STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

April 8, 2020

Calder Lynch
Deputy Administrator and Director
Centers for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Calder:

SUBJECT: 1115 Waiver Demonstration – Medicaid Transformation Project – Amendment Request

The Washington State Health Care Authority (HCA) is pleased to submit a formal amendment request for its section 1115 waiver demonstration, the Medicaid Transformation Project. The primary objective of this amendment is to provide the state with the necessary flexibility to respond to its shortage of inpatient psychiatric capacity, by providing appropriate care for individuals with serious mental illnesses/serious emotional disturbances with high quality care.

We appreciate the guidance that the Centers for Medicare and Medicaid Services (CMS) provided through its November 13, 2018 letter to State Medicaid Directors (SMD # 18–011), this amendment request is in alignment with the goals and milestones set forth in that letter.

Approval of this amendment request will allow Washington State to maintain and expand access to inpatient psychiatric treatment for individuals in need of acute psychiatric care. Use of state dollars to pay for services in institutions for mental disease (IMD) reduces the ability to focus state funding on other vital services.

Allowing beneficiaries to continue enrollment with Medicaid managed care entities when individuals receive services in participating IMDs will also benefit care coordination activities. Current restrictions necessitate that individuals be dis-enrolled from their plan should a stay last more than 15 calendar days—creating administrative challenges and hurdles.

Approval of this amendment request will support necessary bed capacity in the state of Washington, while promoting better outcomes, allowing Medicaid beneficiaries timely access to the individualized care they need.

Washington State is committed and well positioned to meet the goals and milestones CMS has outlined in its guidance letter.

We thank you for the opportunity to build on Medicaid Transformation accomplishments to date, and look forward to working with the CMS as we advance common objectives through this amendment request and implementation plan.

Should you or your staff have questions regarding this request, please feel free to contact me by telephone at 360-725-1863 or via email at maryanne.lindeblad@hca.wa.gov.

Sincerely,

[redacted]

MaryAnne Lindeblad, BSN, MPH
Medicaid Director

By email

cc: David Meacham, Associate Regional Administrator, Region 10, CMS
Mich'l Needham, Chief Policy Officer, PD, HCA
Keri Waterland, Assistant Director, DBHR, HCA

Healthier Washington Medicaid Transformation Section 1115 Waiver Amendment Request

April 7, 2020

Contents

Introduction

Access to the full array of mental health treatment options is vital to ensure safe, healthy communities. Washington State is a leader in providing innovative treatment at all levels of care. Our state legislature invests millions annually across the state to cover inpatient psychiatric care, hospital diversion programs, peer services, crisis stabilization, housing supports, and more. Despite our efforts, immediate access to inpatient psychiatric treatment remains a concern. Community psychiatric hospitals are in most cases operated by private organizations. One key constraint these facilities operate under is economy of scale. Current federal rules limit Medicaid payment for services in dedicated facilities larger than 16 beds. This limitation prevents organizations from expanding services that included larger facilities and better economy of scale.

In its November 8, 2018 letter to State Medicaid Directors (SMD #18-001), CMS provided new guidance on improving access to a full array of mental health (MH) services and quality treatment for Medicaid beneficiaries. CMS offered states the opportunity to apply for an 1115 waiver amendment allowing the use of federal funds in mental health institutions for mental disease (IMDs). As part of this new approach, the Centers for Medicare and Medicaid (CMS) expects states to maintain a focus on outpatient MH services, including crisis stabilization, while meeting several clinical, system, and information technology milestones.

Washington State remains committed to funding outpatient mental health and crisis services, as demonstrated by recent budget provisos. The state funds a full array of mental health services including outpatient, crisis, residential, and inpatient care. This waiver amendment will allow the state to continue to use state funds to maintain and expand this continuum of care. Washington State understands that this waiver opportunity requires states to meet maintenance of effort requirements. The state is committed to maintaining at least the current levels of outpatient services in order to meet waiver requirements.

On January 9, 2017, Washington State received federal approval of its request for a Section 1115 waiver, the Medicaid Transformation Project (MTP). An amendment to that waiver, allowing federal financial participation (FFP) for treatment in substance use disorders (SUD) in IMD facilities, was approved in July 2018. Given the guidance outlined in SMDL #18-001, Washington State is requesting expenditure authority to claim FFP for services provided to Medicaid beneficiaries who receive inpatient MH services in an IMD. Washington State is requesting flexibility through this amendment to the MTP to include the following:

1. The state is requesting expenditure authority to claim FFP for services provided to Medicaid beneficiaries aged 21-64 who receive inpatient psychiatric services in an IMD; and
2. The state is requesting corrections to the Special Terms and Conditions to ensure the terms accurately reflect the agreement between the state and CMS.

Serious Mental Illness/Seriously Emotionally Disturbed amendment request

Background

Approval of this amendment request will allow Washington State to maintain and expand access to inpatient and short-term residential MH treatment. 42 C.F.R. 435.1009 prohibits FFP for expenditures for services provided to

patients in IMDs aged 21 to 64. 42 C.F.R. 438.6(e), as amended in May 2016, prohibits FFP for capitation payments on behalf of Medicaid beneficiaries aged 21-24 residing in IMDs beyond 15 days in a calendar month Medicaid beneficiaries aged 21-64.

Prior to the regulation's change, Washington State was permitted to utilize FFP for capitation payments on behalf of patients in IMD facilities if the services were "in lieu of" services in non-IMD settings. This authority was included in the state's 1915(b) waiver, and deemed a cost-effective alternative to Medicaid State Plan services. Under the 1915(b) in lieu of waiver authority, Washington State was able to demonstrate that using FFP for services in IMD facilities was a cost-effective approach to ensuring network sufficiency for those in need of inpatient and residential services.

Washington State has 636 mental health beds in eleven facilities that meet the definition of an IMD. Because the 2016 Managed Care Final Rule prohibits use of FFP in these facilities when the stay lasts longer than 15 days, the state and the managed care entities it contracts with must use limited state dollars to pay for treatment of critical emergency services. Use of state dollars to pay for services in IMD settings reduces the ability to focus state funding on other vital services.

Detailed request

Washington State is requesting waiver authority to allow FFP for payment of services to Medicaid beneficiaries receiving treatment in a MH IMD. The state is also seeking the authority to make capitation payments to state contracted managed care entities to pay for services to Medicaid beneficiaries regardless of the length of stay in an IMD.

Washington State is requesting that the waiver authorities described in this amendment apply to Medicaid beneficiaries in both the managed care and fee-for-service (FFS) systems. Application of the waiver to both systems would ensure equal access to this benefit for all Medicaid beneficiaries. Specifically, HCA seeks a waiver of the following requirements:

Policy	Waiver/Expenditure Authority	Statutory and Regulatory Citation
Allow the state to make capitated payments to managed care entities for individuals residing in MH IMDs that have an average length of stay of 30 days or less regardless of the individual's length of stay and regardless of the age of the individual. Capitated payments may be used to pay for treatment in IMD settings and services provided before or after discharge from the facility during the calendar month. Any in lieu of services provided in an IMD would meet the requirements of 42 CFR 438.3(e).	Waivers of all IMD payment restrictions Expenditure authority for IMD payments	42 CFR 438.6(e)
To allow for FFP in expenditures for services provided to managed care and fee-for-service (FFS) Medicaid beneficiaries in MH IMD facilities, including IMD facilities that are public institutions.	Expenditure authority for IMD payments	§1905(a)(29) paragraphs A and B

Proposed milestones

Appendix A (Implementation Plan) includes the state's initial approach to key system reform milestones. These

milestones address system reforms described in the State Medicaid Director's letter which outlines a path toward an IMD exception for MH services using the 1115 waiver process.

Budget neutrality

As required by CMS, this amendment request must include a budget neutrality analysis. Based on CMS guidance, the state completed a detailed budget neutrality analysis. The analysis includes calculations that consider expenditures with and without waiver authority, which address:

1. The waiver's expenditure authority (costs not otherwise matchable) is limited to expenditures for otherwise covered services, furnished to otherwise eligible individuals who are receiving inpatient psychiatric treatment and are short-term residents in facilities that meet the definition of an IMD.
2. The waiver's expenditure authority includes expenditure authority for IMD exclusions related to medical assistance, as well as expenditure authority for additional hypothetical[1] services that can be provided outside the IMD.

The full budget neutrality analysis is provided in Appendix C.

Evaluation

The currently approved MTP seeks to advance the following goals:

- Integrate physical and behavioral health purchasing and service delivery to better meet whole person needs.
- Convert 90 percent of Medicaid provider payments to reward outcomes instead of volume.
- Support provider capacity to adopt new payment and care models.
- Implement population health strategies that improve health equity.
- Provide new targeted services that address the needs of the state's aging populations and address key determinants of health.

Washington's 1115 waiver evaluation design was initially approved by CMS on October 26, 2017, and will be modified to incorporate the IMD exclusion waiver amendment. The evaluation design will be modified to incorporate an assessment of whether authorizing expenditure authority for services in IMDs will increase MH inpatient and residential bed capacity, increase Medicaid beneficiary access to inpatient and residential MH treatment services, and increase the likelihood that Medicaid beneficiaries receive MH treatment in the setting most appropriate for their needs.

Public process

Per the MTP's special terms and conditions, the state is required to comply with state notice procedures (set forth in 59 Fed. Reg. 49249, September 27, 1994), and follow the state public notice process (outlined in 42 CFR §431.408). The state requested technical assistance from CMS regarding the public notice process, as 42 CFR §431.408 pertains to waiver applications or extensions, not amendments. As a result, CMS clarified that the state has fulfilled the public process requirements for this amendment request, as this amendment request was the result of a directive from the Washington State Legislature. A copy of this legislation is provided in Appendix C. Additionally, the state was advised

[1] Additional hypothetical services may include optional services that could be included in the State Plan, but are being authorized using expenditure authority

to fulfill the requirements outlined in 59 Fed. Reg. 49249.

Public input

The state is committed to extensive and transparent stakeholder engagement. The state engaged providers by making presentations at the Health Information Technology planning meetings, as well as the Behavioral Health Organization Administrator's meetings and the Statewide Co-occurring Disorders Conference.

Tribal engagement

Washington State is home to 29 federally recognized tribal governments and two urban Indian health organizations. On January 22, 2020, in accordance with 42 CFR 431.408(b), the state notified tribes, urban Indian health organizations, and other tribal parties of its intent to pursue an amendment to its Section 1115 waiver, and request for two roundtable sessions and formal tribal consultation. A copy of the notification letter is provided in Appendix G.

On January 20, 2020 and February 11, 2020, state staff met with representatives and staff from tribes and urban Indian health organizations to foster mutual understanding of the amendment request, and determine the implications and potential benefits for tribes and urban Indian health organizations. The state held formal tribal consultation on February 24, 2020 to further discuss the content and impact of the waiver amendment request. The state incorporated feedback received during tribal consultation, including input on preferred utilization management strategies for FFS claims, highlighting the role of health homes, and the need to implement culturally appropriate assessment tools. The meeting minutes from tribal consultation are provided in Appendix H.

Conclusion

The proposed flexibilities described in this amendment request authority to build on Washington's current efforts to improve care for Medicaid beneficiaries by focusing on building health systems capacity, care delivery redesign, prevention and health promotion, and preparing for a value-based system. These flexibilities will allow us to continue to improve the quality and integration of care delivery, while also strengthening and expanding the state's already robust outpatient MH system.

We look forward to continuing the discussion with CMS regarding Washington's amendment request to improve health outcomes for our Medicaid beneficiaries. We thank our federal partners at CMS in advance for their consideration of this important request.

State contact

Contact information for the state's point of contact for the MTP amendment request:

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Appendices

Appendix A. Budget neutrality analysis

Appendix B. Engrossed Second House Bill 1109

Appendix C. Tribal notification letter

Appendix D. Tribal Consultation minutes

5 Years of Historical SMI Data

Disabled	CY2016	CY2017	CY2018	CY2019	CY2020	Average
Total Expenditure		$201,597	$275,270	$297,508	$339,861	$ 1,114,236
User Months		1,334	1,711	1,732	1,754	6,531
PMPM Cost		$ 151.12	$ 160.88	$ 171.77	$ 193.76	$ 170.61
Disabled Trend Rates			**Annual Change**			**4-Year Average**
Total Expenditure			36.54%	8.08%	14.24%	19.02%
User Months			28.26%	1.23%	1.27%	9.55%
PMPM Cost			6.46%	6.77%	12.80%	8.64%

Non-Disabled	CY2016	CY2017	CY2018	CY2019	CY2020	Average
Total Expenditure		$15,258	$20,864	$24,021	$27,682	$ 87,826
User Months		644	852	863	874	3,233
PMPM Cost		$ 23.69	$ 24.49	$ 27.83	$ 31.67	$ 27.17
Non-Disabled Trend Rates			**Annual Change**			**4-Year Average**
Total Expenditure			36.74%	15.13%	15.24%	21.96%
User Months			32.30%	1.29%	1.27%	10.72%
PMPM Cost			3.36%	13.66%	13.79%	10.16%

Newly Eligible	CY2016	CY2017	CY2018	CY2019	CY2020	Average
Total Expenditure		$106,776	$126,354	$138,341	$161,528	$ 532,999
User Months		2,057	2,391	2,410	2,429	9,287
PMPM Cost		$ 51.91	$ 52.85	$ 57.40	$ 66.50	$ 57.39
Newly Eligible Trend Rates			**Annual Change**			**4-Year Average**
Total Expenditure			18.34%	9.49%	16.76%	14.80%
User Months			16.24%	0.79%	0.79%	5.70%
PMPM Cost			1.80%	8.62%	15.85%	8.61%

AI/AN FFS	CY2016	CY2017	CY2018	CY2019	CY2020	Average
Total Expenditure			$708,139			$ 708,139
User Months			58			58
PMPM Cost			$12,209			$ 12,209.30
AI/AN FFS Trend Rates			**Annual Change**			**4-Year Average**
Total Expenditure						n/a
User Months						n/a
PMPM Cost						n/a

Alternate SMI IMD MEG PMPM Development

		Acute Care PMPM by MEG below			CURRENT State Plan Service(s)			
Medicaid Eligibility Group (MEG)	Estimated Total Expenditures for SMI Medical Assistance Provided in an IMD	Estimated Total Expenditures for All Other non-SMI/IMD Title XIX State Plan Medical Assistance	Estimated Eligible Member Months for All Medical Assistance Provided in an IMD	Estimated PMPM Cost	Disabled	Non-Disabled	Newly Eligible	AI/AN FFS
Disabled	$ 339,861	$ 917.35	1,754	$ 1,111.11	Included			
Non-Disabled	$ 27,682	$ 222.79	874	$ 254.47		Included		
Newly Eligible	$ 161,528	$ 399.42	2,429	$ 465.92			Included	
AI/AN FFS	$ 708,139	$ -	58	$ 12,209				Included
Totals					$1,111.11	$254.47	$465.92	$12,209.30

Demonstration Without Waiver (WOW) Budget Projection: Coverage Costs for Populations

Disabled	Trend	Months	Base Year	Trend	Demonstration Years (DY)					Total WOW
Pop Type: Medicaid	Rate 1	Of Aging	CY 2020	Rate 2	DY 01	DY 02	DY 03	DY 04.5	DY 05	
User Months	9.5%		1,754	1.2%				877	1,776	
PMPM Cost	8.6%	3	$1,111.11	5.1%				$ 1,124.99	$ 1,167.70	
Total Expenditure								$ 986,620	$ 2,073,834	$ 3,060,455

Non-Disabled	Trend	Months	Base Year	Trend	Demonstration Years (DY)					Total WOW
Pop Type: Medicaid	Rate 1	Of Aging	CY 2020	Rate 2	DY 01	DY 02	DY 03	DY 04.5	DY 05	
User Months	10.7%		874	1.3%				437	885	
PMPM Cost	10.2%	3	$ 254.47	4.9%				$ 257.55	$ 267.04	
Total Expenditure								$ 112,550	$ 236,327	$ 348,877

Newly Eligible	Trend	Months	Base Year	Trend	Demonstration Years (DY)					Total WOW
Pop Type: Medicaid	Rate 1	Of Aging	CY 2020	Rate 2	DY 01	DY 02	DY 03	DY 04.5	DY 05	
User Months	5.7%		2,429	0.8%				1,215	2,448	
PMPM Cost	8.6%	3	$ 465.92	5.0%				$ 471.69	$ 489.42	
Total Expenditure								$ 573,100	$ 1,198,097	$ 1,771,196

AI/AN FFS	Trend	Months	Base Year	Trend	Demonstration Years (DY)					Total WOW
Pop Type: Medicaid	Rate 1	Of Aging	CY 2018	Rate 2	DY 01	DY 02	DY 03	DY 04.5	DY 05	
User Months	n/a		58	1.0%				30	61	
PMPM Cost	n/a	27	$ 12,209.30	5.0%				$ 13,625.95	$ 14,133.79	
Total Expenditure								$ 408,778	$ 862,161	$ 1,270,940

Demonstration With Waiver (WW) Budget Projection: Coverage Costs for Populations

Disabled	Trend	Months	Base Year	Demo	Demonstration Years (DY)					Total WW
Pop Type: Medicaid	Rate 1	Of Aging	CY 2020	Trend Rate	DY 01	DY 02	DY 03	DY 04.5	DY 05	
User Months	9.5%	3	1,754	1.2%				877	1,776	
PMPM Cost	8.6%	3	$1,111.11	5.1%				$ 1,124.99	$ 1,167.70	
Total Expenditure								$ 986,620	$ 2,073,834	$ 3,060,455

Non-Disabled	Trend	Months	Base Year	Demo	Demonstration Years (DY)					Total WW
Pop Type: Medicaid	Rate 1	Of Aging	CY 2020	Trend Rate	DY 01	DY 02	DY 03	DY 04.5	DY 05	
User Months	10.7%	3	874	1.3%				437	885	
PMPM Cost	10.2%	3	$ 254.47	4.9%				$ 257.55	$ 267.04	
Total Expenditure								$ 112,550	$ 236,327	$ 348,877

Newly Eligible	Trend	Months	Base Year	Demo	Demonstration Years (DY)					Total WW
Pop Type: Medicaid	Rate 1	Of Aging	CY 2020	Trend Rate	DY 01	DY 02	DY 03	DY 04.5	DY 05	
User Months	5.7%	3	2,429	0.8%				1,215	2,448	
PMPM Cost	8.6%	3	$ 465.92	5.0%				$ 471.69	$ 489.42	
Total Expenditure								$ 573,100	$ 1,198,097	$ 1,771,196

AI/AN FFS	Trend	Months	Base Year	Demo	Demonstration Years (DY)					Total WW
Pop Type: Medicaid	Rate 1	Of Aging	CY 2018	Trend Rate	DY 01	DY 02	DY 03	DY 04.5	DY 05	
User Months	n/a	27	58	1.0%				30	61	
PMPM Cost	n/a	27	$ 12,209.30	5.0%				$ 13,625.95	$ 14,133.79	
Total Expenditure								$ 408,778	$ 862,161	$ 1,270,940

4. DSH

Panel 1: Historic DSH Claims for the Last Five Fiscal Years:

RECENT PAST FEDERAL FISCAL YEARS	20__	20__	20__	20__	20__
State DSH Allotment (Federal share)					
State DSH Claim Amount (Federal share)					
DSH Allotment Left Unspent (Federal share)	$ -	$ -	$ -	$ -	$ -

Panel 2: Projected Without Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)						
State DSH Claim Amount (Federal share)						
DSH Allotment Projected to be Unused (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -

Panel 3: Projected With Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
State DSH Claim Amount (Federal share)						
Maximum DSH Allotment Available for Diversion (Federal share)						
Total DSH Allotment Diverted (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
DSH Allotment Available for DSH Diversion Less Amount Diverted (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -
DSH Allotment Projected to be Unused (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -

Panel 4: Projected DSH Diversion Allocated to DYs

DEMONSTRATION YEARS		DY 01	DY 02	DY 03	DY 04	DY 05
DSH Diversion to Leading FFY (total computable)						
FMAP for Leading FFY						
DSH Diversion to Trailing FFY (total computable)						
FMAP for Trailing FFY						
Total Demo Spending From Diverted DSH (total computable)		$ -	$ -	$ -	$ -	$ -

Budget Neutrality Summary

Without-Waiver Total Expenditures

Medicaid Populations	Demonstration Years (DY)					Total
	DY 01	DY 02	DY 03	DY 04.5	DY 05	
Disabled	$ -	$ -	$ -	$ 986,620	$ 2,073,834	$ 3,060,455
Non-Disabled	$ -	$ -	$ -	$ 112,550	$ 236,327	$ 348,877
Newly Eligible	$ -	$ -	$ -	$ 573,100	$ 1,198,097	$ 1,771,196
AI/AN FFS	$ -	$ -	$ -	$ 408,778	$ 862,161	$ 1,270,940
Total	$ -	$ -	$ -	$ 2,081,048	$ 4,370,419	$ 6,451,467

With-Waiver Total Expenditures

Medicaid Populations	Demonstration Years (DY)					Total
	DY 01	DY 02	DY 03	DY 04.5	DY 05	
Disabled	$ -	$ -	$ -	$ 986,620	$ 2,073,834	$ 3,060,455
Non-Disabled	$ -	$ -	$ -	$ 112,550	$ 236,327	$ 348,877
Newly Eligible	$ -	$ -	$ -	$ 573,100	$ 1,198,097	$ 1,771,196
AI/AN FFS	$ -	$ -	$ -	$ 408,778	$ 862,161	$ 1,270,940
Total	$ -	$ -	$ -	$ 2,081,048	$ 4,370,419	$ 6,451,467

Net Overspend	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

SMI IMD User Months/Caseloads (Historical and Projected)

		Data Year by Calendar Year (CY)		Caseload Projections by Calendar Year (CY)		
	Trend Rate	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
Disabled	1.25%	1,334	1,711	1,732	1,754	1,776
Non-Disabled	1.30%	644	852	863	874	885
Newly Eligible	0.79%	2,057	2,391	2,410	2,429	2,448
AI/AN FFS	1.00%		58	59	60	61

Historical Data Summary

	Member Months			
	2017	2018	2019	2020
Disabled Adults	1,405,664	1,387,352		
Non-Disabled Adults	2,423,707	2,378,937		
Disabled Children	610,921	611,104		
Non-Disabled Children	8,806,130	8,740,733		
Newly Eligible	6,699,279	6,398,899		
Total	19,945,701	19,517,025		

	SMI IMD User Months			
	2017	2018	2019	2020
Disabled Adults	1,250	1,562		
Non-Disabled Adults	311	360		
Disabled Children	84	149		
Non-Disabled Children	333	492		
Newly Eligible	2,057	2,391		
Total	4,035	4,954		

	Behavioral Health Capitation PMPMs			
	2017	2018	2019	2020
Disabled Adults	$ 155.62	$ 168.46	$ 180.25	$ 203.54
Non-Disabled Adults	$ 34.54	$ 37.46	$ 43.15	$ 49.20
Disabled Children	$ 84.25	$ 81.42	$ 82.90	$ 91.22
Non-Disabled Children	$ 13.56	$ 15.00	$ 16.63	$ 18.85
Newly Eligible	$ 51.91	$ 52.85	$ 57.40	$ 66.50

	SMI Blended Behavioral Health Capitation PMPM			
	2017	2018	2019	2020
Disabled	$ 151.12	$ 160.88	$ 171.77	$ 193.76
Non-Disabled	$ 23.69	$ 24.49	$ 27.83	$ 31.67
Newly Eligible	$ 51.91	$ 52.85	$ 57.40	$ 66.50

Acute Care Rates

Program	Waiver MEG	CY 2018 Member Months	CY 2018 Acute Care Capitation Rates	CY 2018 - CY 2020 OACT Expense Annual Trend	Est. CY 2020 Acute Care Capitation Rates
Apple Health SCHIP Rates	Non-Disabled	676,744	$ 124.38	4.06%	$ 134.70
Apple Health Family Child Rates	Non-Disabled	8,061,029	$ 135.42	4.06%	$ 146.65
Apple Health Family Adult Rates	Non-Disabled	1,493,778	$ 301.08	4.39%	$ 328.12
Apple Health Blind/Disabled Rates	Disabled	2,886,570	$ 850.42	3.86%	$ 917.35
Apple Health Adult Coverage (AHAC) Rates	Newly Eligible	6,398,899	$ 360.81	5.22%	$ 399.42

	Acute Care Blended PMPM
Non-Disabled - Child	$ 145.72
Non-Disabled - Adult	$ 328.12
Non-Disabled - Total*	$ 222.79
Disabled	$ 917.35
Newly Eligible	$ 399.42

* Based on SMI IMD Child/Adult Case Mix

AI/AN Data Summary: Historical MC and Estimated FFS [1]

	AI/AN MC SMI IMD User Months		Est. AI/AN FFS SMI IMD User Months		
	2017	2018	2018	2019	2020
Total	167	233	58		

	AI/AN MC SMI IMD Dollars		Est. AI/AN FFS SMI IMD Dollars		
	2017	2018	2018	2019	2020
Total	1,734,286	2,844,767	708,139		

	AI/AN MC SMI IMD Cost Per User Month		Est. AI/AN FFS SMI IMD Cost Per User Month		
	2017	2018	2018	2019	2020
Total	10,385	12,209	12,209		

Estimated AI/AN FFS SMI IMD Cost Per User Month

Source of Information	Blend Percentage	Cost Per User Month
Managed Care AI/AN 2018 Cost Per User Month[1]	100%	$ 12,209
Actual AI/AN FFS SMI IMD 2018 Cost Per User Month	0%	N/A
Estimated AI/AN FFS SMI IMD 2018 Cost Per User Month	-	$ 12,209

Estimated AI/AN FFS SMI IMD User Months

Source of Information	Blend Percentage	User Months
Managed Care AI/AN 2018 User Months	0%	233
Annualized Actual AI/AN FFS SMI IMD 2018 User Months	100%	58
Estimated AI/AN FFS SMI IMD 2018 Cost Per User Month	-	58

Notes:

[1] The development of the AI/AN FFS MEG relies on managed care experience for AI/AN members who opted out of FFS. This data serves as a proxy in the absence of actual AI/AN FFS data.

