and convening.

This section summarizes the HRSN development and implementation activities from July 1 through September 30, 2023.

Community Hubs

Implementation progress

The Taking Action for Healthier Communities (TAHC) Task Force—made up of representatives from ACHs, MCOs, and state agencies—continues to work to shape the community hubs. Part of the task force's mission is to ensure alignment between community hub and MCO service offerings.

Upcoming activities

After a summer hiatus, the TAHC Task Force will reconvene in October. HCA will continue to work with partners on several priority planning efforts in the second reporting period, including the following:

- HRSN Case Management (Community Hub) payment methodology
- Qualifications and criteria for community-based workers
- Collaboration and role clarity between Community Hubs and MCOs, including populations of focus, network coordination, and referral and data sharing expectations

Native Hub

Implementation progress

The Native Hub is being co-developed between HCA and the 29 federally-recognized Tribes and 2 Urban Indian health programs in Washington State. To facilitate co-development, HCA launched a road show to visit these 31 Indian health care providers (IHCPs). The intention of these visits is to discuss community-based care coordination, health related social need services, reentry and the intersection with services provided by Tribes and IHCPs.

Upcoming activities

Next steps include:

- Finish visiting all Tribes and IHCPs;
- Determine the best path forward for co-design, whether that be a newly established workgroup, building off already existing groups or a hybrid approach; and
- Continue to participate in the TAHC Task Force, plus workgroups and committees to ensure alignment between MCOs, ACHs and state agencies with the Native Hub.

Health related social needs (HRSN) services and infrastructure

Implementation progress

- Within HCA, an HRSN Services workgroup has been formed to oversee the design and delivery of waiver-approved HRSN services. One of the workgroup's goals is alignment of delivery between waiver-funded HRSN services for the fee-for-service population and ILOS-approved services for the managed care population.
- Working with ACHs, the state began efforts to define the process for infrastructure funding distribution (pending CMS approval) for CBO and Community Hub capacity building.

Upcoming activities

- The HRSN Services workgroup will identify HRSN services to be launched in phase 1 of the overall implementation.
- In the next reporting period, the state will submit the following deliverables:
  - HRSN Infrastructure protocol document. The state is submitting this document as part 1 of the HRSN Services Protocol in anticipation of prioritized review and approval by CMS. This approval will allow the state to move forward with critical HRSN infrastructure investment to support planning and capacity building, including the application and funds distribution process that will be supported by the ACHs.
  - Maintenance of Effort (MOE) baseline analysis to CMS. The MOE analysis will describe the state's baseline investments in nutrition and housing supports to ensure maintenance of these investments over the course of HRSN services implementation.

Quarterly expenditures

The following table reflects quarterly expenditures for DSRIP, LTSS, and FCS during DY7 (2023). **MCOs earned $0.0** and **ACHs earned $0.0** for VBP incentives in the first reporting period of DY8. Indian Health Care Providers (IHCP) received $5,000,000 in incentives for this quarter.

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-DY8 Total (January 1–December 31)	Funding source: Federal financial participation
Better Health Together	$0.0	$5,514,444	$0.0		$5,514,444	$2,757,222
CHOICE	$0.0	$3,553,253	$0.0		$3,553,253	$1,776,627
Elevate Health	$0.0	$4,401,665	$0.0		$4,401,665	$2,200,833
Greater Health Now	$0.0	$6,730,054	$0.0		$6,730,054	$3,365,027
HealthierHere	$0.0	$10,911,877	$0.0		$10,911,877	$5,455,939
Thriving Together North Central Washington	$0.0	$2,252,070	$0.0		$2,252,070	$1,126,035
North Sound	$0.0	$7,705,759	$0.0		$7,705,759	$3,852,880
Olympic Community of Health	$0.0	$2,113,025	$0.0		$2,113,025	$1,056,513
SWACH	$0.0	$3,500,230	$0.0		$3,500,230	$1,750,115
Indian Health Care Providers	$0.0	$0.0	$5,000,000		$0.0	$2,500,000

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-DY8 Total (January 1–December 31)
Amerigroup WA	$0	1,362,405.00	0		1,362,405.00
CHPW	$0	1,272,727.00	0		1,272,727.00
CCW	$0	938,784.00	0		938,784.00
Molina	$0	2,946,142.00	0		2,946,142.00
United Healthcare	$0	1,479,942.00	0		1,479,942.00

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)	DY7-DY8 Total (January 1–December 31)
Tailored Supports for Older Adults (TSOA)	$5,171,456	$6,189,650	3,523,276		14,884,382.38
Medicaid Alternative Care (MAC)	$159,264	$579,071	117,757		856,092.17
MAC and TSOA not eligible	$259.28	$-	$0.00		259.28
FCS	$7,950,523	$7,705,120	$9,829,628		$25,485,271

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.

The agency recently migrated to a new database and we were not able to transition the data query from the old database in time to pull SUD and SMI member months for this quarter. We anticipate updating the member months in next quarter's report.

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	CE Post-Partum
Jan-17	376,294	0	0	0	0	0	0	0	0	
Feb-17	375,190	0	0	0	0	0	0	0	0	
Mar-17	374,718	0	0	0	0	0	0	0	0	
Apr-17	373,570	0	0	0	0	0	0	0	0	
May-17	373,115	0	0	0	0	0	0	0	0	
Jun-17	373,017	0	0	0	0	0	0	0	0	
Jul-17	372,104	0	0	0	0	0	0	0	0	
Aug-17	371,838	0	0	0	0	0	0	0	0	
Sep-17	370,572	0	0	0	0	0	0	0	0	
Oct-17	370,377	0	0	0	0	0	0	0	0	
Nov-17	370,206	0	0	0	0	0	0	0	0	
Dec-17	370,233	0	0	0	0	0	0	0	0	
Jan-18	370,272	0	0	0	0	0	0	0	0	
Feb-18	368,897	0	0	0	0	0	0	0	0	
Mar-18	368,703	0	0	0	0	0	0	0	0	
Apr-18	367,443	0	0	0	0	0	0	0	0	
May-18	367,806	0	0	0	0	0	0	0	0	
Jun-18	367,084	0	0	0	0	0	0	0	0	
Jul-18	366,826	5	19	91	10	0	0	0	0	
Aug-18	366,226	8	17	95	44	0	0	0	0	
Sept-18	365,228	4	19	80	44	0	0	0	0	
Oct-18	365,227	4	22	93	47	0	0	0	0	
Nov-18	364,759	3	27	93	34	0	0	0	0	
Dec-18	364,210	4	17	96	23	0	0	0	0	
Jan-19	364,136	34	133	411	37	0	0	0	0	
Feb-19	362,453	31	115	391	40	0	0	0	0	
Mar-19	362,105	42	144	398	45	0	0	0	0	
Apr-19	361,634	56	136	473	38	0	0	0	0	
May-19	361,116	43	125	483	49	0	0	0	0	
June-19	360,357	65	150	573	54	0	0	0	0	