SMI Historical Spending Data - 4 Years

Disabled	CY2016	CY2017	CY2018	CY2019	CY2020	Average
Total Expenditure		$201,597	$275,270	$297,508	$339,861	$1,114,236
User Months		1,334	1,711	1,732	1,754	6,531
PMPM Cost		$151.12	$160.88	$171.77	$193.76	$170.61
Disabled Trend Rates			**Annual Change**			**4-Year Average**
Total Expenditure			36.54%	8.08%	14.24%	19.02%
User Months			28.26%	1.23%	1.27%	9.55%
PMPM Cost			6.46%	6.77%	12.80%	8.64%

Non-Disabled	CY2016	CY2017	CY2018	CY2019	CY2020	Average
Total Expenditure		$15,258	$20,864	$24,021	$27,682	$87,826
User Months		644	852	863	874	3,233
PMPM Cost		$23.69	$24.49	$27.83	$31.67	$27.17
Non-Disabled Trend Rates			**Annual Change**			**4-Year Average**
Total Expenditure			36.74%	15.13%	15.24%	21.96%
User Months			32.30%	1.29%	1.27%	10.72%
PMPM Cost			3.36%	13.66%	13.79%	10.16%

Newly Eligible	CY2016	CY2017	CY2018	CY2019	CY2020	Average
Total Expenditure		$106,776	$126,354	$138,341	$161,528	$532,999
User Months		2,057	2,391	2,410	2,429	9,287
PMPM Cost		$ 51.91	$52.85	$57.40	$66.50	$57.39
Newly Eligible Trend Rates			**Annual Change**			**4-Year Average**
Total Expenditure			18.34%	9.49%	16.76%	14.80%
User Months			16.24%	0.79%	0.79%	5.70%
PMPM Cost			1.80%	8.62%	15.85%	8.61%

AI/AN FFS	CY2016	CY2017	CY2018	CY2019	CY2020	Average
Total Expenditure			$708,139			$708,139
User Months			58			58
PMPM Cost			$12,209.30			$12,209.30
AI/AN FFS Trend Rates			**Annual Change**			**4-Year Average**
Total Expenditure						
User Months						
PMPM Cost						

Alternate SMI IMD MEG PMPM Development

Medicaid Eligibility Group (MEG)	Estimated Total Expenditures for SMI Medical Assistance Provided in an IMD	Estimated Total Expenditures for All Other non-SMI/IMD Title XIX State Plan Medical Assistance	Estimated Eligible Member Months for All Medical Assistance Provided in an IMD	Estimated PMPM Cost
Disabled	$ 339,861	$ 917.35	1,754	$ 1,111.11
Non-Disabled	$ 27,682	$ 222.79	874	$ 254.47
Newly Eligible	$ 161,528	$ 399.42	2,429	$ 465.92
AI/AN FFS	$ 708,139	$ -	58	$ 12,209.30

SMI IMD User Months/Caseloads (Historical and Projected)

		Data Year by Calendar Year (CY)		Caseload Projections by Calendar Year (CY)		
	Trend Rate	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
Disabled	1.25%	1,334	1,711	1,732	1,754	1,776
Non-Disabled	1.30%	644	852	863	874	885
Newly Eligible	0.79%	2,057	2,391	2,410	2,429	2,448
AI/AN FFS	1.00%	-	58	59	60	61

Demonstration Without Waiver (WOW) Budget Projection: Coverage Costs for Populations

Disabled	Trend	Months	Base Year	Trend	Demonstration Years (DY)					Total WOW
Pop Type: Medicaid	Rate 1	Of Aging	CY 2020	Rate 2	DY 01	DY 02	DY 03	DY 04.5	DY 05	
User Months	9.5%		1,754	1.2%	-	-	-	877	1,776	
PMPM Cost	8.6%	3	$1,111.11	5.1%	$ -	$ -	$ -	$ 1,124.99	$ 1,167.70	
Total Expenditure					$ -	$ -	$ -	$ 986,620	$ 2,073,834	$ 3,060,455

Non-Disabled	Trend	Months	Base Year	Trend	Demonstration Years (DY)					Total WOW
Pop Type: Medicaid	Rate 1	Of Aging	CY 2020	Rate 2	DY 01	DY 02	DY 03	DY 04.5	DY 05	
User Months	10.7%		874	1.3%	-	-	-	437	885	
PMPM Cost	10.2%	3	$254.47	4.9%	$ -	$ -	$ -	$ 257.55	$ 267.04	
Total Expenditure					$ -	$ -	$ -	$ 112,550	$ 236,327	$ 348,877

Newly Eligible	Trend	Months	Base Year	Trend	Demonstration Years (DY)					Total WOW
Pop Type: Medicaid	Rate 1	Of Aging	CY 2020	Rate 2	DY 01	DY 02	DY 03	DY 04.5	DY 05	
User Months	5.7%		2,429	0.8%	-	-	-	1,215	2,448	
PMPM Cost	8.6%	3	$465.92	5.0%	$ -	$ -	$ -	$ 471.69	$ 489.42	
Total Expenditure					$ -	$ -	$ -	$ 573,100	$ 1,198,097	$ 1,771,196

AI/AN FFS	Trend	Months	Base Year	Trend	Demonstration Years (DY)					Total WOW
Pop Type: Medicaid	Rate 1	Of Aging	CY 2018	Rate 2	DY 01	DY 02	DY 03	DY 04.5	DY 05	
User Months	n/a		58	1.0%	-	-	-	30	61	
PMPM Cost	n/a	27	$12,209.30	5.0%	$ -	$ -	$ -	$ 13,625.95	$ 14,133.79	
Total Expenditure					$ -	$ -	$ -	$ 408,778	$ 862,161	$ 1,270,940

Demonstration With Waiver (WW) Budget Projection: Coverage Costs for Populations

Disabled	Trend	Months	Base Year	Trend	Demonstration Years (DY)					Total WW
Pop Type: Medicaid	Rate 1	Of Aging	CY 2020	Rate 2	DY 01	DY 02	DY 03	DY 04.5	DY 05	
User Months	9.5%		1,754	1.2%	-	-	-	877	1,776	
PMPM Cost	8.6%	3	$1,111.11	5.1%	$ -	$ -	$ -	$ 1,124.99	$ 1,167.70	
Total Expenditure					$ -	$ -	$ -	$ 986,620	$ 2,073,834	$ 3,060,455

Non-Disabled	Trend	Months	Base Year	Trend	Demonstration Years (DY)					Total WW
Pop Type: Medicaid	Rate 1	Of Aging	CY 2020	Rate 2	DY 01	DY 02	DY 03	DY 04.5	DY 05	
User Months	10.7%		874	1.3%	-	-	-	437	885	
PMPM Cost	10.2%	3	$254.47	4.9%	$ -	$ -	$ -	$ 257.55	$ 267.04	
Total Expenditure					$ -	$ -	$ -	$ 112,550	$ 236,327	$ 348,877

Newly Eligible	Trend	Months	Base Year	Trend	Demonstration Years (DY)					Total WW
Pop Type: Medicaid	Rate 1	Of Aging	CY 2020	Rate 2	DY 01	DY 02	DY 03	DY 04.5	DY 05	
User Months	5.7%		2,429	0.8%	-	-	-	1,215	2,448	
PMPM Cost	8.6%	3	$465.92	5.0%	$ -	$ -	$ -	$ 471.69	$ 489.42	
Total Expenditure					$ -	$ -	$ -	$ 573,100	$ 1,198,097	$ 1,771,196

AI/AN FFS	Trend	Months	Base Year	Trend	Demonstration Years (DY)					Total WW
Pop Type: Medicaid	Rate 1	Of Aging	CY 2018	Rate 2	DY 01	DY 02	DY 03	DY 04.5	DY 05	
User Months	n/a		58	1.0%	-	-	-	30	61	
PMPM Cost	n/a	27	$12,209.30	5.0%	$ -	$ -	$ -	$ 13,625.95	$ 14,133.79	
Total Expenditure					$ -	$ -	$ -	$ 408,778	$ 862,161	$ 1,270,940

Trend Development

	Expenses	Enrollees
Population	2020 - 2021 Ann. Trend	2020 - 2021 Ann. Trend
Children	4.81%	1.36%
Adults	5.12%	1.23%
Newly Eligible	5.04%	0.79%

	2018 SMI IMD User Months	2018 AI/AN SMI IMD User Months	Expense Trend	Enrollees Trend
Disabled Adults	1,562	50	5.12%	1.23%
Non-Disabled Adults	360	15	5.12%	1.23%
Disabled Children	149	13	4.81%	1.36%
Non-Disabled Children	492	30	4.81%	1.36%
Newly Eligible	2,391	125	5.04%	0.79%

	2018 SMI IMD User Months	Expense Trend	Enrollees Trend
Disabled	1,711.00	5.09%	1.25%
Non-Disabled	852.00	4.94%	1.30%
Newly Eligible	2,391.00	5.04%	0.79%
All Enrollees	4,954.00	5.00%	1.00%
AI/AN FFS	233.00	5.00%	1.00%

2017 Actuarial Report on the Financial Outlook for Medicaid						
"Table 22 - Past and Projected Medicaid Expenditures, Page 68"						
Historical Data						
Fiscal Year	**Aged**	**Disabled**	**Children**	**Adults**	**Newly Eligible**	**Average**
2000	$ 14,222	$ 12,237	$ 1,819	$ 2,962	n/a	$ 5,496
2001	$ 15,068	$ 13,240	$ 1,925	$ 2,968	n/a	$ 5,718
2002	$ 15,682	$ 14,453	$ 2,076	$ 3,123	n/a	$ 5,969
2003	$ 14,782	$ 15,168	$ 2,124	$ 3,169	n/a	$ 5,960
2004	$ 15,314	$ 15,869	$ 2,125	$ 3,311	n/a	$ 6,124
2005	$ 15,254	$ 16,405	$ 2,247	$ 3,407	n/a	$ 6,308
2006	$ 15,023	$ 15,743	$ 2,348	$ 3,503	n/a	$ 6,255
2007	$ 15,124	$ 16,589	$ 2,591	$ 3,894	n/a	$ 6,700
2008	$ 15,631	$ 17,013	$ 2,640	$ 3,987	n/a	$ 6,863
2009	$ 15,738	$ 17,744	$ 2,723	$ 4,162	n/a	$ 6,982
2010	$ 15,577	$ 18,172	$ 2,731	$ 4,225	n/a	$ 6,926
2011	$ 15,757	$ 18,295	$ 2,865	$ 4,517	n/a	$ 7,124
2012	$ 15,235	$ 17,824	$ 2,762	$ 4,192	n/a	$ 6,874

Projections						
Fiscal Year	**Aged**	**Disabled**	**Children**	**Adults**	**Newly Eligible**	**Average**
2013	$ 15,220	$ 18,614	$ 2,924	$ 4,385	n/a	$ 7,188
2014	$ 14,708	$ 18,499	$ 3,109	$ 4,799	$ 5,511	$ 7,202
2015	$ 14,365	$ 19,152	$ 3,339	$ 5,103	$ 6,365	$ 7,451
2016	$ 14,700	$ 19,754	$ 3,555	$ 5,159	$ 5,965	$ 7,590
2017	$ 14,769	$ 20,048	$ 3,592	$ 5,288	$ 5,813	$ 7,648
2018	$ 15,595	$ 21,209	$ 3,822	$ 5,645	$ 6,036	$ 8,093
2019	$ 15,991	$ 21,853	$ 3,952	$ 5,855	$ 6,355	$ 8,371
2020	$ 16,623	$ 22,878	$ 4,139	$ 6,152	$ 6,682	$ 8,770
2021	$ 17,252	$ 24,016	$ 4,338	$ 6,467	$ 7,019	$ 9,198
2022	$ 17,909	$ 25,223	$ 4,550	$ 6,803	$ 7,385	$ 9,658
2023	$ 18,616	$ 26,500	$ 4,772	$ 7,156	$ 7,770	$ 10,146
2024	$ 19,373	$ 27,851	$ 5,003	$ 7,524	$ 8,167	$ 10,662
2025	$ 20,178	$ 29,291	$ 5,248	$ 7,914	$ 8,591	$ 11,212
2026	$ 21,063	$ 30,815	$ 5,502	$ 8,317	$ 9,031	$ 11,793
2020 - 2021 Ann. Trend	**3.8%**	**5.0%**	**4.8%**	**5.1%**	**5.0%**	**4.9%**
2018-2020 Annual Trend	**3.2%**	**3.9%**	**4.1%**	**4.4%**	**5.2%**	**4.1%**

2017 Actuarial Report on the Financial Outlook for Medicaid							
"Table 16 - Past and Projected Numbers of Medicaid Enrollees, Page 53"							
Historical Data							
Fiscal Year	**Aged**	**Disabled**	**Children**	**Adults**	**Newly Eligible**	**Territories**	**All Enrollees**
2000	3.60	6.70	16.10	6.90	n/a	0.90	33.30
2001	3.70	6.90	17.30	7.70	n/a	0.90	35.60
2002	4.00	7.20	19.10	8.90	n/a	1.00	39.20
2003	4.30	7.50	20.90	9.70	n/a	1.00	42.40
2004	4.40	7.70	21.90	10.10	n/a	1.00	44.10
2005	4.60	8.00	22.50	10.50	n/a	1.00	45.60
2006	4.50	8.20	22.60	10.50	n/a	1.00	45.80
2007	4.50	8.30	22.30	10.20	n/a	1.00	45.30
2008	4.60	8.60	22.80	10.80	n/a	1.00	46.80
2009	4.70	8.90	24.40	11.90	n/a	1.00	49.90
2010	4.90	9.20	26.40	13.10	n/a	1.00	53.60
2011	5.10	9.70	27.20	13.80	n/a	1.00	55.80
2012	5.30	10.00	27.90	14.70	n/a	1.00	57.90

Projections							
Fiscal Year	**Aged**	**Disabled**	**Children**	**Adults**	**Newly Eligible**	**Territories**	**All Enrollees**
2013	5.40	10.40	28.00	15.00	n/a	1.00	58.80
2014	5.50	10.40	28.20	15.20	4.30	1.50	63.60
2015	5.60	10.50	28.10	15.20	9.10	1.50	68.50
2016	5.70	10.60	28.10	15.30	11.20	1.40	70.90
2017	5.80	10.60	28.20	15.50	12.20	1.40	72.30
2018	6.00	10.70	28.50	15.80	12.40	1.40	73.40
2019	6.20	10.90	29.00	16.00	12.50	1.40	74.60
2020	6.40	11.00	29.50	16.20	12.70	1.40	75.80
2021	6.60	11.10	29.90	16.40	12.80	1.40	76.80
2022	6.90	11.20	30.30	16.50	13.00	1.40	77.90
2023	7.10	11.30	30.60	16.60	13.00	1.40	78.60
2024	7.30	11.40	30.90	16.70	13.10	1.40	79.40
2025	7.50	11.50	31.10	16.80	13.20	1.40	80.10
2026	7.70	11.60	31.30	16.90	13.30	1.40	80.80
2020 - 2021 Ann. Trend	**3.1%**	**0.9%**	**1.4%**	**1.2%**	**0.8%**	**0.0%**	**1.3%**
2018-2020 Annual Trend	**3.3%**	**1.4%**	**1.7%**	**1.3%**	**1.2%**	**0.0%**	**1.6%**

CERTIFICATION OF ENROLLMENT

ENGROSSED SUBSTITUTE HOUSE BILL 1109

Chapter 415, Laws of 2019

(partial veto)

66th Legislature
2019 Regular Session

OPERATING BUDGET

EFFECTIVE DATE: May 21, 2019—Except for section 989, which becomes effective June 30, 2019.

Passed by the House April 28, 2019
Yeas 57 Nays 41

FRANK CHOPP

Speaker of the House of Representatives

Passed by the Senate April 28, 2019
Yeas 27 Nays 21

CYRUS HABIB

President of the Senate

Approved May 21, 2019 10:22 AM with the exception of sections 103(2); 127(13); 129(37); 129(43); 129(73); 131(12); 131(13); 144(3); 144(5); 147, page 67, lines 3-8; 203(1)(m); 203(1)(v); 203(1)(x); 204(30); 204(34); 205(1)(d)(ii); 212(6); 222(1)(a); 222(3)(c); 302(10); 302(30); 306(4); 308(22); 309(15); 401(3); 601(9); 613(3); 723; 1005, page 464, lines 11-13; 1020; 1118(3), page 649, lines 12-13; 1118(4), page 656, lines 16-17; and 1702, page 801, lines 28-30, which are vetoed.

CERTIFICATE

I, Bernard Dean, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **ENGROSSED SUBSTITUTE HOUSE BILL 1109** as passed by the House of Representatives and the Senate on the dates hereon set forth.

BERNARD DEAN

Chief Clerk

JAY INSLEE

Governor of the State of Washington

FILED

May 21, 2019
Secretary of State
State of Washington

ENGROSSED SUBSTITUTE HOUSE BILL 1109

AS AMENDED BY THE CONFERENCE COMMITTEE

Passed Legislature - 2019 Regular Session

State of Washington 66th Legislature 2019 Regular Session

By House Appropriations (originally sponsored by Representative Ormsby; by request of Office of Financial Management)

AN ACT Relating to fiscal matters; amending RCW 28B.20.476, 28B.115.070, 28C.04.535, 38.52.105, 41.06.280, 41.26.450, 41.45.230, 41.60.050, 41.80.010, 43.08.190, 43.09.475, 43.43.839, 43.60A.140, 43.70.250, 43.70.445, 43.79.445, 43.101.200, 43.101.220, 43.101.435, 43.330.250, 43.372.070, 43.380.020, 50.16.010, 70.155.120, 76.04.610, 77.12.203, 79.105.150, 79A.25.210, 82.14.310, 82.19.040, 83.100.230, 86.26.007, 90.50A.090, 90.56.500, and 90.56.510; amending 2018 c 299 ss 109, 112, 113, 115, 116, 118, 119, 121, 124, 125, 127, 129, 130, 135, 138, 141, 142, 147, 148, 144, 201, 203, 204, 205, 206, 207, 209, 210, 211, 212, 213, 215, 216, 217, 218, 219, 220, 223, 302, 303, 306, 307, 308, 309, 310, 311, 401, 402, 501, 502, 503, 504, 505, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 601, 602, 603, 604, 605, 606, 607, 609, 610, 612, 613, 615, 701, 702, 703, 801, and 802 and 2017 3rd sp.s. c 1 ss 146 and 702 (uncodified); reenacting and amending RCW 43.155.050, 43.320.110, 69.50.540, 71.24.580, 76.09.405, 79.64.040, and 79.64.110; adding a new section to 2018 c 299 (uncodified); creating new sections; making appropriations; providing an effective date; providing expiration dates; and declaring an emergency.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** (1) A budget is hereby adopted and, subject to the provisions set forth in the following sections, the several amounts specified in parts I through IX of this act, or so much thereof as shall be sufficient to accomplish the purposes designated, are hereby appropriated and authorized to be incurred for salaries, wages, and other expenses of the agencies and offices of the state and for other specified purposes for the fiscal biennium beginning July 1, 2019, and ending June 30, 2021, except as otherwise provided, out of the several funds of the state hereinafter named.

(2) Unless the context clearly requires otherwise, the definitions in this section apply throughout this act.

(a) "Fiscal year 2020" or "FY 2020" means the fiscal year ending June 30, 2020.

(b) "Fiscal year 2021" or "FY 2021" means the fiscal year ending June 30, 2021.

(c) "FTE" means full time equivalent.

(d) "Lapse" or "revert" means the amount shall return to an unappropriated status.

(e) "Provided solely" means the specified amount may be spent only for the specified purpose. Unless otherwise specifically authorized in this act, any portion of an amount provided solely for a specified purpose which is not expended subject to the specified conditions and limitations to fulfill the specified purpose shall lapse.