Jul-19	360,784	65	197	676	55	0	0	0	0
Aug-19	360,356	66	243	744	49	0	0	0	0
Sep-19	359,910	75	214	779	44	0	0	0	0
Oct-19	359,397	73	237	884	36	0	0	0	0
Nov-19	358,533	81	190	812	44	0	0	0	0
Dec-19	358,859	58	213	940	51	0	0	0	0
Jan-20	359,306	32	129	531	44	0	0	0	0
Feb-20	359,309	24	125	478	44	0	0	0	0
Mar-20	361,001	33	133	484	45	0	0	0	0
Apr-20	364,492	42	109	383	21	0	0	0	0
May-20	366,943	25	97	376	29	0	0	0	0
Jun-20	369,741	46	157	553	46	0	0	0	0
Jul-20	372,433	25	84	335	32	0	0	0	0
Aug-20	375,265	51	218	711	38	0	0	0	0
Sep-20	377,486	65	208	680	46	0	0	0	0
Oct-20	379,515	26	93	373	43	0	0	0	0
Nov-20	380,421	54	185	762	27	0	0	0	0
Dec-20	381,872	66	192	827	26	89	58	264	5
Jan-21	383,016	41	131	563	31	242	170	799	17
Feb-21	383,033	25	89	298	18	275	196	876	11
Mar-21	384,324	21	85	318	25	293	239	952	15
Apr-21	385,613	25	97	369	15	267	234	844	18
May-21	386,768	31	85	313	26	278	263	871	16
Jun-21	387,781	17	32	157	21	305	227	878	16
Jul-21	389,346	25	104	368	20	272	179	605	17
Aug-21	391,339	19	91	322	20	250	176	564	14
Sep-21	392,726	16	86	326	15	241	177	604	14
Oct-21	394,018	16	81	273	11	256	199	620	18
Nov-21	395,907	14	77	301	14	248	226	608	27
Dec-21	396,523	7	45	221	13	237	221	625	15
Jan-22	398,125	1	15	66	7	238	237	625	22
Feb-22	399,411	15	97	367	8	221	250	599	24
Mar-22	400,968	18	116	409	3	236	240	672	23
April-22	403,141	22	105	358	20	198	169	459	16
May-22	404,577	3	13	62	11	285	263	691	17
Jun-22	406,797	30	110	401	26	282	218	654	12
Jul-22	408,855	21	91	367	17	239	128	506	9
Aug-22	411,602	24	117	484	16	255	219	685	8
Sep-22	412,976	4	28	152	13	236	199	576	10
Oct-22	414,916	0	12	34	16	77	46	192	6
Nov-22	417,208	26	105	355	15	279	227	694	5
Dec-22	419,767	8	34	168	3	236	173	591	3
Jan-23	421,785	0	0	0	0	73	30	150	0
Feb-23	423,798	0	0	0	0	0	0	0	0

Mar-23	426,501	0	0	0	0	0	0	0	0	
April-23	427,728	0	0	0	0	0	0	0	0	
May-23	427,746	0	0	0	0	0	0	0	0	
Jun-23	419,842	0	0	0	0	0	0	0	0	
Jul-23	411,235	0	0	0	0	0	0	0	0	563
Aug-23	0	0	0	0	0	0	0	0	0	545
Sep-23	0	0	0	0	0	0	0	0	0	548
Total	**30,178,711**	**1,635**	**5,794**	**21,657**	**1,569**	**6,108**	**4,964**	**16,204**	**358**	**1,656**

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)

No updates to report. The state anticipates continuing discussions with CMS in Q4 of 2023.

Overall MTP development and issues

Operational/policy issues

HCA and agency partners continue to work with the Washington State Legislature to answer questions, provide implementation updates, and support budget development aligned with the MTP 2.0 CMS approval.

Consumer issues

The state has not experienced any major consumer issues for MTP 2.0 during this reporting quarter, other than general inquiries about benefits available through MTP 2.0, including new and continuing programs.

MTP evaluation

The MTP Independent External Evaluator's (IEE) quarterly rapid cycle report was put on hold to allow the IEE to prioritize the following activities:

- MTP 1.0 Summative Evaluation Report
- MTP 2.0 evaluation design

Upcoming IEE activities

The state and the IEE qualitative team will determine how the MTP evaluation and IEE report process will continue for the next quarter.

Summary of additional resources, enclosures, and attachments

Additional resources

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

Summary of attachments

- Attachment A: **state contacts**
- Attachment B: **Financial Executor Portal Dashboard**
- 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	Director, Medicaid Transformation Project	360-725-0868
DSRIP program	Chase Napier	Director, Medicaid Transformation Project	360-725-0868
LTSS program	Debbie Johnson	Initiative 2 Program Manager, DSHS	360-725-2531
FCS program	Matthew Christie	Program Administrator, Foundational Community Supports	360-489-2021
SUD IMD waiver	David Johnson	Federal Programs manager	360-725-9404
MH IMD waiver	David Johnson	Federal Programs manager	360-725-9404
Continuous Eligibility	Maggie Clay	OMEDP Deputy Section manager, MPD	360-725-1079
HRSN	Mary Franzen	Connector, Medicaid Transformation Project	360-622-1994
Native Hub	Lena Nachand	Tribal Liaison, Office of Tribal Affairs	360-725-1386
Reentry	Chase Napier	Director, Medicaid Transformation Project	360-725-0868
Contingency Management	Lora Weed	Acting Project Director, State Opioid Response Grant, State Opioid Response Treatment Manager	360-725-1998

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

View this table on the HCA website, which shows all funds earned and distributed through the FE portal through September 30, 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 the state to receive Federal Financial Participation (FFP) for Medicaid recipients residing in institutions for mental disease (IMDs) under the terms of this demonstration for coverage of medical assistance including opioid use disorder (OUD)/substance use disorder (SUD) benefits that would otherwise be matchable if the beneficiary were not residing in an IMD. Under this demonstration, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to ongoing chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. Expenditure authority will allow the state to improve existing SUD services and ensure the appropriate level of treatment is provided, increase the availability of medication assisted treatment (MAT), and enhance coordination between levels of care. The state will continue offering a full range of SUD treatment options using the American Society for Addiction Medicine (ASAM) criteria for assessment and treatment decision making. 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

While there were slight increases in the number of beneficiaries with SUD diagnoses, services, SBIRT treatment, any outpatient SUD treatment, residential or inpatient treatment, withdrawal management, and medication assisted treatment, the numbers were within the range of previously reported rates.

The overall continuity of pharmacotherapy for opioid use disorder has decreased from the previous year, however, the absolute numbers who had continuity in the pharmacotherapy for OUD has increased by 8% from the previous year.

The overall rate of access to ambulatory preventative health services for Adult Medicaid Beneficiaries with SUD has decreased from the previous reporting period. However, the absolute number of individuals who received AAP services has increased.

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.

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 number of beneficiaries with an SUD diagnosis in a given month has increased slightly over the last several months. However, the numbers are within the range of previously reported rates. The pattern is consistent for all subpopulation reporting. 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)
	Not reported this quarter.	07/01/2018 – 06/30/2019	#4: Medicaid beneficiaries with SUD diagnosis (annual)
	Not reported this quarter.	07/01/2018 – 06/30/2019	#5: Medicaid beneficiaries treated in an IMD for SUD
☐ **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 target population(s) of the demonstration.** **☐ ii) The clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration.**			
☒ 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 number of individuals who received any SUD treatment has increased slightly over the last several months. However, the numbers are within the range of previously reported rates. The pattern is consistent for all subpopulation reporting. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#6: Any SUD Treatment
	The number of individuals who received SBIRT treatment has increased slightly over the last several months. However, the numbers are within the range of previously reported rates. The pattern is consistent for all subpopulation reporting. Research within the state has highlighted some barriers to billing for SBIRT, including but not limited to staff turnover and	04/01/2019 – 06/30/2019	#7: Early Intervention

	uncertainty around reimbursement. 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.		
	The number of individuals who received any outpatient SUD treatment has increased slightly over the last several months. However, the numbers are within the range of previously reported rates. The pattern is consistent for all subpopulation reporting. 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 number of individuals who received any residential or inpatient SUD treatment has increased slightly over the last several months. However, the numbers are within the range of previously reported rates. The pattern is consistent for all subpopulation reporting. 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 number of individuals who received withdrawal management has increased slightly over the last several months. However, the numbers are within the range of previously reported rates. The pattern is consistent for all subpopulation reporting. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#11: Withdrawal Management
	The number of individuals who received Medication Assisted Treatment has increased slightly over the last several months. However, the numbers are within the range of previously reported rates. The pattern is consistent for all subpopulation reporting. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of	04/01/2019 – 06/30/2019	#12: Medication Assisted Treatment