PART I
GENERAL GOVERNMENT

NEW SECTION. **Sec. 101. FOR THE HOUSE OF REPRESENTATIVES**

General Fund—State Appropriation (FY 2020). $40,202,000
General Fund—State Appropriation (FY 2021). $43,039,000
Pension Funding Stabilization Account—State
Appropriation. $4,266,000
TOTAL APPROPRIATION. $87,507,000

The appropriations in this section are subject to the following conditions and limitations: $50,000 of the general fund—state appropriation for fiscal year 2020 and $50,000 of the general fund—state appropriation for fiscal year 2021 are provided solely for implementation of Engrossed Substitute House Bill No. 2018

PAGES OMITTED

NEW SECTION. **Sec. 215. FOR THE STATE HEALTH CARE AUTHORITY—COMMUNITY BEHAVIORAL HEALTH PROGRAM**

General Fund—State Appropriation (FY 2020). $556,003,000
General Fund—State Appropriation (FY 2021). $604,424,000
General Fund—Federal Appropriation. $1,966,699,000
General Fund—Private/Local Appropriation. $36,513,000
Criminal Justice Treatment Account—State Appropriation. . $12,986,000
Problem Gambling Account—State Appropriation. $1,461,000
Medicaid Fraud Penalty Account—State Appropriation. $51,000
Dedicated Marijuana Account—State Appropriation
(FY 2020). $28,490,000
Dedicated Marijuana Account—State Appropriation
(FY 2021). $28,493,000
Pension Funding Stabilization Account—State
Appropriation. $1,714,000
TOTAL APPROPRIATION. $3,236,834,000

The appropriations in this section are subject to the following conditions and limitations:

(1) For the purposes of this section, "behavioral health entities" means managed care organizations and administrative services organizations in regions where the authority is purchasing medical and behavioral health services through fully integrated contracts pursuant to RCW 71.24.380, and behavioral health organizations in regions that have not yet transitioned to fully integrated managed care.

(2) Within the amounts appropriated in this section, funding is provided for implementation of the settlement agreement under *Trueblood, et al. v. Department of Social and Health Services, et al.*, United States District Court for the Western District of Washington, Cause No. 14-cv-01178-MJP. In addition to amounts provided solely for implementation of the settlement agreement, class members must have access to supports and services funded throughout this section for which they meet eligibility and medical necessity requirements. The authority must include language in contracts that requires regional behavioral health entities to develop and implement plans for improving access to timely and appropriate treatment for individuals with behavioral health needs and current or prior criminal justice involvement who are eligible for services under these contracts.

(3) $15,605,000 of the general fund—state appropriation for fiscal year 2020, $15,754,000 of the general fund—state appropriation for fiscal year 2021, and $4,789,000 of the general fund—federal appropriation are provided solely for the phase-in of the settlement agreement under *Trueblood, et al. v. Department of Social and Health Services, et al.*, United States District Court for the Western District of Washington, Cause No. 14-cv-01178-MJP. The department, in collaboration with the health care authority and the criminal justice training commission, must implement the provisions of the settlement agreement pursuant to the timeline and implementation plan provided for under the settlement agreement. This includes implementing provisions related to competency evaluations, competency restoration, crisis diversion and supports, education and training, and workforce development.

(4) $8,777,000 of the general fund—state appropriation for fiscal year 2020, $10,424,000 of the general fund—state appropriation for fiscal year 2021, and $20,197,000 of the general fund—federal appropriation are provided solely for the authority and behavioral health entities to continue to contract for implementation of high-intensity programs for assertive community treatment (PACT) teams. In determining the proportion of medicaid and nonmedicaid funding provided to behavioral health entities with PACT teams, the authority shall consider the differences between behavioral health entities in the percentages of services and other costs associated with the teams that are not reimbursable under medicaid. The authority may allow behavioral health entities which have nonmedicaid reimbursable costs that are higher than the nonmedicaid allocation they receive under this section to supplement these funds with local dollars or funds received under subsection (7) of this section. The authority and behavioral health entities shall maintain consistency with all essential elements of the PACT evidence-based practice model in programs funded under this section.

(5) From the general fund—state appropriations in this section, the authority shall assure that behavioral health entities reimburse the department of social and health services aging and long term support administration for the general fund—state cost of medicaid personal care services that enrolled behavioral health entity consumers use because of their psychiatric disability.

(6) $3,520,000 of the general fund—federal appropriation is provided solely for the authority to maintain a pilot project to incorporate peer bridging staff into behavioral health regional teams that provide transitional services to individuals returning to their communities.

(7) $81,930,000 of the general fund—state appropriation for fiscal year 2020 and $81,930,000 of the general fund—state appropriation for fiscal year 2021 are provided solely for persons and services not covered by the medicaid program. To the extent possible, levels of behavioral health entity spending must be maintained in the following priority order: Crisis and commitment services; community inpatient services; and residential care services, including personal care and emergency housing assistance. These amounts must be distributed to behavioral health entities proportionate to the fiscal year 2019 allocation of flexible nonmedicaid funds. The authority must include the following language in medicaid contracts with behavioral health entities unless they are provided formal notification from the center for medicaid and medicare services that the language will result in the loss of federal medicaid participation: "The contractor may voluntarily provide services that are in addition to those covered under the state plan, although the cost of these services cannot be included when determining payment rates unless including these costs are specifically allowed under federal law or an approved waiver."

(8) The authority is authorized to continue to contract directly, rather than through contracts with behavioral health entities for children's long-term inpatient facility services.

(9) $1,204,000 of the general fund—state appropriation for fiscal year 2020 and $1,204,000 of the general fund—state appropriation for fiscal year 2021 are provided solely to reimburse Pierce and Spokane counties for the cost of conducting one hundred eighty-day commitment hearings at the state psychiatric hospitals.

(10) Behavioral health entities may use local funds to earn additional federal medicaid match, provided the locally matched rate does not exceed the upper-bound of their federally allowable rate range, and provided that the enhanced funding is used only to provide medicaid state plan or waiver services to medicaid clients. Additionally, behavioral health entities may use a portion of the state funds allocated in accordance with subsection (7) of this

section to earn additional medicaid match, but only to the extent that the application of such funds to medicaid services does not diminish the level of crisis and commitment, community inpatient, residential care, and outpatient services presently available to persons not eligible for medicaid.

(11) $2,291,000 of the general fund—state appropriation for fiscal year 2020 and $2,291,000 of the general fund—state appropriation for fiscal year 2021 are provided solely for mental health services for mentally ill offenders while confined in a county or city jail and for facilitating access to programs that offer mental health services upon release from confinement. The authority must collect information from the behavioral health entities on their plan for using these funds, the numbers of individuals served, and the types of services provided and submit a report to the office of financial management and the appropriate fiscal committees of the legislature by December 1st of each year of the biennium.

(12) Within the amounts appropriated in this section, funding is provided for the authority to develop and phase in intensive mental health services for high needs youth consistent with the settlement agreement in *T.R. v. Dreyfus and Porter*.

(13) The authority must establish minimum and maximum funding levels for all reserves allowed under behavioral health organization and administrative services organization contracts and include contract language that clearly states the requirements and limitations. The authority must monitor and ensure that behavioral health organization and administrative services organization reserves do not exceed maximum levels. The authority must monitor revenue and expenditure reports and must require a behavioral health organization or administrative services organization to submit a corrective action plan on how it will spend its excess reserves within a reasonable period of time, when its reported reserves exceed maximum levels established under the contract. The authority must review and approve such plans and monitor to ensure compliance. If the authority determines that a behavioral health organization or administrative services organization has failed to provide an adequate excess reserve corrective action plan or is not complying with an approved plan, the authority must reduce payments to the entity in accordance with remedial actions provisions included in the contract. These reductions in payments must continue until the authority determines

that the entity has come into substantial compliance with an approved excess reserve corrective action plan.

(14) During the 2019-2021 fiscal biennium, any amounts provided in this section that are used for case management services for pregnant and parenting women must be contracted directly between the authority and providers rather than through contracts with behavioral health organizations.

(15) Within the amounts appropriated in this section, the authority may contract with the University of Washington and community-based providers for the provision of the parent-child assistance program or other specialized chemical dependency case management providers for pregnant, post-partum, and parenting women. For all contractors: (a) Service and other outcome data must be provided to the authority by request; and (b) indirect charges for administering the program must not exceed ten percent of the total contract amount.

(16) $3,500,000 of the general fund—federal appropriation (from the substance abuse prevention and treatment federal block grant) is provided solely for the continued funding of existing county drug and alcohol use prevention programs.

(17) Within the amounts provided in this section, behavioral health entities must provide outpatient chemical dependency treatment for offenders enrolled in the medicaid program who are supervised by the department of corrections pursuant to a term of community supervision. Contracts with behavioral health entities must require that behavioral health entities include in their provider network specialized expertise in the provision of manualized, evidence-based chemical dependency treatment services for offenders. The department of corrections and the authority must develop a memorandum of understanding for department of corrections offenders on active supervision who are medicaid eligible and meet medical necessity for outpatient substance use disorder treatment. The agreement will ensure that treatment services provided are coordinated, do not result in duplication of services, and maintain access and quality of care for the individuals being served. The authority must provide all necessary data, access, and reports to the department of corrections for all department of corrections offenders that receive medicaid paid services.

(18) The criminal justice treatment account—state appropriation is provided solely for treatment and treatment support services for

offenders with a substance use disorder pursuant to RCW 71.24.580. The authority must offer counties the option to administer their share of the distributions provided for under RCW 71.24.580(5)(a). If a county is not interested in administering the funds, the authority shall contract with behavioral health entities to administer these funds consistent with the plans approved by local panels pursuant to RCW 71.24.580(5)(b). The authority must provide a report to the office of financial management and the appropriate committees of the legislature which identifies the distribution of criminal justice treatment account funds by September 30, 2019.

(19) No more than $27,844,000 of the general fund—federal appropriation may be expended for supported housing and employment services described in initiative 3a and 3b of the medicaid transformation demonstration waiver under healthier Washington. Under this initiative, the authority and the department of social and health services shall ensure that allowable and necessary services are provided to eligible clients as identified by the authority or its providers or third party administrator. The department and the authority in consultation with the medicaid forecast work group, shall ensure that reasonable reimbursements are established for services deemed necessary within an identified limit per individual. The authority shall not increase general fund—state expenditures under this initiative. The secretary in collaboration with the director of the authority shall report to the joint select committee on health care oversight no less than quarterly on financial and health outcomes. The secretary in cooperation with the director shall also report to the fiscal committees of the legislature all of the expenditures of this subsection and shall provide such fiscal data in the time, manner, and form requested by the legislative fiscal committees.

(20) $6,858,000 of the general fund—state appropriation for fiscal year 2020, $6,858,000 of the general fund—state appropriation for fiscal year 2021, and $8,046,000 of the general fund—federal appropriation are provided solely to maintain new crisis triage or stabilization centers. Services in these facilities may include crisis stabilization and intervention, individual counseling, peer support, medication management, education, and referral assistance. The authority shall monitor each center's effectiveness at lowering the rate of state psychiatric hospital admissions.

(21) $1,125,000 of the general fund—federal appropriation is provided solely for the authority to develop a memorandum of understanding with the department of health for implementation of chapter 297, Laws of 2017 (opioid treatment programs). The authority must use these amounts to reimburse the department of health for costs incurred through the implementation of the bill.

(22) $6,655,000 of the general fund—state appropriation for fiscal year 2020, $10,015,000 of the general fund—state appropriation for fiscal year 2021, and $12,965,000 of the general fund—federal appropriation are provided solely for the operation of secure withdrawal management and stabilization facilities. The authority may not use any of these amounts for services in facilities that are subject to federal funding restrictions that apply to institutions for mental diseases, unless they have received a waiver that allows for full federal participation in these facilities. Within these amounts, funding is provided to increase the fee for service rate for these facilities up to $650 per day. The authority must require in contracts with behavioral health entities that, beginning in calendar year 2020, they pay no lower than the fee for service rate. The authority must coordinate with regional behavioral health entities to identify and implement purchasing strategies or regulatory changes that increase access to services for individuals with complex behavioral health needs at secure withdrawal management and stabilization facilities.

(23) $23,090,000 of the general fund—state appropriation for fiscal year 2020, $23,090,000 of the general fund—state appropriation for fiscal year 2021, and $92,444,000 of the general fund—federal appropriation are provided solely to maintain the enhancement of community-based behavioral health services that was funded in fiscal year 2019. Twenty percent of the general fund—state appropriation amounts for each regional service area must be used to increase their nonmedicaid funding and the remainder must be used to increase medicaid rates above FY 2018 levels. Effective January 2020, the medicaid funding is intended to increase rates for behavioral health services provided by licensed and certified community behavioral health agencies as defined by the department of health. This funding must be allocated to the managed care organizations proportionate to their medicaid enrollees. The authority must require the managed care organizations to provide a report on their implementation of this

funding. The authority must submit a report to the legislature by December 1, 2020, summarizing how this funding was used and provide information for future options of increasing behavioral health provider rates through directed payments. The report must identify different mechanisms for implementing directed payment for behavioral health providers including but not limited to minimum fee schedules, across the board percentage increases, and value-based payments. The report must provide a description of each of the mechanisms considered, the timeline that would be required for implementing the mechanism, and whether and how the mechanism is expected to have a differential impact on different providers. The report must also summarize the information provided by managed care organizations in implementing the funding provided under this section.

(24) $27,917,000 of the general fund—state appropriation for fiscal year 2020, $36,095,000 of the general fund—state appropriation for fiscal year 2021, and $60,644,000 of the general fund—federal appropriation are provided solely for the department to contract with community hospitals or freestanding evaluation and treatment centers to provide long-term inpatient care beds as defined in RCW 71.24.025. Within these amounts, the authority must meet the requirements for reimbursing counties for the judicial services for patients being served in these settings in accordance with RCW 71.05.730. The authority must coordinate with the department of social and health services in developing the contract requirements, selecting contractors, and establishing processes for identifying patients that will be admitted to these facilities. Sufficient amounts are provided in fiscal year 2020 for the authority to reimburse community hospitals serving medicaid clients in long-term inpatient care beds as defined in RCW 71.24.025 at a rate of $1,171 per day, or the hospital's current psychiatric inpatient per diem rate, whichever is higher. The rate paid to hospitals in this subsection cannot exceed one-hundred percent of the hospitals eligible costs based on their most recently completed medicare cost report. The authority in collaboration with the Washington state hospital association must convene a work group to develop a methodology for reimbursing community hospitals serving these clients. In developing this methodology, the authority must account for cost structure differences between teaching hospitals and other hospital types. The

authority must provide a report to the appropriate committees of the legislature by December 1, 2019. The report must:

(a) Describe the methodology developed by the work group;

(b) Identify cost differences between teaching hospitals and other hospital types;

(c) Provide options for incentivizing community hospitals to offer long-term inpatient care beds day beds including a rate recommendation;

(d) Identify the cost associated with any recommended changes in rates or rate setting methodology; and

(e) Outline an implementation plan.

(25) $1,455,000 of the general fund—state appropriation for fiscal year 2020, $1,401,000 of the general fund—state appropriation for fiscal year 2021, and $3,210,000 of the general fund—federal appropriation are provided solely for the implementation of intensive behavioral health treatment facilities within the community behavioral health service system pursuant to Second Substitute House Bill No. 1394 (behavioral health facilities).

(26) $21,000 of the general fund—state appropriation for fiscal year 2020, $152,000 of the general fund—state appropriation for fiscal year 2021, and $173,000 of the general fund—federal appropriation are provided solely to implement chapter 70, Laws of 2019 (SHB 1199) (health care/disability).

(27)(a) $12,878,000 of the dedicated marijuana account—state appropriation for fiscal year 2020 and $12,878,000 of the dedicated marijuana account—state appropriation for fiscal year 2021 are provided for:

(i) A memorandum of understanding with the department of children, youth, and families to provide substance abuse treatment programs;

(ii) A contract with the Washington state institute for public policy to conduct a cost-benefit evaluation of the implementations of chapter 3, Laws of 2013 (Initiative Measure No. 502);

(iii) Designing and administering the Washington state healthy youth survey and the Washington state young adult behavioral health survey;

(iv) Maintaining increased services to pregnant and parenting women provided through the parent child assistance program;

(v) Grants to the office of the superintendent of public instruction for life skills training to children and youth;

(vi) Maintaining increased prevention and treatment service provided by tribes and federally recognized American Indian organization to children and youth;

(vii) Maintaining increased residential treatment services for children and youth;

(viii) Training and technical assistance for the implementation of evidence-based, research based, and promising programs which prevent or reduce substance use disorder;

(ix) Expenditures into the home visiting services account; and

(x) Grants to community-based programs that provide prevention services or activities to youth.

(b) The authority must allocate the amounts provided in (a) of this subsection amongst the specific activities proportionate to the fiscal year 2019 allocation.

(28)(a) $1,125,000 of the general fund—state appropriation for fiscal year 2020 and $1,125,000 of the general fund—state appropriation for fiscal year 2021 is provided solely for Spokane behavioral health entities to implement services to reduce utilization and the census at eastern state hospital. Such services must include:

(i) High intensity treatment team for persons who are high utilizers of psychiatric inpatient services, including those with co-occurring disorders and other special needs;

(ii) Crisis outreach and diversion services to stabilize in the community individuals in crisis who are at risk of requiring inpatient care or jail services;

(iii) Mental health services provided in nursing facilities to individuals with dementia, and consultation to facility staff treating those individuals; and

(iv) Services at the sixteen-bed evaluation and treatment facility.

(b) At least annually, the Spokane county behavioral health entities shall assess the effectiveness of these services in reducing utilization at eastern state hospital, identify services that are not optimally effective, and modify those services to improve their effectiveness.

(29) $24,819,000 of the general fund—state appropriation for fiscal year 2020 is provided solely to assist behavioral health entities with the costs of providing services to medicaid clients receiving services in psychiatric facilities classified as institutions of mental diseases. The authority must distribute these amounts proportionate to the number of bed days for medicaid clients in institutions for mental diseases that were excluded from behavioral health organization calendar year 2019 capitation rates because they exceeded the amounts allowed under federal regulations. The authority must also use these amounts to directly pay for costs that are ineligible for medicaid reimbursement in institutions of mental disease facilities for American Indian and Alaska Natives who opt to receive behavioral health services on a fee-for-service basis. The amounts used for these individuals must be reduced from the allocation of the behavioral health organization where the individual resides. If a behavioral health organization receives more funding through this subsection than is needed to pay for the cost of their medicaid clients in institutions for mental diseases, they must use the remainder of the amounts to provide other services not covered under the medicaid program. The authority must submit an application for a waiver to allow, by July 1, 2020, for full federal participation for medicaid clients in mental health facilities classified as institutions of mental diseases. The authority must submit a report on the status of the waiver to the office of financial management and the appropriate committees of the legislature by December 1, 2019.

(30) The authority must require all behavioral health organizations transitioning to full integration to either spend down or return all reserves in accordance with contract requirements and federal and state law. Behavioral health organization reserves may not be used to pay for services to be provided beyond the end of a behavioral health organization's contract or for startup costs in full integration regions except as provided in this subsection. The authority must ensure that any increases in expenditures in behavioral health reserve spend-down plans are required for the operation of services during the contract period and do not result in overpayment to providers. If the nonfederal share of reserves returned during fiscal year 2020 exceeds $35,000,000, the authority shall use some of the amounts in excess of $35,000,000 to support the final regions transitioning to full integration of physical and

behavioral health care. These amounts must be distributed proportionate to the population of each regional area covered. The maximum amount allowed per region is $3,175 per 1,000 residents. These amounts must be used to provide a reserve for nonmedicaid services in the region to stabilize the new crisis services system.

(31) $1,850,000 of the general fund—state appropriation for fiscal year 2020, $1,850,000 of the general fund—state appropriation for fiscal year 2021, and $13,312,000 of the general fund—federal appropriation are provided solely for the authority to implement a medicaid state plan amendment which provides for substance use disorder peer support services to be included in behavioral health capitation rates beginning in fiscal year 2020 in accordance with section 213(5)(ss), chapter 299, Laws of 2018. The authority shall require managed care organizations to provide access to peer support services for individuals with substance use disorders transitioning from emergency departments, inpatient facilities, or receiving treatment as part of hub and spoke networks.

(32) $1,256,000 of the general fund—state appropriation for fiscal year 2021 and $1,686,000 of the general fund—federal appropriation are provided solely for the authority to increase the number of residential beds for pregnant and parenting women. These amounts may be used for startup funds and ongoing costs associated with two new sixteen bed pregnant and parenting women residential treatment programs.

(33) Within the amounts appropriated in this section, the authority must maintain a rate increase for community hospitals that provide a minimum of 200 medicaid psychiatric inpatient days pursuant to the methodology adopted to implement section 213(5)(n), chapter 299, Laws of 2018 (ESSB 6032) (partial veto).

(34) $1,393,000 of the general fund—state appropriation for fiscal year 2020, $1,423,000 of the general fund—state appropriation for fiscal year 2021, and $5,938,000 of the general fund—federal appropriation are provided solely for the authority to implement discharge wraparound services for individuals with complex behavioral health conditions transitioning or being diverted from admission to psychiatric inpatient programs. The authority must coordinate with the department of social and health services in establishing the standards for these programs.

(35) $850,000 of the general fund—federal appropriation is provided solely to contract with a nationally recognized recovery residence organization and to create a revolving fund for loans to operators of recovery residences seeking certification in accordance with Second Substitute House Bill No. 1528 (recovery support services). If the bill is not enacted by June 30, 2019, the amount in this subsection shall lapse.

(36) $212,000 of the general fund—state appropriation for fiscal year 2020, $212,000 of the general fund—state appropriation for fiscal year 2021, and $124,000 of the general fund—federal appropriation are provided solely for the implementation of Engrossed Second Substitute House Bill No. 1874 (adolescent behavioral health). Funding is provided specifically for the authority to provide an online training to behavioral health providers related to state law and best practices in family-initiated treatment, adolescent-initiated treatment, and other services and to conduct an annual survey to measure the impacts of implementing policies resulting from the bill. If the bill is not enacted by June 30, 2019, the amounts in this subsection shall lapse.

(37) $500,000 of the general fund—state appropriation for fiscal year 2020, $500,000 of the general fund—state appropriation for fiscal year 2021, and $1,000,000 of the general fund—federal appropriation are provided solely for the authority to implement a memorandum of understanding with the criminal justice training commission to provide funding for community grants pursuant to Second Substitute House Bill No. 1767 (alternatives to arrest). If the bill is not enacted by June 30, 2019, the amounts provided in this subsection shall lapse.

(38) $500,000 of the general fund—state appropriation for fiscal year 2020 and $500,000 of the general fund—state appropriation for fiscal year 2021 are provided solely for provision of crisis stabilization services to individuals who are not eligible for medicaid in Whatcom county. The authority must coordinate with crisis stabilization providers, managed care organizations, and behavioral health administrative services organizations throughout the state to identify payment models that reflect the unique needs of crisis stabilization and crisis triage providers. The report must also include an analysis of the estimated gap in nonmedicaid funding for crisis stabilization and triage facilities throughout the state. The

authority must provide a report to the office of financial management and the appropriate committees of the legislature on the estimated nonmedicaid funding gap and payment models by December 1, 2019.