	these services is unknown. Any changes in trends should be interpreted with caution.		
	Not reported this quarter.	07/01/2018 – 06/30/2019	#36: Average Length of Stay in IMDs
☐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) 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 treatment 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.	Not reported this quarter.	07/01/2018 – 06/30/2019	#13: SUD provider availability
	Not reported this quarter.	07/01/2018 – 06/30/2019	#14: SUD provider availability – MAT
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.	Not reported this quarter.	01/01/2017 – 12/31/2017	#15: Initiation and Engagement of Alcohol and Other Drug Treatment
☐The state has no trends to report for this reporting topic.	Not reported this quarter.	01/01/2018 – 12/31/2018	#18: Use of Opioids at High Dosage in Persons without Cancer (modified by State)
	Not reported this quarter.	01/01/2018 – 12/31/2018	#21: Concurrent Use of

			Opioids and Benzodiazepines (modified by State)
	The overall rate of continuity of pharmacotherapy for opioid use disorder has decreased from the previous year. However, the absolute number of individuals who had continuity in the pharmacotherapy for OUD has increased by 8% from the previous year. 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)
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.	Not reported this quarter.	01/01/2017 – 12/31/2017	#17(1): Follow-Up after Emergency Department Visit for Alcohol or Other Drug Dependence
	Not reported this quarter.	01/01/2017 – 12/31/2017	#17(2): Follow-Up after Emergency Department Visit for Mental Illness
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.	Not reported this quarter.	07/01/2017 – 06/30/2018	Q1: PDMP Statewide Fatal Drug Overdoses – All, All Opioids, Heroin, Prescription Opioids (excluding synthetic opioids), Synthetic Opioids (not Methadone)
	Not reported this quarter.	07/01/2018 – 06/30/2019	Q2: Substance Use Disorder Treatment

			Penetration Rate
	Not reported this quarter.	07/01/2018 – 06/30/2019	Q3: Foundational Community Supports Beneficiaries with Inpatient or Residential SUD Services
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" supports 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 the state'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.**	Not reported this quarter due to data issue.	04/01/2019 – 06/30/2019	#23: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries
	Not reported this quarter due to data issue.	04/01/2019 – 06/30/2019	#24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries

	Not reported this quarter.	07/01/2018 – 06/30/2019	#25: Readmissions Among Beneficiaries with SUD
	Not reported this quarter due to data issue.	07/01/2017 – 06/30/2018	#26: Overdose Deaths (count)
	Not reported this quarter due to data issue.	07/01/2017 – 06/30/2018	#27: Overdose Deaths (Rate)
	The overall rate of AAP for Adult Medicaid Beneficiaries with SUD has decreased from the previous reporting period. However, the absolute number of individuals who received AAP services has increased. 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.	01/01/2017 – 12/31/2017	#40: Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD.
☐ 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 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 measure 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 Substance Use Disorder 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 should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of the VS with the 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	July 1, 2018-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 utilization rate of inpatient mental health services increased slightly compared with prior months. However, the utilization is similar to the utilization in Q1 of CY2021 and CY2022, suggesting that the increase may be due to seasonality.

The utilization rate of intensive outpatient and partial hospitalization mental health services has remained consistent with prior months.

The utilization rate of outpatient mental health services increased slightly compared with prior months. However, the utilization is similar to the utilization in Q1 of CY2021 and CY2022, suggesting that the increase may be due to seasonality.

The utilization rate of emergency department mental health services has remained consistent with prior months.

The utilization rate of telehealth mental health services decreased compared with prior months. This is likely a continuation of the downward trend of telehealth utilization as concerns around COVID-19 exposures waned and due to changes in how audio-only telehealth services were billed (effective January 1, 2023).

The utilization of any mental health services has remained consistent with prior months.