(39) The authority must conduct an analysis to determine whether there is a gap in fiscal year 2020 behavioral health entity funding for services in institutions for mental diseases and submit a report to the office of financial management and the appropriate committees of the legislature by November 1, 2019. The report must be developed in consultation with the office of financial management and staff from the fiscal committees of the legislature and must include the following elements: (a) The increase in the number of nonmedicaid bed days in institutions for mental diseases from fiscal year 2017 to fiscal year 2019 by facility and the estimated annual cost associated with these increased bed days in FY 2020; (b) the increase in the number of medicaid bed days in institutions for mental diseases from fiscal year 2017 to fiscal year 2019 by facility and the estimated annual cost associated with these increased bed days in FY 2020; (c) the amount of funding assumed in current behavioral health entity medicaid capitation rates for institutions for mental diseases bed days that are currently allowable under medicaid regulation or waivers; (d) the amounts provided in subsection (29) of this section to assist with costs in institutions for mental diseases not covered in medicaid capitation rates; and (e) any remaining gap in behavioral health entity funding for institutions for mental diseases for medicaid or nonmedicaid clients.

(40) $1,968,000 of the general fund—state appropriation for fiscal year 2020, $3,396,000 of the general fund—state appropriation for fiscal year 2021, and $12,150,000 of the general fund—federal appropriation are provided solely for support of and to increase clubhouse facilities across the state. The authority shall work with the centers for medicare and medicaid services to review opportunities to include clubhouse services as an optional "in lieu of" service in managed care organization contracts in order to maximize federal participation. The authority must provide a report to the office of financial management and the appropriate committees of the legislature on the status of efforts to implement clubhouse programs and receive federal approval for including these services in managed care organization contracts as an optional "in lieu of" service.

(41) $1,000,000 of the general fund—federal appropriation (from the substance abuse prevention and treatment federal block grant) is provided solely for the authority to contract on a one-time basis with the University of Washington behavioral health institute to develop and disseminate model programs and curricula for inpatient and outpatient treatment for individuals with substance use disorder and co-occurring disorders. The behavioral health institute will provide individualized consultation to behavioral health agencies in order to improve the delivery of evidence-based and promising practices and overall quality of care. The behavioral health institute will provide training to staff of behavioral health agencies to enhance the quality of substance use disorder and co-occurring treatment delivered.

(42) The number of beds allocated for use by behavioral health entities at eastern state hospital shall be one hundred ninety two per day. The number of nonforensic beds allocated for use by behavioral health entities at western state hospital shall be five hundred twenty-seven per day. During fiscal year 2020, the authority must reduce the number of beds allocated for use by behavioral health entities at western state hospital by sixty beds to allow for the repurposing of two civil wards at western state hospital to provide forensic services. Contracted community beds provided under subsection (24) of this section shall be allocated to the behavioral health entities in lieu of beds at western state hospital and be incorporated in their allocation of state hospital patient days of care for the purposes of calculating reimbursements pursuant to RCW 71.24.310. It is the intent of the legislature to continue the policy of expanding community based alternatives for long-term civil commitment services that allow for state hospital beds to be prioritized for forensic patients.

(43) $190,000 of the general fund—state appropriation for fiscal year 2020, $947,000 of the general fund—state appropriation for fiscal yar 2021, and $1,023,000 of the general fund—federal appropriation are provided solely for the authority to develop a statewide plan to implement evidence-based coordinated specialty care programs that provide early identification and intervention for psychosis in behavioral health agencies in accordance with Second Substitute Senate Bill No. 5903 (children's mental health). If the

bill is not enacted by June 30, 2019, the amounts in this subsection shall lapse.

(44) $708,000 of the general fund—state appropriation for fiscal year 2021 and $799,000 of the general fund—federal appropriation are provided solely for implementing mental health peer respite centers and a pilot project to implement a mental health drop-in center beginning January 1, 2020, in accordance with Second Substitute House Bill No. 1394 (behavioral health facilities).

(45) $250,000 of the general fund—state appropriation for fiscal year 2020 and $250,000 of the general fund—state appropriation for fiscal year 2021 are provided on a one-time basis solely for a licensed youth residential psychiatric substance abuse and mental health agency located in Clark county to invest in staff training and increasing client census.

(46) $509,000 of the general fund—state appropriation for fiscal year 2020, $494,000 of the general fund—state appropriation for fiscal year 2021, and $4,823,000 of the general fund—federal appropriation are provided solely for diversion grants to establish new law enforcement assisted diversion programs outside of King county consistent with the provisions of Substitute Senate Bill No. 5380 (opioid use disorder).

(47) The authority must compile all previous reports and collaborate with any work groups created during the 2019-2021 fiscal biennium for the purpose of establishing the implementation plan for transferring the full risk of long-term inpatient care for mental illness into the behavioral health entity contracts by January 1, 2020.

(48) $225,000 of the general fund—state appropriation for fiscal year 2020 and $225,000 of the general fund—state appropriation for fiscal year 2021 are provided solely to continue funding one pilot project in Pierce county to promote increased utilization of assisted outpatient treatment programs. The authority shall provide a report to the legislature by October 15, 2020, which must include the number of individuals served, outcomes to include changes in use of inpatient treatment and hospital stays, and recommendations for further implementation based on lessons learned from the pilot project.

(49) $18,000 of the general fund—state appropriation for fiscal year 2020, $18,000 of the general fund—state appropriation for fiscal

year 2021, and $36,000 of the general fund—federal appropriation are provided solely for the implementation of Substitute Senate Bill No. 5181 (involuntary treatment procedures). If the bill is not enacted by June 30, 2019, the amounts in this subsection shall lapse.

(50) $814,000 of the general fund—state appropriation for fiscal year 2020, $800,000 of the general fund—state appropriation for fiscal year 2021, and $1,466,000 of the general fund—federal appropriation are provided solely for the authority to implement the recommendations of the state action alliance for suicide prevention, to include suicide assessments, treatment, and grant management.

(51) Within existing appropriations, the authority shall prioritize the prevention and treatment of intravenous opiate-based drug use.

(52) $446,000 of the general fund—state appropriation for fiscal year 2020, $446,000 of the general fund—state appropriation for fiscal year 2021, and $178,000 of the general fund—federal appropriation are provided solely for the University of Washington's evidence-based practice institute which supports the identification, evaluation, and implementation of evidence-based or promising practices. The institute must work with the authority to develop a plan to seek private, federal, or other grant funding in order to reduce the need for state general funds. The authority must collect information from the institute on the use of these funds and submit a report to the office of financial management and the appropriate fiscal committees of the legislature by December 1st of each year of the biennium.

NEW SECTION. **Sec. 216. FOR THE HUMAN RIGHTS COMMISSION**

General Fund—State Appropriation (FY 2020). $2,510,000
General Fund—State Appropriation (FY 2021). $2,543,000
General Fund—Federal Appropriation. $2,613,000
Pension Funding Stabilization Account—State Appropriation. . $190,000
TOTAL APPROPRIATION. $7,856,000

The appropriations in this section are subject to the following conditions and limitations: $103,000 of the general fund—state appropriation for fiscal year 2020 and $97,000 of the general fund—state appropriation for fiscal year 2021 are provided solely for implementation of Second Substitute Senate Bill No. 5602

STATE OF WASHINGTON

HEALTH CARE AUTHORITY

626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

January 22, 2020

Dear Tribal Leader:

SUBJECT: Tribal Roundtables and Consultation on Amendments to the Section 1115 Medicaid Waiver

In accordance with section 1902(a)(73)(A) of the Social Security Act regarding the solicitation of advice prior to the submission of any Medicaid State Plan Amendment (SPA) or waiver likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations, the Health Care Authority (the Agency) hereby seeks your advice on the following matter.

After discussion at the January monthly tribal meeting, the Agency has scheduled two Tribal Roundtables followed by a Tribal Consultation on the following dates and times.

Meeting	Date	Time	Location Webinar Registration URL
Roundtable #1	January 31, 2020	1:00–2:30 PM	Apple Conference Room, Cherry Street Plaza 626 - 8th Ave. SE, Olympia, WA (during the second and third hours of the HCA Monthly Tribal Meeting) *https://attendee.gotowebinar.com/register/8910998988498384642*
Roundtable #2	February 11, 2020	11:00–12:30 PM	Sue Crystal Conference Center, Cherry Street Plaza 626 - 8th Ave. SE, Olympia, WA *https://attendee.gotowebinar.com/register/523760464590528514*
Consultation	February 24, 2020	11:00–1:00 PM	Sue Crystal Conference Center, Cherry Street Plaza 626 - 8th Ave. SE, Olympia, WA *https://attendee.gotowebinar.com/register/5755630414711492098*

For those who cannot attend in person, we offer webinar access (registration links for each meeting are provided above). Even if you wish to participate by phone (without the webinar), please register for the webinar – you will receive a phone number after registration.

Purpose

The Agency intends to submit to the Centers for Medicare and Medicaid Services (CMS) an amendment to the state's Section 1115 Medicaid waiver to authorize the state to use Medicaid funds to pay for short term (acute) mental health treatment services provided to Medicaid beneficiaries ages 21 to 65 years of age in participating Institutions for Mental Disease (IMDs, which are defined in Section 1905(i) of the Social Security Act as any hospital, nursing facility, or other institution of

more than 16 beds that is primary engaged in providing diagnosis, treatment, or care of persons with mental diseases and for which states may not use Medicaid funds) for more than 15 days during a month. CMS guidance on this waiver is available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Waiver Amendment(s) related to IMDs
Through a Section 1915b behavioral health waiver, the state was previously able to use Medicaid funds (with federal match) to pay for acute residential substance use disorder (SUD) treatment services in IMDs. House Bill 1190, enacted during the 2019 legislative session, directs the Agency to apply for a federal waiver authorizing the state to use Medicaid funds (with federal match) to pay for acute mental health treatment services in IMDs, effective July 1, 2020.

For residential SUD treatments in IMDs, the Agency requested an amendment to the Section 1115 Medicaid waiver to authorize the state to use federal funds in both the Medicaid managed care and fee-for-service (FFS) programs. The effective date for this amendment was July 1, 2018.

HCA plans to request an amendment to the Section 1115 Medicaid waiver for mental health treatment in IMDs. Amending the 1115 Medicaid waiver would authorize the state to use federal funds in both the Medicaid managed care and FFS programs. The proposed effective date for this amendment is July 1, 2020.

Anticipated Impact on Indians/Indian Health Programs/Urban Indian Health Organizations
The proposed amendments related to IMDs could have impacts on American Indian/Alaska Native (AI/AN) Medicaid beneficiaries and Indian Health Programs.
A CMS milestone expectation of this waiver opportunity includes a specific requirement to ensure that "beneficiaries have access to the appropriate levels and types of care and provide oversight on lengths of stay." To comply with this requirement, HCA may be required to implement utilization management (UM) processes for the FFS behavioral health program, such as prior authorization. On the other hand, the state's ability to draw federal funds for inpatient mental health treatment in IMDs could lead the state to re-appropriate those state funds for other behavioral health programs.

Copy Available on Request
Attached is the current draft of the waiver application.

Comments and Questions
The Agency would appreciate any input or concerns that Tribal representatives wish to share regarding this waiver amendment. To request a copy of the draft waiver or return any comments:

- For the IMD related waiver amendments, please contact David Johnson, Federal Programs Manager, by telephone at 360-725-9404 or via email at david.johnson@hca.wa.gov, by February 17, 2020.

Please contact Jessie Dean, Tribal Affairs Administrator, by telephone at 360-725-1649 or via email at jessie.dean@hca.wa.gov if you would like to request formal consultation or have tribal affairs-related questions.

Please forward this information to any interested party.

Sincerely,

[redacted]

MaryAnne Lindeblad, BSN, MPH
Medicaid Director

cc: Keri Waterland, Assistant Director, DBHR, HCA
Jessie Dean, Tribal Affairs Administrator, EXO, HCA
Louise Nieto, Supervisor, Behavioral Health Policy and Planning, DBHR, HCA
David Johnson, Federal Programs Manager, DBHR, HCA
Mich'l Needham, Chief Policy Officer, PD, HCA

Notes:

General Overview

SUD had 6 milestones

MH had 4 milestones

- Ensuring quality of care in psychiatric facilities
    - Establishing of oversight of the facilities
- Utilization review
    - Process in place for managed care
    - How do we do FFS utilization management
        - We need to describe that in this application
        - What is affordable, cost effective, and consumer friendly
        - Utilization review is inappropriate regarding length of stay that our patients respond the best to.
        - We might not really know how this is on the MH side.
        - If we are talking about items in the contract such as historical trauma, childhood trauma, this changes
        - Tribal facilities would want to establish own processes
        - There are Tribes that want to have an IMD - more than 16 bed
        - HCA - Is the impact for UM for FFS is this for MH as well as SUD?
    - Medicaid Policy - federal government has not wanted to pay for services in Institutions of Mental Disease more than 50% of the population is MH, and more than 16 beds.
        - Cascade, Navos, Smokey Point, Rainier Springs, Inland
        - In early 2010s all of the dollars for individuals for 21-65 are using state dollars. Medicaid emergency psychiatric demonstration project that would pay Medicaid dollars. Provisions to claim in leu of for managed care plan - up to 30 days of a stay if the person in managed care can be paid for federal care. For FFS it was only a limitation.
        - Waiver opportunity gives the state greater flexibility for having that allowance to say to show an average in participating facilities.
        - We want language in here, if Tribes are opening stages of opening a facility want to ensure that the federal government honors trust responsibility. Stabilizing the adults in order to stabilize the youth
    - 11 facilities and 543 psychiatric beds
    - Depending and allowances depending on licensing type
    - Budget neutrality -
        - Funding changes to IT infrastructure
        - Contracting with RDA to fund data to be reporting to CMS
        - Independent modeling
        - Federal requirement
        - Revise system in a way that benefits your system
    - Evaluation
        - Ensure that Tribes are not going to have to follow the second bullet. Tribes do not have to follow the second bullet of the overall MTP evaluation.
        - HCA - What is the theory that this waiver is extending in 2 years?
        - HCA- There are plans to extend the waiver.
        - SUD - State Plan Amendment Allowances
            - Grand total 30 days per individual per year
            - The 1115 waiver gives flexibility
        - Interested in looking at innovative care models.

Comments from RT #1

- Tulalip MOU to develop a 90 day 180 commitment
- Overview of comments from RT #1
- There may be Tribes that want to have an IMD in the future
- Include language that ensures the federal government honors trust responsibilities to AI/AN
- Tribal facilities will want to establish their own process for utilization management based on medical necessity.
- For utilization management, consider historical trauma and childhood trauma
- Current UM strategies are not appropriate regarding the length of stay that our patients respond best to, as patients may need longer stays than 30 days.
- Interested in looking at innovative care models: Consider innovative care models for AI/AN individuals

Adjourned at 2:00 pm.

Convened at 11am – 1pm

11:00 AM Webinar Check, Welcome, Acknowledgement, Blessing, and Introductions

11:10 AM Overview of 1115 Waiver Application

11:30 AM Review of the Waiver Application Implementation Plan – CMS Template

Notes:

General Overview

- Initiative 5 of the 1115 Waiver Application
- Purpose of this initiative is to make an agreement with CMS - in exchange for maintaining and continuing to improve crisis availability and strengthening the system, and transitioning individuals to various levels of care, CMS may consider agreeing to be flexible with using federal funds for inpatient stays in IMDs.
- There is a current flexibility for individuals in managed care, Medicaid will pay for individuals on managed care for no more than 15 days. If longer than 15 days, then state dollars must be used for the entire stay.
- State has a mechanism to support stays longer than 15, however it is a strain on the state system.
- The State uses these funds in facilities that have an average length of stay of 15 days or less. The idea is to not use IMDs for long term care, but for short term care to move individuals to lower levels of acuity.
- Review of timeline and requirements as they compare to SUD IMD 1115 Waiver.
    - Changes to HIT
    - There are already exceptions for individuals under 21 so this is not needed for this waiver
    - Additional concerns and scrutiny of length of stays, ensure proper um occur and individuals do not have unduly long lengths of stay.
- Broad milestones provided (see PPT)

Comments from RT #1

- Tulalip MOU to develop a 90 day 180 commitment
- Overview of comments from RT #1
- There may be Tribes that want to have an IMD in the future
- Include language that ensures the federal government honors trust responsibilities to AI/AN
- Tribal facilities will want to establish their own process for utilization management based on medical necessity.
- For utilization management, consider historical trauma and childhood trauma
- Current UM strategies are not appropriate regarding the length of stay that our patients respond best to, as patients may need longer stays than 30 days.
- Interested in looking at innovative care models: Consider innovative care models for AI/AN individuals

Overview of Implementation Plan

- This has not been sent for public comments at this time
- This is a draft and not final
- Please share comments on current draft.

Milestone 1:

- We do not have a utilization process in place right now and there may be concerns that the placement of a facility for an individual is not appropriate. We have had cases.
- From MCO Consultation - Utilization management will take in the needs of diverse populations, expanding to include ACES, health disparities, risk factors, historical trauma. Any utilization management that we process in the future.
- Tribe Comment: Concerns that this section is not currently outlined in the draft.
    - This is a requirement from CMS - Do you have an idea of what CMS is looking for in this section? How detailed or broad this language needs to be?

- HCA Response: We can use the language that we just spoke of.
- Can we use language on how we can work with the Tribes and IHCPs to develop this at a later date? Do we have to do this now?
- HCA Response: Yes, we can ask CMS to say we would like to work with the Tribes on developing this process. They have been open to this concept in other areas such as HIT.

- Tribe Comment: Was this an issue with the SUD?
  - This was not.
- NPAIHB Comment: Instead of using language "to be determined" can we include language such as "working with patient measures around access of services to make sure that AI/AN individuals are not accepted last". When the change to BHOs and there the AI/AN FFS program was established, there was a lack of understanding by the provider on if there was coverage for individuals under FFS. There were barriers for AI/AN individuals in getting access to services.
- AIHC Comment: There is a misconception that AI/AN individuals have their own care so providers are unwilling to take individual or refer them back to the Tribe.
- Evaluate the UM of AI/AN as a whole and a percentage of individuals seen. Ensure AI/AN are not constantly waiting.
- HCA Response: Later in the template, milestone 3 to include language around access. We would like to consider adding these comments in milestone 3.
- HCA Comment: Ongoing monitoring and communication to ensure there is an understanding of the expectation.
- HCA Comment: It will be useful to have a hands on way to identify if an individual is referred then they are getting access to facilities.
- NPAIHB Comment: Will an action item be to notify the Tribe if an individual is from a Tribe and going to be placed in an IMD?
- AIHC Comment - Will this apply to individuals that are on ITA?
- HCA Response: Yes, this may involve individuals that are ITA. Medical necessity is present.

Milestone 2:

- This is a focus on care coordination. We can focus some of these elements discussed in this section, including tying to establish FFS care coordination programs including Health Homes and PCCM.
- Improving care coordination and transitioning to community-based care.
  - We can fold in the Health Homes, FFS, other care coordination tools part of the health transformation demonstrations.
- Page 10, discusses rules and MCO contract requirements.
- Comment: in the "Current statewide strategies" section - Can incorporate a section on FFS?
- AIHC comment: - Recommend adding - Tribal Crisis Coordination Plans and protocols.
  - HCA Response: will Include FFS section - tribal coordination plans
- Recommendation to add separate numbered items under this section around
  - Crisis Coordination Hub
  - Leg to expand access
  - TCBHAB
  - Maintenance of Effort
- 2.c - Federal Language - include language to establish Tribes as more than community-based providers
  - Recommend including work around BH Aides - or other strategies that other IHCPs use to get patients into more appropriate care rather than emergencies. Developing training for BHA - fill the gap to keep people out of inpatient services. Training and certification program - statewide strategies. \

Milestone 3

- Facilities are not always operating at 100% full. We are looking to find a system that would track bed capacity but there are issues around accepting individuals that have concerns that they will not be able to treat. Are we going to describe what efforts on to develop a tracking system are?
    - HCA Response: Yes. We will be discuss this and provide updates.
    - Recommendation to use the language used in SB 6259 around bed tracking and inclusion of IHCPs in this effort.
    - Recommendation: Add language of the Crisis Care Coordination hub.
- HCA-OTA Comment: 3.d - Is this current WAC? –
- HCA Response: Yes, we are going to do a final check. This is a DOH WAC. Appropriate assessment tools.
- AIHC Recommendation - Incorporate use of culturally appropriate assessments from the bill.
- 3.e - refer to above

Milestone 4 - Earlier Identification and Engagement in treatment
Recommended sections to include:

- SE/SH
- Health Homes
- Add Include BH Aide work
- Add Certified Peer Specialists
- Add Integrated health provider
- Section 1003 workgroups - suggested legislation youth suicide prevention summit, THRIVE, Zero Suicides
- LEAD
- 4.b - medicaid transformation initiative 1 - including intro on medicaid transformation
- about the Tribal projects - including tribal BH project, using national Tribal BH Agenda. Culturally appropriate strategies.
    - Use the MTP reports
- 4.c - Serious Emotional Disturbances - Serious Mental Illness
    - Investments in crisis triage stabilization, mobile crisis, WISe services

5 - Financing Plan - what is the purpose of the financing section

- Related to maintenance of effort

6 - IT Plan

- We need to ask the legislature for funding
- We need to figure out a replacement for the TARGET system, but also trying to tackle issues around data. Refer to upcoming collaboration with Tribes on data and IT.
- NBHAB - Reduce duplication of data who have IT systems.
- 2.1 - CMS did not include BH in its HIT capacity efforts.

For Tribes with RPMS - had to file an exception for quality behavioral health, will there be additional requirements.

- We will send the language as soon as we can for the consultation.
- Shared contact information

Adjourned at 1:00 pm.

Convened at 11am – 1pm

11:00 AM Webinar Check, Welcome, Acknowledgement, Blessing and Introductions
11:15 AM Overview of 1115 Waiver Application (B) (David Johnson and Louise Nieto)
11:30 AM Review of the Waiver Application Implementation Plan – CMS Template

Notes:

General Overview of Waiver Application

- Initiative 5 of the 1115 Waiver Application
- Purpose of this initiative is to make an agreement with CMS - in exchange for maintaining and continuing to improve crisis availability and strengthening the system, and transitioning individuals to various levels of care, CMS may consider agreeing to be flexible with using federal funds for inpatient stays in IMDs.
- There is a current flexibility for individuals in managed care, Medicaid will pay for individuals on managed care for no more than 15 days. If longer than 15 days, then state dollars must be used for the entire stay.
- State has a mechanism to support stays longer than 15, however it is a strain on the state system.
- The State uses these funds in facilities that have an average length of stay of 15 days or less. The idea is to not use IMDs for long term care, but for short term care to move individuals to lower levels of acuity.
- Review of timeline and requirements as they compare to SUD IMD 1115 Waiver.
    - Changes to HIT
    - There are already exceptions for individuals under 21 so this is not needed for this waiver
    - Additional concerns and scrutiny of length of stays, ensure proper um occur and individuals do not have unduly long lengths of stay.

Broad milestones provided (see PPT)

Comments from RT #1 (B) see PP

- Target date for submission is March 1, 2020.
- CM has provided tech assistance and guidance on the application.
- Requirements similar to those under the SUD IMD 1115 waiver
- see PP for notes
- Requirements different than those under the SUD IMD waiver.

See PP for notes

Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings

- 1.c Utilization Review
    - Request to add section on FFS AI/AN Program following information regarding MCO process. Confirm that HCA will request to work on a utilization process in partnership with Tribes and urban Indian health programs.
- 1. e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions…
    - Request to add a section on how this is done in the AI/AN FFS program following section on MCO requirements.

Milestone 2: Improving Care Coordination and Transitions to Community-based Care

- 2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning…
    - Request to add a section on relevant FFS programs following section on relevant managed care contract requirements to include Health Home program and Primary Case Management, and Medicaid Administrative Claiming programs.
    - Request to add a section on efforts by Tribes and urban Indian health programs to expand efforts to participate in the behavioral health and crisis systems including, the Indian Behavioral Health Legislation that insures notification of Tribal members that have been involuntarily committed to Tribal governments, the future development of the Tribal crisis coordination hub, and the implementation of the Community Behavioral Health Aide Program in WA State.
- 2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available**.**
    - Request to add relevant FFS Programs following the Relevant MCO requirements including Health homes.
    - Under "Current Statewide Strategies" under initiative 3 add "Non-traditional provider and behavioral health providers including Indian Health Care Providers are able to participate as a SE/SH provider."
- 2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community- based providers through most effective means possible…
    - Request to add section on relevant FFS programs following the Relevant MCO Contract Requirements
    - Request to add to "current statewide strategies": Development of language to establish Tribes as more than community-based providers
- 2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission
    - Request to add a section on the development of the Community Behavioral Health Aide program.

Milestone 3: Access to Continuum of Care Including Crisis Stabilization

- 3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds
    - Request to include a section on the statewide tracking system to be developed by HCA and the inclusions of Tribes to have access to the statewide tracking system as outlined in the Indian BH Legislation SSB 6259. Add a section on the Tribal Crisis Coordination Hub.
- 3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay
    - Request to add a section on the AI/AN FFS System and the requirement for the state to work with Tribes to develop culturally appropriate assessments and ITA evaluations as outline in the Indian BH legislation SSB 6259.

Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration

- 4.b Plan for increasing integration of behavioral health care in non-specialty settings to

improve early identification of SED/SMI and linkages to treatment
    - Recommend to include additional current statewide strategies including WISe Services, Jail Services, Juvenile Justice Programs, healing courts, Telehealth Capabilities, and Community Health Aide Program development.
- Comment: CMS understanding that not many state offer this service. It is important to align efforts and be thoughtful of where we need to go. This will ensure information gets back to referring provider. Especially with rural providers.

Closed Loop Referrals and e-Referrals (Section 1)

- 1.3 Closed loop referrals and e- referrals from physician/mental health provider to community based supports
    - Request to add section on the Support Act – 1003 work at HCA and the development of the Tribal Crisis Care Coordinating Hub under future state.

Future Work/Next Steps

HCA to submit to CMS by early March. Next steps to incorporate some of the suggestions from this group. We are open to receiving additional language from the group by early next week (March 4). HCA requests from Tribal representatives to let HCA know by end of the week if they want another meeting. A revised document will be sent out with a DTLL.

Adjourned at 1:30 pm.

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

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

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

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

State may submit additional supporting documents in Section 3.

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

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

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

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

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

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

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

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

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

State	*Washington State.*
Demonstration name	*Washington State Medicaid Transformation Project No. 11-W-00304/0*
Approval date	*January 9, 2017*
Approval period	*January 9, 2017-December 31, 2021*
Implementation date	*07/01/2020*

2. Required implementation information, by SMI/SED milestone

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

This template only includes SMI/SED policies.

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk. *To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.*	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	*Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.* Washington State currently has 10 mental health Institute of Mental Disease facilities providing inpatient care. All these facilities are Joint Commission accredited, Medicare participating facilities licensed by the Washington State Department of Health.
	Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings. The state believes it currently meets this requirement. If the waiver is approved, the state will only use federal financial participation for facilities that are state licensed and accredited by the Joint Commission or other federally recognized

	organization.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action N/A

Prompts	Summary
1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	*Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.* All inpatient mental health facilities that meet the institute of mental disease designation in Washington are Joint Commission accredited and subject to Joint Commission auditing and certification processes. In addition, all psychiatric hospitals and evaluation and treatment facilities are licensed by the Washington State Department of Health. The Department of Health provides annual and unannounced site visits to both facility types. Additionally, the Washington State Legislature recently passed Substitute House Bill 2426 in March of 2020 which became effective on of the date of the Governor's signature. This legislation: • Establishes penalties for psychiatric hospitals that fail or refuse to comply with state licensing standards, including civil fines and stop placements. • Requires psychiatric hospitals to report patient elopements and specified types of deaths that occur on their grounds. • Requires the Department of Health to post health care facility inspection related information on its website.
	Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings. The state believes it meets the requirements of this milestone.

	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A
1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	*Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.* **Managed Care:** Approximately 85% of Washington State Medicaid recipients are enrolled in managed care entities which are a risk for their inpatient psychiatric services at participating facilities not owned by or directly contracted with the state. Authorization and payment of services follow CMS approved language which follows the requirements of 42 CFR 438.206 with patient protections for access to emergency services as required by 42 CFR 438.114. Staff making authorization decisions must be credentialed in mental health (MCO IMC contract term 11.1.4). Managed care entities must publish their criteria used for utilization management decision making. Managed care entities must report on utilization management authorization turnaround time compliance (MCO IMC contract term 11.1.6.5). Beginning July 2020, the state will require Managed Care Organization utilization management decision making to take into account the greater and particular needs of diverse populations, as reflected in health disparities, risk factors (such as Adverse Childhood Experiences for enrollees of any age), historical trauma, and the need for culturally appropriate care. **Fee-for-Service:** Prior authorization is not required for fee-for-service at this time. Services are reviewed retrospectively.
	Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings.

	Managed Care: The state believes it meets the requirements of this milestone for this population. **Fee-for-Service:** The state is currently exploring ways to ensure appropriate care coordination and lengths of stay for fee-for-service inpatient psychiatric services and community-based services for patients with less acute mental health treatment needs. The state will ensure collaboration with tribes on the development of utilization management processes for fee-for-service psychiatric stays.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. Review mechanisms for notification and review of stays by health homes etc.
1.d Compliance with program integrity requirements and state compliance assurance process	*Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.* All facilities participating in the state's Medicaid program must be enrolled with the Health Care Authority (HCA). HCA has a process for conducting risk-based screening of all newly enrolling providers and revalidating existing providers pursuant to 42 CFR Part 455 Subparts B and E. HCA requires providers enter into Medicaid provider agreements pursuant to 42 CFR 431.107.
	Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings. The state believes it meets the requirements of this milestone.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A

1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	*Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.* Washington State's Medicaid inpatient psychiatric care network includes two distinct levels of care: 1. Psychiatric hospitals 2. Residential treatment facilities licensed as evaluation and treatment centers At this time, all of the state's inpatient psychiatric Institute of Mental Disease facilities are Medicare participating, nationally accredited, state licensed hospitals. State rules and managed care contract require assessment of co-occurring substance use disorder and physical health issues. When comorbid conditions arise, facilities must treat the condition on site or refer the individual to treatment. **Relevant Washington Administrative Code Rules:** 1. (E&T) WAC 246-337-080 Residential Treatment Facilities must provide or accept a health screening of all residents. They are required to assist residents with all health care needs and refer to the appropriate level of care when needed. Residential treatment facilities must have policies and procedures in place to address how they will deal with medical emergency situations and that outline the referral process. 2. (E&T) WAC 246-341-0610 All behavioral health agencies, including residential treatment facilities and crisis stabilization units, must provide a thorough assessment of the client upon admit. This assessment includes medical a medical history and information about the individual's primary care physician. The assessment must also include an employment and housing assessment. 3. (Hospitals) WAC 246-341-1126 and (Psychiatric Hospitals) WAC 246-322-170 Facilities must provide a health assessment within 24 hours of admit. The assessment is completed by a nurse practitioner, physician, or physician's assistant and must determine whether the individual needs to be transferred to another level of care due to medical concerns. In addition, facilities must have access to a medical provider for consultation 24 hours a day, 7 days a week.

	4. (E&T) WAC 246-341-0610 Facilities must conduct an assessment of any risk of harm to self and others, including suicide, homicide, and a history of self-harm. In addition, all clinical staff in Washington State must attend a training on suicide assessment. **Relevant Managed Care Contract Requirements:** HCA contracts with five Managed Care Organizations to cover inpatient mental health services. HCA contracts require Managed Care Organizations to manage co-occurring disorders at all levels of care: 1. All individuals must be screened using the GAIN-SS SUD and mental health co-occurring disorder tool. 2. Managed Care Organizations must ensure network providers are trained on co-occurring disorders. (IMC 9.11.2.4) 3. Utilization management staff must have an understanding of co-occurring assessment and treatment. (IMC 11.1.4; 11.1.18) **Relevant Fee-for-Service Program Requirement:** Psychiatric hospitals and residential treatment facilities contracted with the state to provide services are required to follow appropriate Washington Administrative Codes related to this topic.
	Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings. The state believes that the Washington Administrative Code requirements for health and co-morbid screening and treatment within inpatient facilities meets the requirements of this milestone.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A

1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	*Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.* Per WAC 246-341-0320: Agency licensure and certification—on-site reviews and plans of correction. To obtain and maintain a department-issued license and to continue to provide department-certified behavioral health services, each agency is subject to an on-site review to determine if the agency is in compliance with the minimum licensure and certification standards. (1) A department review team representative(s) conducts an entrance conference with the agency and an on-site review that may include: (a) A review of: (i) Agency policies and procedures; (ii) Personnel records; (iii) Clinical records; (iv) Facility accessibility; (v) The agency's internal quality management plan, process, or both, that demonstrates how the agency evaluates program effectiveness and individual participant satisfaction; and (vi) Any other information, including the criteria in WAC 246-341-0335 (1)(b), that the department determines to be necessary to confirm compliance with the minimum standards of this chapter; and (b) Interviews with: (i) Individuals served by the agency; and (ii) Agency staff members. (2) The department review team representative(s) concludes an on-site review with an exit conference that includes a discussion of findings. (3) The department will send the agency a statement of deficiencies report that will include instructions and time frames for submission of a plan of correction. (4) The department requires the agency to correct the deficiencies listed on the plan of correction: (a) By the negotiated time frame agreed upon by the agency and the department review team representative; or (b) Immediately if the department determines health and safety concerns require immediate corrective action.

	Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings. The state believes that the Washington Administrative Code requirements for agency licensure and certification meet the requirements for this milestone.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.
SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.	
Improving Care Coordination and Transitions to Community-based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.	*Current Status: Provide information on the state's current care coordination benefits/requirements including actions to connect beneficiaries with community-based care including pre-discharge planning, post discharge follow-up, and information-sharing among providers.* Washington State's behavioral health delivery system strives for a culture of effective care coordination among all provider types and between all levels of care. The HCA's move to integrate management of physical and behavioral health and the state's efforts through the other four 1115 demonstration waiver initiatives are evidence of this commitment. While many coordination of care requirements have been in place in the mental health system for decades, the state continues to improve the overall behavioral and physical health link. The state Medicaid director's letter (SMD # 18–0011) announcing the 1115 Mental Health Institute of Mental Disease waiver opportunity states that nationwide only 38% of adult beneficiaries had a follow-up within 7 days of discharge from a psychiatric admission. 60% had a follow-up visit within 30 days of discharge. Washington State's most recent numbers are significantly higher than the national average. In 2018, 64% had a follow-up within 7 days, and 81% within 30 days.

	Relevant Washington Administrative Code Rules: The state's inpatient and residential treatment facilities licensing rules require consideration of discharge planning early in the individual's stay. Inpatient facilities must coordinate care with the individual's current or future outpatient provider. Discharge plans are documented. 1. (Hospital) WAC 246-320-226 The initial assessment must include a consideration of discharge planning and estimated timeframe. Discharge planning must be coordinated with the outpatient agency and family or caregivers. 2. (Psychiatric Hospital) WAC 246-322-170 Hospitals must provide discharge planning and documentation including a review of the patient's hospitalization, condition upon discharge, and recommendations for follow-up and continuing care. Discharge planning must be coordinated with outpatient providers. 3. (E&T) WAC 246-337-095 Evaluation and Treatment Centers must document a discharge summary including recommendations for follow up care. 4. (Inpatient MH) WAC 246-341-1126 The initial treatment plan must include a plan for discharge and follow up care. 5. (Crisis Stabilization and Crisis Triage) WAC 246-341-1150 and WAC 246-341-1142 Crisis stabilization and crisis triage units must coordinate with outpatient providers and develop a discharge plan with dates, times, and addresses of follow up care appointments. 6. (All BHA) WAC 246-341-0640 Related to documentation of discharge and applies to all Behavioral Health Administrations. **Relevant Managed Care Contract Requirements:** As mentioned under Milestone II.E, the state requires Managed Care Organizations to ensure individuals are screened for comorbid conditions. Coordination with physical health and substance use disorder providers is part of the screening and referral process. Managed Care organizations are also required to ensure coordination occurs between inpatient and outpatient levels of care. Contract requirements include:

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

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

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

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

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

1. Health Home program – This program provides care management and coordination, transition planning, support for the individual and family, referrals to support services in the hopes of promoting better health. Services are provided by a care coordinator who works with the patient and family to develop a health action plan, assist in transitions between types of care and work with providers. Beneficiaries with a chronic condition and at risk for a second condition are eligible. Dual eligible beneficiaries (Medicare and Medicaid) may also participate in the program. Eligibility is determined by HCA, but services/agreements are coordinated through the Department of Social and Health Services, Aging and Long-Term Services Administration (ALTSA-DSHS). Tribes can participate in the Health Home program as lead organizations or care coordination organizations.

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

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

Current Statewide Strategies:
The state has invested in several strategies to improve coordination of care and post discharge treatment for individuals

	leaving inpatient care. Some of these efforts are described below. 1. The Peer Bridgers program delivers services individuals in state and community hospitals prior to discharge and after their return to their communities. The Peer Bridger develops a relationship of trust with the participant. In developing this trust, the Peer Bridger may function as a role model, peer support, a mentor, a teacher, an advocate, and an ally as they communicate hope and encouragement. 2. State Plan Services: Washington's Medicaid State Plan includes a rehabilitation case management service allowing liaisons from the community to actively participate in discharge planning for individuals receiving psychiatric inpatient care. This is currently a state funded service for individuals in Institute of Mental Disease facilities. 3. Crisis Triage and Stabilization Investments: ongoing. Between 2017-18, the state funded several new triage and crisis stabilization facilities across the state. Three facilities are open and four expected to open in the coming year, for a total of 102 crisis stabilization and triage beds across six regions of the state. The 2019 state Legislature funded even more 16-bed triage and stabilization facilities. The Legislature also funded Mobile Outreach Crisis teams. 4. The Legislature recently funded five mental health peer respite centers to divert individuals from crisis services as well as a pilot program to provide mental health drop-in center services. 5. Step Down Facilities: The Legislature appropriated funding for a new community facility type to address the need for additional discharge placements for individuals leaving the state psychiatric hospitals. Intensive behavioral health treatment facilities serve individuals who possess higher levels of behavioral challenges that existing alternative behavioral health facilities cannot accommodate. 6. The Housing and Recovery through Peer Services (HARPS) program builds on the successes of the Permanent Options for Recovery-Centered Housing (PORCH) project. PORCH provided consumers with meaningful choice and control of housing and support services, using peer housing specialists. The HARPS project reduces homelessness and supports the recovery and resiliency of individuals with serious mental illness. Each team consists of three full-time employees (a mental health professional and two certified peer counselors). One of the priority target populations for the HARPS program is individuals discharging from inpatient psychiatric care. The state Legislature recently funded four additional HARPS teams with a focus on individuals discharging from

forensic facilities.

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

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

9. State-tribal collaboration to improve access to behavioral health care for American Indians and Alaska Natives. The state is currently in collaboration with a newly formed Tribal Centric Behavioral Health Advisory Board to develop a comprehensive plan to increase access to crisis services and culturally appropriate behavioral health care services for American Indians and Alaska Natives in Washington State. This plan includes:

    - Legislation to improve the ability of Indian health care providers and tribal governments to participate in the crisis system.
    - Facility siting.
    - Development of culturally appropriate clinical models and strategies for facility operations and Involuntary Treatment Act evaluations by tribal designated crisis responders.
    - Establishment of an inter-tribal governance structure for a consortium to establish and operate facilities that are beyond the capacity of individual tribes and that can provide behavioral health prevention, treatment, and recovery support services statewide to American Indians and Alaska Natives beneficiaries.
    - Tribal Crisis Coordination Hub to support tribes, Indian health care providers, and non-tribal providers with inpatient placement, transition planning, and care coordination across the continuum of treatment for

	American Indians and Alaska Natives beneficiaries. • Community Health Aide program – Behavioral Health Aides. The Indian Health Service and the tribes in Idaho, Oregon, and Washington are developing a plan to implement the Community Health Aide program (CHAP) in this three-state region, with a certification board to certify community health aides, dental health aide therapists, and behavioral health aides. Behavioral health aides are entry and mid-level behavioral health providers recruited from their communities who are trained and certified to provide behavioral health care services within their certification scope. As a result, behavioral health aides are much more likely to have trust from, and deeper understanding of the culture and needs of their communities – thereby improving the quality of culturally appropriate care they can provide within their certification scope.
	Future Status: Describe planned improvements to care coordination benefits/requirements and connections to community-based care, including pre-discharge planning, post discharge follow-up, and information-sharing among providers. The state believes that the Washington Administrative Code requirements and statewide investments and strategies meet the requirements of this milestone.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	*Current Status: Provide information on the state's current care coordination benefits/requirements including actions to connect beneficiaries with community-based care including pre-discharge planning, post discharge follow-up, and information-sharing among providers.* HCA understands that housing is an integral part of stability for the individuals we serve. Safe and stable housing increases the chances that individuals remain stable in the community and reduces the likelihood of unnecessary inpatient stays. The state has requirements in place requiring providers and managed care entities to address housing issues. In addition, there are several statewide initiatives addressing this issue.

	Relevant Washington Administrative Code Rules: In addition to screenings and assessments for comorbid disorders described in other sections, state rules require facilities to assess for housing and employment needs. • (E&T) WAC 246-341-0610 All behavioral health agencies, including residential treatment facilities and crisis stabilization units, must provide a thorough assessment of the client upon admit. This assessment includes a medical history and information about the individual's primary care physician. The assessment must also include an employment and housing assessment. **Relevant Managed Care Contract Requirements:** The state's requirements that Managed Care Organizations participate in discharge planning and coordinate care include a focus on determining and addressing an individual's housing needs. 1. Managed Care Organizations must establish protocols for discharge planning that include community supports necessary for recovery, including housing, transportation, employment and educational concerns, and social supports. (11.1.29.3) 2. Within 60 days of enrollment, Managed Care Organizations must conduct initial health screening assessments, to include a housing and housing instability assessment. (14.3.4). 3. Managed Care Organizations must demonstrate ongoing coordination with housing agencies (14.1.9.1/14.10.1.17). **Relevant Fee-for-Service Programs:** 1. Health Homes and Medicaid Administrative Claiming programs provide support for coordination with housing service providers, including tribal housing support programs for American Indians and Alaska Natives beneficiaries covered by the Medicaid fee-for-service program. **Current Statewide Strategies:** 1. Washington State has several coordinated entry programs that assist homeless or at-risk individuals in obtaining housing. These programs are available in each region of the state.

	2. The state has developed an institutional discharge planning toolkit that involves guidance and a housing assessment tool for individuals discharging from institutions. 3. Initiative 3 of the state's 1115 demonstration waiver focuses on supportive housing and employment services. As of March 2019, 1,991 beneficiaries were enrolled in supportive housing. Non-traditional providers and behavioral health providers, including Indian health care providers, are able to participate in this program. 4. Step Down Facilities: The Legislature appropriated funding for a new community facility type to address the need for additional discharge placements for individuals leaving the state psychiatric hospitals. Intensive behavioral health treatment facilities serve individuals who possess higher levels of behavioral challenges that existing alternative behavioral health facilities cannot accommodate. 5. The Housing and Recovery through Peer Services (HARPS) program builds on the successes of the Permanent Options for Recovery-Centered Housing (PORCH) project. PORCH provided consumers with meaningful choice and control of housing and support services, using peer housing specialists. The HARPS project reduces homelessness and supports the recovery and resiliency of individuals with serious mental illness. Each team consists of three full-time employees (a mental health professional and two certified peer counselors). One of the priority target populations for the HARPS program is individuals discharging from inpatient psychiatric care. The state Legislature recently funded four additional HARPS teams with a focus on individuals discharging from forensic facilities. 6. Program for Assertive Community Treatment (PACT) teams provide wrap around services for individuals in outpatient treatment. When the individual is in an inpatient facility, the PACT team coordinates care with the inpatient unit and work to ensure stable housing and follow-up care. Currently there are 14 PACT teams across the state. In May 2019 the Legislature provided funding for eight additional PACT teams statewide.
	Future Status: Describe planned improvements to care coordination benefits/requirements and connections to community-based care, including pre-discharge planning, post discharge follow-up, and information-sharing among providers. The state believes that the Washington Administrative Code requirements and statewide strategies meet the requirements of this milestone.

	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A

Prompts	Summary
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	*Current Status: Provide information on the state's current care coordination benefits/requirements including actions to connect beneficiaries with community-based care including pre-discharge planning, post discharge follow-up, and information-sharing among providers.* **Current Status:** The state understands the importance of immediate follow-up care upon discharge from an inpatient or residential facility. The rules and initiatives in place demonstrate the state's commitment to ensuring clients receive adequate and immediate care when discharging from a psychiatric facility. **Relevant Washington Administrative Code Rules:** While there are no specific statewide rules regarding follow-up within 72 hours of discharge, see Milestones II.A and II.B for a full discussion of Washington Administrative Code requirements around discharge planning and coordination of care reviews. **Relevant Managed Care Contract Requirements:** As described under Milestone II.A, Managed Care Organizations must develop a plan with inpatient facilities regarding discharge planning responsibilities. This includes a follow-up call within two to three business days of discharge. (14.17) See section II.A and II.B for a full discussion of contract requirements related to discharge planning and coordination of care with outpatient providers. **Relevant Fee-for-Service Programs:** Health Homes and Medicaid Administrative Claiming programs provide support for coordination with housing service providers, including tribal care coordination and tribal governmental social service programs for American Indians and Alaska Natives beneficiaries covered by the Medicaid fee-for-service program. **Current Statewide Strategies:** See Milestones II.A and II.B for a full discussion of the state's efforts around discharge planning and coordination of care.