The number of beneficiaries with a SMI/SED diagnosis has remained consistent with prior months.

There were no grievances reported in this reporting period, The number of appeals reported is consistent with prior quarters.

The number of critical incidents reported is higher than prior quarters. However, the number of critical incidents reported varies widely from quarter to quarter. It is unclear whether this pattern will continue.

Over half of the community based psychiatric hospitals who bill Medicaid in Washington reported using HIT for discharge summaries in CY2022. This is the first time this data has been reported. 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.

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.

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 this quarter.	01/01/2020-12/31/2020	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)
☒ 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 settings**		
☒ 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 this quarter.	All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated

			Physical and Behavioral Health Care (PMH-20)
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Medication Continuation Following Inpatient Psychiatric Discharge
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH)
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Follow-up After Hospitalization for Mental Illness: Age

			18 and Older (FUH-AD)
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA-AD)
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20)

☒ **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 utilization rate of inpatient mental health services increased slightly compared with prior months. However, the utilization is similar to the utilization in Q1 of CY2021 and CY2022, suggesting that the increase may be due to seasonality. 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 - Inpatient
	The utilization rate of intensive outpatient and partial hospitalization mental health services has remained consistent with prior months. 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 utilization rate of outpatient mental health services increased slightly compared with prior months. However, the utilization is similar to the utilization in Q1 of CY2021 and CY2022, suggesting that the increase may be due to seasonality. 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 utilization rate of emergency department mental health services has remained consistent with prior	04/01/2021-06/01/2021	Mental Health

	months. 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.		Services Utilization - ED
	The utilization rate of telehealth mental health services decreased compared with prior months. This is likely a continuation of the downward trend of telehealth utilization as concerns around COVID-19 exposures waned and due to changes in how audio-only telehealth services were billed (effective January 1, 2023). 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 - Telehealth
	The utilization of any mental health services has remained consistent with prior months. 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 metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Average Length of Stay in IMDs
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Average Length of Stay in IMDs (IMDs receiving FFP only)

	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Beneficiaries With SMI/SED Treated in an IMD for Mental Health
☐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 make other 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 number of beneficiaries with a SMI/SED diagnosis has remained consistent with prior months. 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.	04/01/2022-6/30/22	Count of Beneficiaries With SMI/SED (monthly)
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Count of Beneficiaries With SMI/SED (annually)
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Access to Preventive/ Ambulatory Health Services for Medicaid Beneficiaries With SMI
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Metabolic Monitoring for Children and Adolescents

			on Antipsychotics
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication
☐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.	Over half of the community based psychiatric hospitals who bill Medicaid in Washington reported using HIT for discharge summaries in CY2022. This is the first time this data has been reported. 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.	*01/01/2022-12/31/2022*	Community Based Psychiatric Hospitals Using HIT for Discharge Summaries
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Mental Health Treatment Penetration Rate
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Foundational Community Supports for Beneficiaries with Inpatient or Residential Mental

	Health Services
☐**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 broader 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 state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED -

			Inpatient or Residential
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential
	There were no grievances reported in this reporting period. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2021-06/01/2021	Grievances Related to Services for SMI/SED
	The number of appeals reported is consistent with prior quarters. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of	04/01/2021-06/01/2021	Appeals Related to

	these services is unknown. Any changes in trends should be interpreted with caution.		Services for SMI/SED
	The number of critical incidents reported is higher than prior quarters. However, the number of critical incidents reported varies widely from quarter to quarter. It is unclear whether this pattern will continue. 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	Critical Incidents Related to Services for SMI/SED
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Per Capita Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Mental Health Treatment

			Penetration Rate
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2020-12/31/2020	Foundational Community Supports for Beneficiaries with Inpatient or Residential Mental Health Services
☐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 updates on 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 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 topic.

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

The MPT, FUH-CH, 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 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 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 measure 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 should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of the VS with the non-NCQA measures and any coding contained in the VS.