	Current Status: The state understands the importance of immediate follow-up care upon discharge from an inpatient or residential facility. The rules and initiatives in place demonstrate the state's commitment to ensuring clients receive adequate and immediate care when discharging from a psychiatric facility. **Relevant Washington Administrative Code Rules:** While there are no specific statewide rules regarding follow-up within 72 hours of discharge, see Milestones II.A and II.B for a full discussion of Washington Administrative Code requirements around discharge planning and coordination of care reviews. **Relevant Managed Care Contract Requirements:** As described under Milestone II.A, Managed Care Organizations must develop a plan with inpatient facilities regarding discharge planning responsibilities. This includes a follow-up call within two to three business days of discharge. (14.17) See section II.A and II.B for a full discussion of contract requirements related to discharge planning and coordination of care with outpatient providers. **Current Statewide Strategies:** See Milestones II.A and II.B for a full discussion of the state's efforts around discharge planning and coordination of care.
	Future Status: Describe planned improvements to care coordination benefits/requirements and connections to community-based care, including pre-discharge planning, post discharge follow-up, and information-sharing among providers. The state believes that the Washington Administrative Code requirements and statewide strategies meet the requirements of this milestone.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. As described above.

2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	*Current Status: Provide information on the state's current care coordination benefits/requirements including actions to connect beneficiaries with community-based care including pre-discharge planning, post discharge follow-up, and information-sharing among providers.* **Current Status:** Washington State demonstrates its commitment to reducing the length of stay in emergency departments through a number of efforts focused on clinical interventions and coordination of care. **Relevant Washington State Law:** Washington law require designated crisis responders to respond to emergency department requests within specified time frames. When an individual self-presents in an emergency department, the hospital may only hold the person for up to six hours before the designated crisis responder must make their determination (RCW 71.05.050). If a peace officer delivers the individual to the emergency department, the individual must be examined by a mental health professional within three hours. The designated crisis responder must determine if the individual meets involuntary treatment criteria within 12 hours of patient arrival. **Relevant Managed Care Contract Requirements:** Reducing unnecessary emergency department visits is a focus of the managed care system in Washington State. Contract requirements include efforts around coordination of care and sharing of information. Examples include: 1. Managed Care Organizations must have a process for communicating with primary care providers around overuse of the ED. (14.5.7.3.3) 2. Unnecessary emergency department visits is a required measure Managed Care Organizations must include in their quality plans. (7.1.1.2.16) 3. Managed Care Organizations utilize the Emergency Department Information Exchange (EDIE) to track and intervene with emergency department high utilizers. **Relevant Fee-for-Service Programs:** The Health Home program helps to prevent or decrease lengths of stay in emergency departments among beneficiaries with SMI or SED prior to admission through intensive case management and care coordination services for eligible beneficiaries covered by the Medicaid fee-for-service program.

	Current Statewide Strategies: The state has implemented a number of programs directed at reducing unnecessary emergency department visits and reducing the overall length of stay in emergency departments for individuals presenting with a behavioral health issue. 1. The Peer Bridgers program delivers services individuals in state and community hospitals prior to discharge and after their return to their communities. The Peer Bridger develops a relationship of trust with the participant. In developing this trust, the Peer Bridger may function as a role model, peer support, a mentor, a teacher, an advocate, and an ally as they communicate hope and encouragement. 2. Crisis Triage and Stabilization Investments: Between 2017-18, the state funded several new triage and crisis stabilization facilities across the state. Three facilities are open and four expected to open in the coming year, for a total of 102 crisis stabilization and triage beds across six regions of the state. The 2019 state Legislature funded even more 16-bed triage and stabilization facilities. The Legislature also funded Mobile Outreach Crisis Teams. 3. The Legislature recently funded five mental health peer respite centers to divert individuals from crisis services as well as a pilot program to provide mental health drop-in center services. 4. The Housing and Recovery through Peer Services (HARPS) program builds on the successes of the Permanent Options for Recovery-Centered Housing (PORCH) project. PORCH provided consumers with meaningful choice and control of housing and support services, using peer housing specialists. The HARPS project reduces homelessness and supports the recovery and resiliency of individuals with serious mental illness. Each team consists of three full-time employees (a mental health professional and two certified peer counselors). One of the priority target populations for the HARPS program is individuals discharging from inpatient psychiatric care. The state Legislature recently funded four additional HARPS teams with a focus on individuals discharging from forensic facilities. 5. Program for Assertive Community Treatment (PACT) teams provide wrap around services for individuals in outpatient treatment. When the individual is in an inpatient facility, the PACT team coordinates care with the inpatient unit and works to ensure stable housing and follow-up care. Currently there are 14 PACT teams across the state. In May 2019 the Legislature provided funding for eight additional PACT teams statewide.

	6. Washington State's Department of Commerce announced $7.1 million in grants to six health care providers across Washington, adding 71 additional beds to facilities that help people with a wide variety of behavioral health issues. Twenty-eight of the new beds are dedicated as an alternative to treatment in state psychiatric hospitals. These grants are part of the governor's five-year plan to modernize and transform the state's mental health care systems by shifting out of large institutions to smaller, community-based facilities. 7. Co-Responders with Law Enforcement: The state continues to expand programs that fund mental health professionals who ride along with law enforcement as they respond to calls where mental health conditions may be involved. 8. Emergency Department is for Emergencies Workgroup. 9. Development of Behavioral Health Aides: The state is collaborating with tribes to support behavioral health aides, who can provide early identification and treatment support for beneficiaries with SED or SMI, to prevent emergency department admission.
	Future Status: Describe planned improvements to care coordination benefits/requirements and connections to community-based care, including pre-discharge planning, post discharge follow-up, and information-sharing among providers. The state believes that the Washington Administrative Code requirements and statewide investments and strategies meet the requirements of this milestone.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A
2.e Other State requirements/policies to improve care coordination and connections to community-based care	*Current Status: Provide information on the state's current care coordination benefits/requirements including actions to connect beneficiaries with community-based care including pre-discharge planning, post discharge follow-up, and information-sharing among providers.* See sections above.

	Future Status: Describe planned improvements to care coordination benefits/requirements and connections to community-based care, including pre-discharge planning, post discharge follow-up, and information-sharing among providers. N/A
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A

Prompts	Summary
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	
Access to Continuum of Care Including Crisis Stabilization	
3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports.	*Current Status: Provide information on the status of the state's assessment of mental health provider availability and an overview of the current continuum of care, including crisis stabilization, the state's ability of the state to track availability of beds, and the use of patient assessment tools.* Washington State initiated integrated substance abuse and mental health purchasing in April 2016 and completed its process of moving to integrated care with primary health by January 2020. Washington now has all 10 regional service areas with integrated care. These changes have driven substance use disorder treatment services from a fee-for service program to a managed care model which required changes in how data is being collected. Due to the change, the Mental Health Client Information System (MHD-CIS) and the Treatment and Assessment Report Generation Tool (TARGET) data systems needed to be replaced by an integrated Behavioral Health Data System (BHDS) and Provider One (claims based data system).The one caveat to the integration is with the American Indian and Alaska Native population, who will have the option of receiving mental health and substance use disorder treatment through the Medicaid managed care system or through a fee-for-service delivery system. Specifically, for fee-for-service, the state continues to maintain a legacy data system known as TARGET for data. The Behavioral Health Data System has modernized the flow of data, provided increased security, improved accountability, and increased transparency of information, which will assist in refined management decisions and policy development. This system has also strengthened the monitoring and quality of the service delivery system, enhanced outcome analysis for the entire organization, and will further align the organization to a managed care model while maintaining the Health Care Authority, Division of Behavioral Health and Recovery's (HCA/DBHR) ability to track priority outcomes, such as employment and housing for adults with serious mental illness. Through legislative direction in 2013, the Department of Social and Health Services (DSHS), Research and Data

	Analysis (RDA) created a dashboard to measure the outcomes of the system. Using their integrated client data system DSHS/RDA can match administrative data records from multiple administrative data systems including the Behavioral Health Data System to provide and measure outcomes. This same legislation (2SSB5732) also directed the Washington State Institute for Public Policy in partnership with HCA/DBHR to create an inventory of evidence-based, research-based, and promising practices of interventions in adult mental health and substance use treatment services. To make data-informed needs assessments with planning, policy development, service provision, and reporting HCA/DBHR continues to integrate stakeholder input, including input from the Behavioral Health Advisory Council, as well as the independent peer review summaries. Additionally, the State Epidemiological Outcomes Workgroup plays an important role in primary prevention and treatment planning. The State Epidemiological Outcomes Workgroup is currently housed in HCA/DBHR and is co-chaired by the HCA/DBHR Substance Use Disorder Prevention and Mental Health Promotion Section Manager and leadership at the Department Health. Members of State Epidemiological Outcomes Workgroup include epidemiologists from multiple state agencies and universities tasked with monitoring and improving the behavioral health of the population. HCA/DBHR is committed to ensure that tribal behavioral health needs define statewide needs by including representatives from the Northwest Portland Area Indian Health Board Epidemiological Center and the Urban Indian Health Institute as members for the State Epidemiological Outcomes Workgroup. The State Epidemiological Outcomes Workgroup collects and provides guidance on the collection of data related to substance use and mental health, including consumption and prevalence, consequences of use, and intervening variables. Data is sourced from both national and state surveys and administrative databases and is collected statewide covering all age and demographic groups. To allow for more in-depth geographic analysis, data are maintained at the lowest geographical level possible which allows Washington to support community-based initiatives. The S State Epidemiological Outcomes Workgroup developed and biennially updates the Prevention Needs Assessment for the Strategic Prevention Enhancement Consortium Strategic Plan. Strategy to identify unmet needs and gaps. HCA/DBHR's planning of prevention and treatment services draws on data from various sources. The biennial statewide Healthy Youth Survey provides reliable estimates of substance use prevalence and, mental health status among in-school adolescents, as well as risk factors that predict poor behavioral health outcomes. The survey, supported by four state agencies and administered every two years in over 80% of the state's public schools, is used by HCA/DBHR to estimate prevalence rates at state, county, Behavioral Health Organizations, Accountable Communities of Health, school districts, and even school building levels. The most recent Healthy Youth Survey was conducted in the fall of 2018 which provided data for HCA/DBHR's needs assessment, including broadening surveillance capacity for lesbian, gay, bisexual, transgender, and queer communities, teen anxiety and substance use issues related to vapor

	products. For young adults, adults, and older adults, the main data sources for prevalence estimates and epidemiological analyses are the National Survey on Drug Use and Health, the Behavioral Risk Factor Surveillance System, and the Washington Youth Adult Health survey. National Survey on Drug Use and Health is used to estimate and monitor substance use prevalence rates for various types of substances and Behavioral Risk Factor Surveillance System provides information to identify needs and gaps among various demographic and socioeconomic subpopulations. For example, the Washington Behavioral Risk Factor Surveillance System includes questions that allow us to identify pregnant/parenting women and the lesbian, gay, bisexual, transgender, and queer subpopulation needs. However, the small sample size limits the ability to create estimates for these subpopulations without combining multiple years of data, and the minimal number of questions about marijuana and alcohol on these surveys limits the ability to assess how recent policy changes are shaping substance use patterns. HCA/DBHR has partnered with researchers at the University of Washington to conduct the Youth Adult Health survey, filling these gaps with a larger sample to allow for comparison of sub-populations, and detailed questions that enable assessment of how substance use patterns are changing among young adults in the state. Moving forward, the State Epidemiological Outcomes Workgroup will continue to assess data for priority populations and advise on potential data sources to address these gaps. The use of evidence-based practices in the field of behavioral health is very well established. The Washington State Legislature has acknowledged the importance of evidence-based practices in children's mental health and adult behavioral health services. HCA/DBHR has established a partnership with the University of Washington's Evidence-based Practice Institute to assess the need for evidence-based practices in the children's behavioral health system. The collaboration aims to formulate evidence-based practices reporting guidelines and to monitor the use of evidence-based practices by providers and identify gaps in EMP implementation using data from the Behavioral Health Data System. As mentioned earlier, Washington State Institute for Public Policy identified a three-step process for identifying evidence-based practices, RBP and primary prevention for adult behavioral health services through a rigorous meta-analysis of the research, costs and return on investment of the intervention and conducting a risk analysis of the results. Primary prevention services are chosen by sub-recipients from a list of approved evidence-based programs and strategies created by Washington State's Evidence-Based Program Workgroup. The list is posted on the Athena Forum website (https://www.TheAthenaForum.org/EBP). The Evidence-based Practices Workgroup is comprised of researchers and experts from the University of Washington's Social Development Research Group and Washington State University's Improving Prevention through Action Research Lab, with input from Washington State Institute for Public Policy, the prevention research sub-committee, and Pacific Institute for Research and Evaluation. The programs and strategies on the list come from three primary resources: the National Registry for Evidence-based Programs and Practices (NREPP), a separate list of programs

	identified as evidence-based by the state of Oregon; and, the Pacific Institute for Research and Evaluation's (PIRE) "Scientific Evidence for Developing a Logic Model on Underage Drinking: A Reference Guide for Community Environmental Prevention" report. For specific priority subpopulations, including pregnant injecting drug users, pregnant substance abusers, injecting drug users, and women with dependent children, data will be drawn from other state surveys and administrative databases as well as service data to identify the un-met need. For example, we will use data from the Pregnancy Risk Assessment Monitoring System (PRAMS) to estimate the prevalence of substance use among pregnant women and treatment data to identify the rate of treatment for pregnant substance users. When prevalence data is unavailable for certain priority subpopulations, such as women with dependent children, treatment data will be used to monitor rates of admission to substance use disorder treatment. The State Epidemiological Outcomes Workgroup will identify data gaps for priority subpopulations and advise on potential data sources. At the sub-state level, we will use a synthetic process to estimate substance abuse treatment needs. This process combines data from U.S. Census sources for geographic and demographic subgroups to "expand" the National Survey on Drug Use and Health state-level estimates of AOD treatment need into the desired subgroups (defined by poverty level, age, race/ethnicity, gender). Detailed community level needs and resource assessments will be used to develop strategic plans to support the individual, community, and local system level. In addition to Healthy Youth survey, the Community Outcomes and Risk Evaluation (CORE) System will be used in community level needs assessment. The CORE Geographic Information System, developed as a set of social indicators highly correlated with adolescent substance use, are kept at the lowest possible level (at least county level, and address level in some instances). Most indicators originate from the Department of Health (including the Prescription Monitoring program), DSHS, the Uniform Crime Report, and the Office of Superintendent of Public Instruction. Behavioral Health Data Store. Washington State is in the transition phase of successfully integrating behavioral health services, which includes mental health and substance use disorder treatment, into the primary medical service system. This phased approach to transitioning the Behavioral Health Organizations into Integrated Managed Care will be fully implemented by July 2020. Washington State has also collaborated on transitioning staff and data resources from a Behavioral Health Organization model to an Integrated Managed Care model. This involved the move of DBHR from the DSHS to HCA. As part of this transition, multiple workgroups and steering committees were established to ensure coverage for all the transition needs. These needs included, but were not limited to plans for database transfers; access and firewall adjustments; requirement reporting tasks allocated to appropriate resources; and staff relocation planning. One of the main data sources that was in scope for the transition project was the Behavioral Health Data Store. The Behavioral Health Data Store is the data system that replaced the MH-CIS data system, and most of the Treatment and Assessment Report Generation Tool (TARGET) data system, starting in April 2016. The Behavioral Health Data Store stores both mental health and substance use disorder data to support various programs throughout integrated HCA. With the

	movement from the Behavioral Health Organization model to the Integrated Managed Care model, the providers and billing agencies are also accommodating a change in their systems and processes. For the Behavioral Health Organization regions still not yet fully transitioned, the report and submission requirements have not changed. Those Behavioral Health Organizations continue to submit HIPAA-level claim transactional data, as well as the non-claim transactional data to support the additional fields within the Behavioral Health Data Store, to support Substance Abuse and Mental Health Service Administration reporting and other state-required reporting. For the Integrated Managed Care regions, the claim submissions to HCA's Provider One claims system have been limited due to the clarifications needed around submission requirements for the mental health and substance use disorder data. A workgroup was generated, called the Behavioral Health Reporting and Data Standardization workgroup, to develop a long-term data solution that follows Substance Abuse and Mental Health Service Administrations block grant reporting requirements; supports and other necessary state reporting needs; and standardizes the native data collection process as part of an approved Substance Abuse and Mental Health Service Administration Corrective Action Plan. The Behavioral Health Reporting and Data Standardization workgroup is reviewing both the ability of the Managed Care Organizations and behavioral health ASO to collect data for submission to the state and the administrative burden on the behavioral health provider community. The Behavioral Health Reporting and Data Standardization workgroup is working with a contracted vendor, Milliman, to review the needs assessment and gaps in the data. Because of the Behavioral Health Reporting and Data Standardization workgroup's findings, there are a number of modifications and significant system and reporting changes that need to take place in order for Washington State to have consistent and high-quality data for its required reporting. To ensure all entities are reporting accurate and consistent data, the Behavioral Health Reporting and Data Standardization workgroup is going to move forward with modifying the Behavioral Health Data Store to better meet the needs of Substance Abuse and Mental Health Service Administration reporting, as well as state reporting requirements. These Behavioral Health Data Store enhancements involve a number of contract changes, system changes, and reporting logic changes. This change effort will increase the quality of the data being reported, will provide clarity to the Integrated Managed Care regions and the provider community, and will allow for the behavioral health transition project from DSHS to HCA to be fully executed. Strategy to align behavioral health funding with unmet needs and gaps; the funding allocation methodology for non-Medicaid services was reviewed as part of the integration of mental health and substance use disorder treatment for the Behavioral Health Organizations. Treatment needs by county, as well other factors such as utilization patterns, penetration and retention rates were also used for developing the

	methodology. After much review with stakeholders, the final methodology that was incorporated into the model is 70% prevalence, 20% penetration and 10% retention. Integrating these factors allows us to maintain focus on priority populations and the full continuum of care. Mental health resource allocation will continue to be based on prevalence and treatment needs. For example, HCA/DBHR recently updated the state hospital bed allocation formula with current prevalence rates of serious mental illnesses and prior utilization rates. Using a data-based approach, the Washington State Prevention Enhancement Policy Consortium is developing an update to the state's Substance Abuse Prevention and Mental Health Promotion Strategic Plan, projected to be completed in Fall 2019. The current state of Washington Substance Abuse and Mental Health Promotion Five-Year Strategic Plan was developed in 2012. It was updated in 2015 and 2017, and both past plans and the current plan are posted at www.TheAthenaForum.org/spe. The Consortium is comprised of representatives from 26 state and tribal agencies and organizations. The goal of the Consortium is that through partnerships. Washington State will strengthen and support an integrated system of community-driven substance abuse prevention programming, mental health promotion programming, and programming for related issues. Prevention funding, under the state's Community Prevention Wellness Initiative and through grants awarded to Washington State Community-based organizations, are targeted to communities with the highest needs. The SEOW identifies highest-need communities through a risk ranking that integrates data on prevalence of and consequences related to substance use; separate rankings were developed for underage drinking, marijuana use, opioid use, and all ATOD use. Using the most recent data, State Epidemiological Outcomes Workgroup periodically updates the risk rankings. The most recent update was in spring 2019. Because the Healthy Youth survey and Community Outcomes and Risk Evaluation data are available at the community and school level, communities and neighborhoods can be identified that otherwise might be overlooked if data were only available at larger geographic units. An important aspect of HCA/DBHR's surveillance work is providing increasingly sophisticated access to data for our program managers, Behavioral Health Organizations, and other providers.
	Future Status: Describe plans to expand community-based services, including references to the financing plan as appropriate, and the state's plans to improve annual assessments of the availability of mental health providers and the state's ability to track availability of beds, and plans to encourage widespread use of patient assessment tools. We are striving to reconcile Department of Health certification and licensure records with HCA claims and encounter records.

	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. The state will report metrics required by this demonstration opportunity.

Prompts	Summary
3.b Financing plan	*Current Status: Provide information on the status of the state's assessment of mental health provider availability and an overview of the current continuum of care, including crisis stabilization, the state's ability of the state to track availability of beds, and the use of patient assessment tools.* Financing Plan is included in separate section see below.
	Future Status: Describe plans to expand community-based services, including references to the financing plan as appropriate, and the state's plans to improve annual assessments of the availability of mental health providers and the state's ability to track availability of beds, and plans to encourage widespread use of patient assessment tools. See Below.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. See Below.
3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	*Current Status: Provide information on the status of the state's assessment of mental health provider availability and an overview of the current continuum of care, including crisis stabilization, the state's ability of the state to track availability of beds, and the use of patient assessment tools.* The state tracks provider availability and inpatient psychiatric beds and inpatient diversion resources using: • Monitoring of managed care encounters. • No bed reporting. • Periodic surveys of inpatient and crisis bed provider capacity. While there are resources to report on bed availability of beds in psychiatric inpatient settings and residential treatment facilities capable of providing unscheduled/crisis admissions, the system has been underutilized.

	Future Status: Describe plans to expand community-based services, including references to the financing plan as appropriate, and the state's plans to improve annual assessments of the availability of mental health providers and the state's ability to track availability of beds, and plans to encourage widespread use of patient assessment tools. HCA is considering requiring that Medicaid participating inpatient, and residential providers accepting unscheduled admissions actively participate in the Washington State Department of Health's WATrac system. WATrac is an online communication system that enables users across health care disciplines to accurately track bed availability and agency status. Key features include: • Tracking bed availability and surgical specialists. • Status reports for individual agencies and for the region. • Data sharing and planning through a report writer, a virtual library, and a survey builder. • Real-time communications using an alert manager, emergency contacts, and an online chat center.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. To be determined.
3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	*Current Status: Provide information on the status of the state's assessment of mental health provider availability and an overview of the current continuum of care, including crisis stabilization, the state's ability of the state to track availability of beds, and the use of patient assessment tools.* **Relevant Washington Administrative Code (WAC) Rules:** • (E&T) WAC 246-341-0610 WAC 246-341-0610 Related to assessments for all Behavioral Health Administration Facilities must provide an age-appropriate, strengths-based psychosocial assessment that

	considered current needs and the patient's relevant history according to best practices. Such information may include, if applicable: (a) Identifying information; (b) Presenting issues; (c) Medical provider's name or medical providers' names; (d) Medical concerns; (e) Medications currently taken; (f) Mental health history; (g) Substance use history, including tobacco; (h) Problem and pathological gambling history; (i) An assessment of any risk of harm to self and others, including suicide, homicide, and a history of self-harm; (j) A referral for provision of emergency/crisis services must be made if indicated in the risk assessment; (k) Legal history, including information that a person is or is not court-ordered to treatment or under the supervision of the department of corrections; (l) Employment and housing status; (m) Treatment recommendations or recommendations for additional program-specific assessment; and (n) A diagnostic assessment statement, including enough data to determine a diagnosis supported by the current and applicable Diagnostic and Statistical Manual of Mental Disorders (DSM-5). • (All inpatient) WAC 246-341-1126 The individual must be assessed daily for the purpose of determining the need for continued involuntary treatment. • (Other) WAC 246-341-1134 Related to notification of the peace officer when the person has been released. **Relevant Managed Care Contract Requirements:** Managed Care Organization contracts include several requirements around utilization management and authorization of inpatient care:

	• 1.35 Care management must include evidence-based approach for screening and intervention; • 9.11.2.2.1 Must train behavioral health providers on evidence-based practices; • 14.3.2.1 Use of evidence-based screening tools; • 11.1.4 Requirements of utilization management staff; ▪ 11.1.15-18; • 11.1.11 Inter rater reliability; • 11.1.9 Utilization management policy requirements; • 11.1.29 LOC guidelines.
	Future Status: Describe plans to expand community-based services, including references to the financing plan as appropriate, and the state's plans to improve annual assessments of the availability of mental health providers and the state's ability to track availability of beds, and plans to encourage widespread use of patient assessment tools. In addition to Washington Administrative Code, the state plans to work with the tribes in the next twelve months to develop written guidelines for conducting culturally appropriate evaluations of American Indians and Alaska Natives.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. The state intends to take steps to ensure access for American Indian and Alaska Native individuals.

Prompts	Summary
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	*Current Status: Provide information on the status of the state's assessment of mental health provider availability and an overview of the current continuum of care, including crisis stabilization, the state's ability of the state to track availability of beds, and the use of patient assessment tools.* The state described its requirements around access to a full continuum of care in the sections above.
	Future Status: Describe plans to expand community-based services, including references to the financing plan as appropriate, and the state's plans to improve annual assessments of the availability of mental health providers and the state's ability to track availability of beds, and plans to encourage widespread use of patient assessment tools. N/A
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A
SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	
Earlier Identification and Engagement in Treatment	
4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported employment and supported programs	*Current Status: Provide information on current strategies to increase earlier identification/ engagement in treatment, integration of behavioral care in non-specialty settings, and specialized programs for young people with SED/SMI.* **Current Statewide Strategies:** 1. Trauma Informed approach a. HCA awarded nearly 1.4 million dollars in grants to organizations across the state to build on the trauma-informed work already happening across the state, and to support interest that has been unfunded to date.

b. From July through September 2019, HCA offered free trainings throughout Washington State on trauma informed approach for direct care staff, supervisors, leaders, and community members, including train the trainer sessions.

c. HCA is offering trainings for state agency employees through October 31. State employees only. Learn more and register.

d. Online versions of the training sessions will be available soon.

e. HCA, in collaboration with other state agencies and people throughout the state, is creating a toolkit of trauma informed resources, which will be available later this year.

f. Federal block grant funds, awarded through the Substance Abuse and Mental Health Service Administration, are allocated for HCA's trauma-informed work

2. Initiative 3, Supported Employment, includes services that identify and assist individuals in obtaining employment based on their preferences, and support to maintain employment to reduce higher cost services and incarceration. In March 2019, 2,562 clients were enrolled in Supported Employment.

3. The Becoming Employed Starts Today (BEST) project is designed to promote sustainable access to evidence-based supported employment. Becoming Employed Starts Today provides consumers with meaningful choice and control of employment, provides support services, uses peer counselors, reduces unemployment, and supports the recovery and resiliency of individuals with serious mental illness, including co-occurring disorders. The project will provide services to 450 people over five years.

4. In May 2019 the state Legislature eliminated the income and age limits from the Healthcare for Workers with Disabilities program. Funding was provided for additional clients expected to enroll in this program as a result of these eligibility changes.

Future Status: Describe planned strategies to increase early identification/ engagement in treatment, integration of behavioral health care in non-specialty settings, and availability of specialized programs for young people with SED/SMI.

The state believes the efforts described above meet the requirements of this milestone.

	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	*Current Status: Provide information on current strategies to increase earlier identification/ engagement in treatment, integration of behavioral care in non-specialty settings, and specialized programs for young people with SED/SMI.* Beginning July 2020, the state will require Managed Care Organization utilization management decision making to take into account the greater and particular needs of diverse populations, as reflected in health disparities, risk factors (such as adverse childhood experiences for enrollees of any age), historical trauma, and the need for culturally appropriate care. **Current Statewide Strategies:** 1. WISe Services – Wraparound intensive services 2. Jail services 3. Juvenile justice programs – healing courts 4. Telehealth 5. School settings 6. Primary care a. PHQ-9 screening tool promotion. 7. The state recently increased funding to develop a statewide plan to implement evidence-based specialty care programs that provide early identification and intervention for individuals experiencing psychosis. This includes funding to increase the number of teams providing these services from five to ten by October 1, 2020. 8. The Legislature recently funded five mental health peer respite centers to divert individuals from crisis services as well as a pilot program to provide mental health drop-in center services. 9. Consultation b. The state obtained funding to create and operate a tele-behavioral health video call center staffed by the University of Washington's Department of Psychiatry and Behavioral Sciences to serve emergency department providers, primary care providers, and county and municipal correctional facility providers

	with on demand tele-psychiatry and substance use disorder consultation. c. Other Consultation i. PALS kids psych ii. Other?
	Future Status: Describe planned strategies to increase early identification/ engagement in treatment, integration of behavioral health care in non-specialty settings, and availability of specialized programs for young people with SED/SMI. Community Health Aide program – Behavioral Health Aides. The state is collaborating with tribes to support behavioral health aides, who can expand capacity for tribal behavioral health services and enable more integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A

Prompts	Summary
4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	*Current Status: Provide information on current strategies to increase earlier identification/ engagement in treatment, integration of behavioral care in non-specialty settings, and specialized programs for young people with SED/SMI.* **Current Status:** Washington State has included crisis stabilization and crisis triage services in its array of services for many years. These interventions are part of a full continuum of care and are a key element in efforts to reduce unnecessary psychiatric inpatient stays. **Current Statewide Strategies:** 1. The Peer Bridgers program delivers services individuals in state and community hospitals prior to discharge and after their return to their communities. The Peer Bridger develops a relationship of trust with the participant. In developing this trust, the Peer Bridger may function as a role model, peer support, a mentor, a teacher, an advocate, and an ally as they communicate hope and encouragement. 2. State Plan Services: Washington's Medicaid State Plan includes a rehabilitation case management service allowing liaisons from the community to actively participate in discharge planning for individuals receiving psychiatric inpatient care. This is currently a state funded service for individuals in institute of mental disease facilities. 3. Crisis Triage and Stabilization Investments: Between 2017-18, the state funded several new triage and crisis stabilization facilities across the state. Three facilities are open and four expected to open in the coming year, for a total of 102 crisis stabilization and triage beds across six regions of the state. The 2019 state Legislature funded even more 16-bed triage and stabilization facilities. The Legislature also funded Mobile Outreach Crisis Teams. 4. The Legislature recently funded five mental health peer respite centers to divert individuals from crisis services as well as a pilot program to provide mental health drop-in center services. 5. Step Down Facilities: The Legislature appropriated funding for a new community facility type to address the need for additional discharge placements for individuals leaving the state psychiatric hospitals. Intensive behavioral health treatment facilities serve individuals who possess higher levels of behavioral challenges that existing

	alternative behavioral health facilities cannot accommodate. 6. The Housing and Recovery through Peer Services (HARPS) program builds on the successes of the Permanent Options for Recovery-Centered Housing (PORCH) project. PORCH provided consumers with meaningful choice and control of housing and support services, using peer housing specialists. The HARPS project reduces homelessness and supports the recovery and resiliency of individuals with serious mental illness. Each team consists of three full-time employees (a mental health professional and two certified peer counselors). One of the priority target populations for the HARPS program is individuals discharging from inpatient psychiatric care. The state Legislature recently funded four additional HARPS teams with a focus on individuals discharging from forensic facilities. 7. Program for Assertive Community Treatment (PACT) teams provide wrap around services for individuals in outpatient treatment. When the individual is in an inpatient facility, the PACT team coordinates care with the inpatient unit and works to ensure stable housing and follow-up care. Currently there are 14 PACT teams across the state. In May 2019 the Legislature provided funding for eight additional PACT teams statewide. 8. Washington State's Department of Commerce announced $7.1 million in grants to six health care providers across Washington, adding 71 additional beds to facilities that help people with a wide variety of behavioral health issues. Twenty-eight of the new beds are dedicated as an alternative to treatment in state psychiatric hospitals. These grants are part of the governor's five-year plan to modernize and transform the state's mental health care systems by shifting out of large institutions to smaller, community-based facilities. 9. Wraparound intensive services (WISe).
	Future Status: Describe planned strategies to increase early identification/ engagement in treatment, integration of behavioral health care in non-specialty settings, and availability of specialized programs for young people with SED/SMI. The state believes the efforts described above meet the requirements of this milestone. The state has been collaborating with tribes and Indian health care providers to develop a WISe provider curriculum that is culturally appropriate to serving American Indians and Alaska Native individuals and families. The state has also established a wraparound intensive services case rate for tribes and Indian health care providers.

	In addition, beginning July 2020, the state will require Managed Care Organization utilization management decision making to take into account the greater and particular needs of diverse populations, as reflected in health disparities, risk factors (such as adverse childhood experiences for enrollees of any age), historical trauma, and the need for culturally appropriate care.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A
4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	*Current Status:* New Journeys is a collaborative effort of HCA (The State Medicaid Agency and Mental Health Authority), the University of Washington, and Washington State University. New Journeys is a program focusing on first episode psychosis.
	Future Status: Describe planned strategies to increase early identification/ engagement in treatment, integration of behavioral health care in non-specialty settings, and availability of specialized programs for young people with SED/SMI Expand program as legislative funding allows.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. Monitor outcomes of New Journey.

Prompts	Summary
SMI/SED.Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.	
F.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	*Current Status*
	Future Status
	Summary of Actions Needed
F.b 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.	*Current Status*
	Future Status
	Summary of Actions Needed

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

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

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

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

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

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

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

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

Responses to these questions will help us:

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

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

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

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

Prompts	Summary

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

Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[2] and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	The state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory and 45 CFR 170 Subpart B and, based on that assessment, intends to include these standards as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts and in the design, development, and implementation of health IT tools. The state anticipates that (i) the assessment of the applicability of Interoperability Standards Advisory standards will be ongoing as these standards evolve and (ii) standards will be included in the state's Medicaid Managed Care contracts and in the design, development, and implementation of health IT tools as standards emerge and as gaps in our infrastructure are identified and can be addressed. For example, in our January 2020 Medicaid Managed Care Organization contract requirements: • Managed Care Organization contractors are required to (i) support provider use of health information technology/health information exchange tools and services including certified electronic health record Technology and (ii) develop policies and procedures for care coordination and care management services that encourage and support the use of health information technology and health information exchange technologies (e.g., certified electronic health records, existing statewide health information exchange and health information technology, and other technology solutions) to coordinate care across the care continuum including with entities that provide mental health, substance use disorder services, and oral health services. Managed Care Organization contractors are required to participate in a workgroup with HCA to explore the extent to which the health information technology infrastructure can be developed to support care coordination and continuity of care requirements. • As part of our 2020 Health IT Operational Plan we have included a task requiring: o HCA and Managed Care Organization staff participate in a workgroup to identify, prioritize, and explore methods to address gaps in an interoperable health information technology infrastructure to support these services, including electronic care plans and closed loop referrals. o We anticipate that this workgroup will include consideration of standards available via the Interoperability Standards Advisory.

	We anticipate that future Managed Care Organizations contract requirements will require the use ISA standards related to care plans and closed loop referral (as these standards emerge). • Managed Care Organization contractors are required to develop data exchange protocols (in accordance with applicable privacy laws, including HIPAA and 42 C.F.R. Part 2) including consent to release before initiating services with any subcontracted entity. Protocols must support integrated behavioral health-physical health coordination (including sharing of claims and pharmacy data, treatment plans or care plans, crisis plans) to coordinate service delivery, and care management for each enrollee. As reflected in our 2020 Health IT Operational Plan, HCA is supporting work as part of its Substance Use Disorder Institute of Mental Disease Waiver (leveraging funds available via the Partnership/SUPPORT Act) to specify requirements to enable the electronic exchange of information subject to 42 CFR Part 2 and will use available Health IT interoperability standards. Once these requirements are final and ready for widespread use, we anticipate that future Managed Care Organization contract language will incorporate the use of these requirements. • Managed Care Organization contractors are required to submit to HCA their "Population Health Management" Plans. Population Health Management Systems are defined in our Managed Care Organizations contract language as "health information technology and health information exchange technologies that are used at the point-of-care, and to support service delivery. Examples of health information technology tools include, but are not limited to, electronic health records, OneHealthPort clinical data repository, registries, analytics, decision support and reporting tools that support clinical decision-making and care management. The overarching goal of Population Health Management Systems is to expand interoperable health information technology and health information exchange infrastructure and tools so that relevant data (including clinical and claims data) can be captured, analyzed, and shared to support value-based purchasing models and care delivery redesign. We anticipate that future Managed Care Organization contract requirements related to Population Health Management activities will require the use of specific Interoperability Standards Advisory standards.

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

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

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

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

exchange of this content.
  - Opportunities for shared/sustaining investments.

- The HCA health information technology section will:
  - Lead this work in collaboration with other HCA components, Managed Care Organizations, Accountable Communities of Health, technology vendors, and behavioral health and physical health providers; and
  - Present the scope of work, progress reports, and recommendations to the (i) HCA Medicaid Steering Committee and (ii) Mental Health Institute of Mental Disease Waiver Workgroup.

- Contingent on the availability of funds, a contract for this scope of work will be awarded in July and work will be completed in December 2020.

- Contingent on the availability of funds, HCA will engage a contractor to specify requirements and design an open source FHIR-Based APIs for
  - E-consults;
  - Close-loop referral processes; and
  - Interoperable care plans, including the identification of care team members (including mental health providers).

- Contingent on the availability of funds, a contract for this scope of work will be awarded in January 2021 and work will be completed in June 2021.

- Contingent on the availability of funds, HCA will support pilots (including physicians and mental health providers) using the FHIR-Based APIs for:
  - E-consults; and
  - Close-loop referral processes: The pilot will include use of a FHIR-Based API to support electronic and closed loop referrals:
    - Between physicians/mental health providers.
    - From institution/hospital/clinic to physician/mental health provider.
    - From physician/mental health provider to community-based supports.
  - Care plans

	• Contingent on the availability of funds, a contract for this scope of work will be awarded in March 2021 and work will be complete in December 2021.

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

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

Prompts	Summary
1.2 Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* See Section 1.1.
	Future State: Describe the future state of the health IT functionalities outlined below: See Section 1.1.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: See Section 1.1.
1.3 Closed loop referrals and e-referrals from physician/mental health provider to community based supports	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* See Section 1.1.
	Future State: Describe the future state of the health IT functionalities outlined below: See Section 1.1.

	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: See Section 1.1.
Electronic Care Plans and Medical Records (Section 2)	
2.1 The state and its providers can create and use an electronic care plan	Current State: Describe the current state of the health IT functionalities outlined below: Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal. **Behavioral Health Provider Survey:** As described in Assurance Statement #1 above, responses by behavioral health agencies (including those providing mental health services) to the 2019 Behavioral Health Provider survey raise questions about the relative extent of electronic health records/certified electronic health records adoption among these agencies and their use of electronic health records/certified electronic health records to support the behavioral health agencies' clinical operations and wider role in a healthcare ecosystem. As a result, the 2020 HCA Behavioral Health Provider survey will drill down on specific uses of the electronic health records by the behavioral health (including mental health) providers and gather information about specific functionality, use and exchange, including the use of electronic health records to create and use electronic interoperable care plans accessible by all relevant members of the care team, including mental health providers. Responses to these questions will help us: • Target needed enhancements to electronic health records functionality required by the Mental Health Institute of Mental Disease Waiver; and • Identify and make available supports for the use this functionality by behavioral health agencies that provide mental health services. **The HCA 2020 Health IT Operational Plan includes the following requirements (contingent on the availability of funds):**

	Task 2-06: Requires that the HCA health information technology section, in collaboration with other HCA staff, will gather information on use of electronic/interoperable care plans by behavioral health (including mental health), providers; collaborate and coordinate with Managed Care Organizations via a workgroup to develop a shared care plan template; and coordinate with Department of Corrections and jails to consider the need for and use of care plans between health care providers in jails/prisons and community-based health providers. Task 2-07: HCA/DBHR staff, in collaboration with other HCA staff, will: • Identify best practice standards for transition planning from inpatient and residential care prior to discharge. • Consider strategies to incentivize discharge outcomes that ensure housing stability. • Advance recommendations to implement best practices for successful discharge planning. HCA Policy staff will explore opportunities to support information exchange on behalf of incarcerated persons 30 days prior to release. Health information technology section staff, in coordination with HCA Policy, DBHR, and data governance staff, will explore opportunities and approaches to support creation, exchange, and access of CCDs/other health records including: • From youth-oriented systems of care to and from adult systems of care; and • On behalf of incarcerated persons, including: o Providing technical assistance to these providers regarding: ▪ The creation, exchange and access to CCDs via clinical data repository. ▪ View/download of the Problems, Medication, and Interventions (PAMI) report from the clinical data repository. o Access to clinical data repository/ Problems, Medication, and Interventions by health providers upon incarceration. HCA/DBHR staff, in coordination with other HCA staff, will work to align the requirements in Task 2-07 in the Health IT Operational Plan with Managed Care Organization requirements, including in Sec. 14 of the Managed Care Organization Integrated Managed Care contract. **Managed Care Organization Requirements:** Task 2-07 in the Health IT Operational Plan cross references several requirements in Sec. 14 of the Managed Care

	Organization Integrated Managed Care contract, including requirements that the MCO: • Develop in collaboration agencies and systems transition plans to that identify enrollees' goals, objectives, and strategies to achieve goals as these individuals transition between systems of care; • Complete the Uniform Discharge Tool reporting template for every individual discharging from a mental health inpatient setting hospital stay. • Coordinate with the behavioral health treatment agencies to ensure there is adequate coordination for enrollees transitioning between various levels of treatment services to ensure continuity of care (i.e., an enrollee receives timely and applicable follow-up services from ancillary referral agencies). This includes ensuring that discharge plans and facilitation to post-discharge services are documented in the enrollee's electronic health record. Task 2-09: Requires the HCA health information technology section to: • Contract to gather information on additional data sources including use/barriers/options to encourage use of electronic/interoperable care plans and electronic assessment/screening/ intake tools (among other requirements). • Coordinate with Office of the National Coordinator for Health IT and CMS and other states to standardize selected intake assessment and screening tools. • Link standardized care plans and electronic assessment/screening/intake tools with health information technology standards. • Create FHIR enabled interoperable tools for the exchange of care plans and electronic assessment/screening/intake tools. • Pilot use of the FHIR-enabled interoperable care plans and electronic assessment/screening/intake tools. Task 8-01: HCA staff will, based on a review of Accountable Communities of Health submitted documents, consult with Accountable Communities of Health to better understand some of the shared needs identified across several Accountable Communities of Health (e.g., shared care plans, population health management, closed loop referral); and identify activities and funding sources that could be leveraged to support sustainable shared health information technology/health information exchange needs and technical support for providers across Accountable Communities of Health.

	Task 8-02: Q1- Q4: HCA staff, in consultation with representatives from Accountable Communities of Health and their partnering providers (e.g., acute care, primary care, behavioral health, federal qualified health centers, jails) and other stakeholders will produce written descriptions of: • Best practices across communities to provide health information technology-enabled integrated person-level care; and • Opportunities for shared/sustaining investments. The paper will include descriptions of practices and opportunities to provide health information technology-enabled integrated person-level care including the use of e-consults and close-loop referral processes, shared care plans, and population health. Task 8-04: Q1-Q2: HCA health information technology section staff, in collaboration with Policy and DBHR staff, will engage Managed Care Organizations in a workgroup to: • Identify how plans define: service coordination, care coordination services, care management, and complex care management services; and • Identify, prioritize, and methods to address gaps in an interoperable health information technology infrastructure to support these services, including electronic care plans and closed loop referrals. HCA staff will summarize for the Medicaid Transformation Priorities Steering Committee gaps identified by the Workgroup and suggested methods for addressing these gaps. Task 8-05: references Medicaid managed care management and care coordination services. This section of the Health IT Operational Plan references the: **MCO Requirements:** Managed Care Organizations contract requirements that became effective 1/1/2020 require that Managed Care Organizations: • Support, to the maximum extent possible, the development and implementation of, and updates to interoperable electronic care plans;

	• Ensure that such care plans are transmitted to the clinical data repository when developed and updated; and • Participate in a workgroup with HCA to assess the utilization of interoperable care plans and barriers to using electronic care plans. Task 12-07: Requires that HCA, in collaboration with Accountable Communities of Health and providers, identify existing health information technology standards and interoperable care management tools that could be deployed in conjunction with the health information exchange and clinical data repository (e.g., consider: shared care planning, post-discharge care management for patients recently discharged from inpatient mental health facilities). Task 12-08: Requires HCA to develop a Discharge Summary API (for use by providers with limited technology adoption) and guidance that conforms with the Discharge Summary C-CDA specifications adopted for the 2015 version of certified electronic health records.
	Future State: Describe the future state of the health IT functionalities outlined below: Contingent on the availability of funds, mental health providers in Washington State will pilot use Health IT functionalities to support the: • Creation and use of electronic interoperable care plan accessible by all relevant members of the care team, including mental health providers including via the clinical data repository; • Creation, exchange, and access of clinical data repository's/other health records via the clinical data repository. • Creation and exchange interoperable discharge tools
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: HCA will conduct a survey in 2020 of behavioral health providers adoption and use of certified electronic health records technologies including the use of this technology to support electronic referrals to and from physicians and mental health providers. • The HCA/DBHR is leading the survey of behavioral health providers. • Preliminary survey results will be published by July 2020.

- Contingent on the availability of funds, using the contractor to be identified for work referenced in Sec. 1 (Closed Loop Referrals and e-Referrals), HCA will engage this contractor to support Tasks 2-06 (in addition to Tasks 8-01 and 8-02; and Tasks 8-04) to incorporate into written document a description of:

    - Current practices and opportunities to support and advance the use of health information technology-enabled integrated person-level care including the use of e-consults and close-loop referral processes, interoperable care plans, and population health.
        - The description will include information on the opportunities and barriers to exchange interoperable care plans and other documents on behalf of incarcerated persons and persons being released from incarceration, including the exchange of information 30 days prior to release from incarceration.
    - The availability of standards in the Interoperability Standards Advisory to support interoperable exchange of this content.
    - Opportunities for shared/sustaining investment.

Per Section 1 (Closed Loop Referrals and e-Referrals), and contingent on the availability of funds, the contract for this scope of work will be awarded in July and work will be complete in December 2020.

- Contingent on the availability of funds, HCA will engage a contractor to map the work flow of mental health providers related to:

    - Completion of intake, screening, and assessment tools;
    - Development of care plans;
    - Referrals for ancillary services; and
    - Discharge/transition planning.

- The workflow will highlight opportunities and barriers to the use of health IT to support interoperable exchange and re-use of this information within and across care providers.

- The HCA health information technology section, Policy, and DBHR staff will co-lead this work:

    - In collaboration with other HCA components, Managed Care Organization, Accountable Communities of Health, technology vendors, and behavioral health and physical health providers; and

- Present the scope of work, progress reports, and recommendations to the (i) HCA Medicaid Steering Committee and (ii) Mental Health Institute of Mental Disease Waiver Workgroup.

Contingent on the availability of funds, a contract for this scope of work will be awarded in July and work will be complete in December 2020.

- Contingent on the availability of funds and the ability to leverage the expertise of Oregon Health Sciences University and activities underway via the Sec. 1003 Roadmap to Recovery grant, HCA will:

  - Engage the Oregon Health Sciences University to identify best/promising practices to support transition planning prior to discharge on behalf of individuals transitioning from inpatient and residential care;
  - Identify and advance recommendations to implement best practices for successful discharge planning as part of the Roadmap to Recovery produced under the Sec. 1003 grant.

  HCA, Clinical Quality and Care Transformation, in collaboration with DBHR staff, will lead this work. If needed, a contract for this scope of work will be awarded no later than September 2020 and will be complete by March 2021.

- Contingent on the availability of funds, HCA will engage a contractor to specify requirements for and design open source FHIR-Based APIs that could be piloted using certified electronic health records for the exchange:

  - Interoperable care plans, including the identification of care team members (including mental health providers); and
  - Interoperable discharge summaries.

  Requirements will include the transmission and receipt of care plans and discharge summary documents to the clinical data repository, between providers using certified electronic health records (including members of the care team), and by providers to Managed Care Organizations.

  The health information technology section will lead this work.

  Contingent on the availability of funds a contract for this scope of work will be awarded in January 2021 and

	work will be complete in December 2021.
	
	• Contingent on the availability of funds, HCA will support pilots using the FHIR-Based APIs to support the creation and electronic exchange of:
	  o Care plans
	  o Discharge summaries
	
	• The pilot will include mental health providers:
	
	  o Sending electronic interoperable care plans and discharge summaries to other providers, the clinical data repository, and Managed Care Organizations.
	  o Receiving interoperable care plans and discharge summaries from other providers.
	  o Sending interoperable care plans and discharge summaries to the clinical data repository.
	  o Viewing interoperable care plans and discharge summaries created by other providers in the clinical data repository.
	
	The health information technology section will lead this work.
	
	Contingent on the availability of funds a contract for this scope of work will be awarded in January 2021 and work will be complete in December 2021.

Prompts	Summary
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	*Current State: Describe the current state of the health IT functionalities outlined below:* See description above in Sec. 2.1.
	Future State: Describe the future state of the health IT functionalities outlined below: See description above in Sec. 2.1.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: See description above in Sec. 2.1.
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State: Describe the current state of the health IT functionalities outlined below:* See description above in Sec. 2.1.
	Future State: Describe the future state of the health IT functionalities outlined below: See description above in Sec. 2.1.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: See description above in Sec. 2.1.

2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State: Describe the current state of the health IT functionalities outlined below:* See description above in Sec. 2.1.
	Future State: Describe the future state of the health IT functionalities outlined below: See description above in Sec. 2.1.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: See description above in Sec. 2.1.

Prompts	Summary
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* See description above in Sec. 2.1.
	Future State: Describe the future state of the health IT functionalities outlined below: See description above in Sec. 2.1.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: See description above in Sec. 2.1.
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* Beginning in 2018: • HCA sponsored an environmental scan to identify states and communities that had deployed electronic consent management solutions intended to support the exchange of information subject to 42 CFR Part 2; and • Whether these solutions incorporated the use of health IT standards to support the exchange of this sensitive information.

- HCA led a public-private substance use disorder workgroup that assisted in the development and publication of "Sharing Substance Use Disorder Information: A Guide for Washington State". The guide helps clarify the applicable federal regulations and law (e.g., HIPAA and 42 CFR Part 2) and includes additional provider and patient resources, such as a sample paper consent form.

- In addition, HCA started work to specify the requirements that an electronic consent management solution would need to support to comply with 42 CFR Part 2 requirements.

The HCA 2020 Health IT Operational Plan includes the following requirements:
Task 2.08: HCA health information technology section is required to:

- Enter into contracts to support:

  - Development of technical assistance materials for substance use disorder and mental health providers re: privacy requirements (related to 42 CFR Part 2).
  - Substance use disorder provider workflow related to consent.
  - Vendor procurement and system development for consent management solution.
  - Pilot an electronic consent management solution.
  - Seek continued funding to expand consent management past pilot.

Task 3-09: Beginning in Q3 - Q4, the HCA health information technology section is required to: develop and pilot an electronic consent management solution that can be used to support the exchange of information subject to 42 CFR Part 2 and allow for the appropriate re-disclosure of this information.

Task 14-01: Requires that HCA continue conversations with Tribal partners and the American Indian Health Commission on the value of health information exchange including how the technical solution to be deployed for consent management could be extended to protect tribal members health information in the clinical data repository.

In 2020, leveraging federal funds available through the Partnership/SUPPORT Act, HCA contracted for work that includes:

- Development and implementation of technical assistance materials for providers regarding requirements related

	to the consent and sharing of information subject to 42 CFR Part 2: • Completion of the requirement specifications for an electronic consent management solution that supports information exchange in compliance with 42 CFR Part 2; and • Solicitation of a request for proposal for an electronic consent management solution.
	Future State: Describe the future state of the health IT functionalities outlined below: Contingent on the availability of funds, mental health providers in Washington State who treat individuals with substance use disorders and are subject to the requirements of 42 CFR Part2 will pilot the: • Exchange protected information in compliance with 42 CFR Part 2; and • Use an electronic consent management tool that supports the exchange protected information in compliance with 42 CFR Part 2.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: Contingent on the availability of funds, HCA will: • Develop/acquire an electronic consent management solution that support the exchange of protected information in compliance with 42 CFR Part 2; and • Pilot the use of an electronic consent management solution, including by mental health providers who treat persons with substance use disorders and are subject to 42 CFR Part 2 requirements.
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* **Behavioral Health Provider Survey:** As described in Assurance Statement #1 above, responses by behavioral health agencies (including those providing mental heatlh services) to the 2019 Behavioral Health Provider survey raise questions about the relative extent of

	electronic health records/certified electronic health records adoption among these agencies and their use of electronic health records/certified electronic health records to support the behavioral health agencies' clinical operations and wider role in a healthcare ecosystem. As a result, the 2020 HCA Behavioral Health Provider survey will drill down on specific uses of the electronic health records by the behavioral health (including mental health) providers and gather information about specific functionality, use and exchange, including the use of electronic health records to record intake, assessment, and screening information including whether that information is interoperable with other health information technology systems. Responses to these questions will help us: • Target needed enhancements to electronic health records functionality required by the Mental Health Institute of Mental Disease Waiver; and • Identify and make available supports for the use this functionality by behavioral health agencies that provide mental health services. **The HCA 2020 Health IT Operational Plan includes the following requirements (contingent on the availability of funds):** Task 2-09: Requires the HIT Section: • Contract to gather information on additional data sources including use/barriers/options to encourage use of electronic/interoperable care plans and electronic assessment/screening/intake tools (among other requirements). • Coordinate with Office of the National Coordinator for Health IT, CMS and other states to standardize selected intake, assessment and screening tools. • Link standardized care plans and electronic assessment/screening/intake tools with health information technology standards. • Create FHIR enabled interoperable tools for the exchange of care plans and electronic assessment/screening/intake tools. • Pilot use of the FHIR-enabled interoperable care plans and electronic assessment/screening/intake tools. Task 12-05: Requires the HCA health information technology section to design and develop four use cases for providers/entities with limited health information technology/electronic health records technology to • Create and; • Transmit and/or;

	• Download information to/from the clinical data repository. Initial use case may focus on health action plans. If additional funds become available, use cases could focus on discharge plans/assessment, screening and intake tools. **Managed Care Organization Requirements:** The January 2020 Managed Care Organization requirements include several requirements related intake, screening, and assessment applicable to behavioral health providers including (but not limited to) the following sections of the Integrated Managed Care Plan: • Sec. 9.5 Health Care Provider Subcontracts; • Sec. 9.7 Administrative Functions with Subcontractors and Subsidiaries (changed in Sec. 9.8 effective July 1, 2020); • Sec. 9.11 Provider Education (changed in Sec. 9.12 effective July 1, 2020); • Sec. 9.16 Behavioral Health Administrative Service Organization (BH-ASO) (changed to 917 effective July 1, 2020); • Sec. 14.3 Population Health Management: Identification and Triage; • Sec. 14.5 Bi-Directional Behavioral and Physical Health Integration; • Sec. 14.6 Care Coordination Services (CCS); • Sec. 14.13 Children's Long-Term Care Inpatient Program; • Sec. 17.1 Contract Services.
	Future State: Describe the future state of the health IT functionalities outlined below: Contingent on the availability of funds, mental health providers in Washington State will pilot use of health IT functionalities to record interoperable intake, assessment, and screening information.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: HCA will conduct a survey in 2020 of behavioral health providers adoption and use of c certified electronic health records technologies including the use of this technology to support electronic and interoperable intake, assessment and screening tools.

- HCA/DBHR is leading the survey of behavioral health providers.
- Preliminary survey results will be published by July 2020.
- Contingent on the availability of funds, HCA will engage a contractor to support work required in the Health IT Operational Plan Tasks 2-06 and 12.05. Specifically, this contractor will:
    - Gather information (from mental health providers, Managed Care Organizations, and technology vendors) and produce a written description of:
        - Assessment, screening, and intake tools that are commonly used by mental health providers and/or required (e.g., by Managed Care Organizations) in Washington State; and
        - Whether any of these tools are electronic, included in electronic health records, and interoperable with other Health IT systems (i.e., incorporate standards from the Interoperability Standards Advisory).
    - If needed, and in consultation with HCA, create a framework for prioritizing which intake, assessment and screening tools should be made electronic and linked with health IT standards (including FHIR). For example, the framework would take into account intake, assessment and screening tools:
        - Used for different populations and conditions (including for patients experiencing their first episode of psychosis);
        - That are required to be used in Washington State;
        - That are freely available for use (e.g., open source);
        - That are electronic;
        - That have been (at least partially) linked to health IT standards;
        - That other states that have received a Mental Health Institute of Mental Disease Waiver are seeking to advance.

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

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

Prompts	Summary
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* The 2020 Health IT Operational Plan includes the following task: Task 2.10: The State will complete the following: • HCA, Policy and the health information technology section will explore: o Medicaid Managed Care coverage and payment policies regarding telehealth. o Activities being undertaken by the University of Washington related to telehealth to identify whether there are gaps that need to be filled and options for addressing these gaps. HCA Clinical Quality and Care Transformation Clinical Policy staff will leverage and analyze information emerging via the following workgroups to help inform telehealth coverage policies to support access to high quality services: • National Academy for State Health Policy (NASHP) convened a Telehealth Affinity Group of policymakers and stakeholders to learn about the Patient Centered Outcomes Research Institute (PCORI)'s emerging telehealth research and explore associated policy challenges and solutions. • MED Telehealth workgroup (a forum for state agencies) to discuss telehealth issues facing Medicaid programs including coverage policies, utilization, expenditures, patient privacy and security, and patient outcomes. The workgroup also explores best practices and evidence related to telehealth and monitors emerging telehealth advancements that may be relevant to Medicaid agencies. • Identify, disseminate, and promote information on telehealth, including grant opportunities HCA Clinical Quality and Care Transformation is recruiting a Behavioral Health Telehealth Program Manager who will be responsible for: • Drafting policy guidance about the telehealth technology landscape with a focus on the needs of the behavioral

	healthcare system. • Reviewing best practice models of telehealth services related to behavioral health care within and outside of Washington State to evaluate effective methods of telehealth clinical consultation and evaluation. • Consulting with representatives from state agencies, payers, provider and other service organizations to identify opportunities and barriers to use, coverage, and payment of telehealth services on behalf of children and adults with behavioral health needs. • Exploring Medicaid managed care coverage and payment policies regarding telehealth. • Participating in the National Academy of State Health Policy and other similar telehealth workgroups. • Identifying, defining, and developing possible funding sources to support existing and planned telehealth initiatives. • Providing a road map for future planning for telehealth implementation within substance use disorder treatment and behavioral healthcare settings.
	Future State: Describe the future state of the health IT functionalities outlined below: By July 2021, HCA will: • Provide policy guidance about the use tele-behavioral health technology in Washington State. • Include in Managed Care Organization contract language examples of when tele-behavioral technologies could be used to support the integration of physical and mental health services.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: Beginning in April 2020, the HCA Clinical Quality and Care Transformation Behavioral Health Telehealth Program Manager will lead, in collaboration with other HCA Sections (e.g., health information technology, Medicaid Program Operations and Integrity), the development of a tele-behavioral health landscape assessment. By December 2020, the HCA Clinical Quality and Care Transformation will draft policy guidance about the tele-behavioral health technology in Washington State. By April 2021, HCA will publicly disseminate policy guidance about the tele-behavioral health technology in Washington State. By January 2021, the HCA Clinical Quality and Care Transformation will submit draft Managed Care Organization

	contract language that includes examples of when tele-behavioral technologies could be used to support the integration of physical and mental health services. This language will be integrated into Managed Care Organization contract requirements effective July 1, 2021.
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment[5])	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* **Managed Care Organization Contract Provisions:** Include the several requirements related to supporting the continuity of care including as individuals transition between care settings, ensuring the delivery of needed services and referrals, addressing the needs for persons at risk of re-hospitalization, and provider responsibilities if the individual discontinues treatment. Some of these requirements are listed below: 14 Care Coordination 14.1 Continuity of Care The Contractor shall ensure Continuity of Care for Enrollees in an active course of treatment for a chronic or acute physical or behavioral health condition… The Contractor shall ensure medically necessary care for Enrollees is not interrupted and transitions from one setting or level of care to another are supported with a continuity of care period that is no less than ninety (90) days for all new Enrollees. 14.1.8 The Contractor shall provide for the smooth transition of care for Enrollees who lose Medicaid eligibility while hospitalized in behavioral health inpatient or residential treatment facilities or while incarcerated or in homeless shelters. The Contractor shall include protocols for coordination with the BH-ASO to facilitate referral for state funded or federal block grant services, when such funds are available, in order to maintain Continuity of Care. 14.6 Care Coordination Services (including): 14.6.6 The Care Coordinator is responsible for: 14.6.6.1 Conducting IHS [Initial Health Screen] or collecting IHS data from providers, to assess Enrollees for unmet health care or social service needs;

	14.6.6.2 Communicating utilization patterns to providers and ensuring action by the provider on under or over-utilization patterns requiring action; 14.6.6.3 Ensuring clinical and social service referrals are made to meet identified Enrollee health and community service needs; 14.6.6.4 Ensuring referrals are made and services are delivered, including any follow-up action; 14.6.6.6 Ensuring collaboration with the regional Behavioral Health Administrative Services Organization (BH-ASO), including developing processes to ensure an Enrollee is followed up with within seven (7) calendar days of when the Enrollee has received crisis services. Section. 14.17:Transitional Services 14.17.1 The Contractor shall ensure transitional services described in this Section are provided to all Enrollees who are transferring from one care setting to another or one level of care to another. 14.17.3.1 Development of an individual Enrollee plan to mitigate the risk for re-institutionalization, re-hospitalization or treatment recidivism to include: 14.17.3.1.1 Information that supports discharge care needs, Medication Management, interventions to ensure follow-up appointments are attended, and follow-up for self-management of the Enrollee's chronic or acute conditions, including information on when to seek medical care and emergency care. Formal or informal caregivers shall be included in this process when requested by the Enrollee; 14.17.3.1.2 A written discharge plan, including scheduled follow-up appointments, provided to the Enrollee and all treating providers; 14.17.3.1.3 Systematic follow-up protocol to ensure timely access to follow-up care post discharge and to identify and re-engage Enrollees who do not receive post discharge care; 14.17.3.1.4 Organized post-discharge services, such as home care services, after-treatment services, and occupational and physical therapy services; 14.17.3.1.5 Telephonic reinforcement of the discharge plan and problem-solving two (2) to three (3) business days following Enrollee discharge; 14.17.3.1.6 Information on what to do if a problem arises following discharge; 14.17.3.1.7 For Enrollees at high risk of re-hospitalization, a visit by the PCP or Care Coordinator at the Facility before discharge to coordinate transition; 14.17.3.1.8 For Enrollees at high risk of re-hospitalization, the Contractor shall ensure the Enrollee has an in-person assessment by the Enrollee's PCP or Care Coordinator for post-discharge support within seven (7) calendar days of hospital discharge. The assessment must include follow-up of: discharge instructions, assessment of environmental safety issues, medication reconciliation, an assessment of support network adequacy and services, and linkage of the Enrollee to appropriate referrals;

	14.17.3.1.9 Scheduled outpatient Behavioral Health and/or primary care visits within seven (7) calendar days of discharge and/or physical or mental health home health care services delivered within seven (7) calendar days of discharge; 14.17.3.1.10 Follow-up to ensure the Enrollee saw his/her provider; and 14.17.3.1.11 Planning that actively includes the patient and family caregivers and support network in assessing needs. 14.17.5.3 If the Enrollee discontinues services, the Subcontractor will document as such and attempt to facilitate transition back into the community. 14.17.5.4 If a behavioral health treatment agency discontinues treatment of an Enrollee, the agency must meet all discharge requirements noted in subsections 14.17.5.2 and 14.17.5 above. In addition, MCO contract provisions include the several requirements related to the development and use of Population Health Management Plans and Interventions. 14.2 Population Health Management: Plan The Contractor shall develop a plan to address Enrollee needs across the continuum of care, and ensure services are coordinated for all Enrollees. The plan shall be reviewed by HCA during the annual monitoring review. The Population Health Management plan shall include at a minimum the following focus areas: 14.2.1 Keeping Enrollees healthy; 14.2.2 Managing Enrollees with emerging risk; 14.2.3 Enrollee safety and outcomes across settings; 14.2.4 Managing multiple chronic conditions; and 14.2.5 Managing individuals with multiple service providers (e.g., physical health and behavioral health). The Contractor's Population Health Management plan shall establish methods to identify targeted populations for each focus area and include interventions that meet the requirements of NCQA and the subsections below. The Contractor's Population Health Management plan shall take into account available and needed: (i) data and analytic infrastructure, (ii) HIT and HIE infrastructure and tool, and (iii) other resources needed to support population health management activities. 14.3 Population Health Management: Identification and Triage 14.3.6 The Contractor will risk stratify the population to determine the level of intervention enrollees require.

	14.4 Population Health Management: Interventions 14.4.1 The Contractor shall work with providers to achieve population health management goals, and shall provide PCPs with clinical information about their patients to improve their care. 14.4.1.1The Contractor shall make clinical decision support tools available to providers for use at the point of care that follow evidence-based guidelines for: 14.4.1.1.1 Behavioral health conditions. 14.4.1.1.2 Chronic medical conditions. 14.4.1.1.3 Acute conditions. 14.4.1.1.4 Unhealthy behaviors. 14.4.1.1.5 Wellness. 14.4.1.1.6 Overuse/appropriateness issues.
	Future State: Describe the future state of the health IT functionalities outlined below: *MCO contract language will be refined to enhance the identification of and interventions for persons at risk of discontinuing treatment.* Contingent on the availability of funds, a closed loop referral tool will be available for piloting by mental health providers. (See Section #1.)
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: HCA/DBHR staff will lead a workgroup to identify methods to reduce the risk of patients discontinuing/stopping treatment. The workgroup will include HCA staff (i.e., staff from HCA Clinical Quality and Care Transformation (including clinical; analytics research and measurement; and health information technology, and Medicaid Program Operations and Integrity staff). The workgroup will: • Take into account the written documents and closed loop referral tool developed under Section 1 (Closed Loop Referrals and e-Referrals). • Consider whether and if so, how Managed Care Organization Population Health Management Plans, identification, and interventions could be enhanced to identify and intervene on behalf of individuals at risk discontinuing/stopping treatment. • Consider other needed enhancements to Managed Care Organization contract language to better identify patients

	at risk for discontinuing or stopping treatment, and intervene on behalf of these individuals (including notifying their care teams to ensure continuation or resumption of treatment). The workgroup will convene beginning in September 2020, develop a charter describing the scope and focus of its activities, and develop recommendations to enhance the identification of and interventions for persons at risk of discontinuing treatment. The workgroup will present its charter, progress reports, and recommendations to the: • HCA/DBHR leadership; • HCA Medicaid Steering Committee; and; • Mental Health Institute of Mental Disease Waiver Workgroup. Enhancements to Managed Care Organizations contract language will be advanced in January and September 2021.

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

Prompts	Summary
6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* **Evidence-based Specialty Care Programs: Early Identification and Intervention for Individuals Experiencing Psychosis:** The state recently increased funding to develop a statewide plan to implement evidence-based specialty care programs that provide early identification and intervention for individuals experiencing psychosis. This includes funding to increase the number of teams providing these services from five to ten by October 1, 2020. **New Journeys:** New Journeys is a collaborative effort of HCA (The State Medicaid Agency and Mental Health Authority), the University of Washington, and Washington State University. New Journeys is a program focusing on first episode psychosis. **The 2020 Health IT Operational Plan requires that the State complete the following:** • The health information technology section, Policy, and Medicaid Program Operations and Integrity will collaborate to identify health IT/health information exchange tools that could support care coordination workflow of HCA, payers, and providers and options for developing needed tools; and • The health information technology section and DBHR will identify the providers involved in caring for persons experiencing their first episode of psychosis, the workflow involved, and the technical tools needed to support care coordination on behalf of these individuals.
	Future State: Describe the future state of the health IT functionalities outlined below: Contingent on the availability of funds, mental health providers providing services to persons experiencing their first episode of psychosis will pilot health IT tools that support: • Interoperable intake, screenings, and assessments; • Electronic and interoperable care plans; and • E-closed loop referrals.

	See Sections 1, 2, and 4 above.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: *See Sections 1, 2, and 4 above.* HCA staff (DBHR, health information technology section, Policy, and Medicaid Program Operations and Integrity) and staff from the University of Washington and Washington State University will collaborate to identify any additional health IT/health information exchange tools that could support caring for and care coordination on behalf of persons experiencing their first episode of psychosis. DBHR staff will take the lead in initiating these conversations, no later than September 2020. If additional health IT tools are identified as needed, in January 2021, HCA/DBHR will present recommendations to: • DBHR leadership; • HCA Medicaid Steering Committee; and • Mental Health Institute of Mental Disease Waiver Workgroup.
Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* Currently, the state is in the planning phase to create a multi-agency master person index that will facilitate identity management across multiple agencies and programs. The state's health and human service agencies (Department of Health, Department of Social and Health Services, Health Care Authority, Department of Children, Youth and Families and the Health Benefit Exchange) are partnering to pursue this effort. We are currently in the planning phase and are working to develop a proof of concept and a roadmap for implementation

	Future State: Describe the future state of the health IT functionalities outlined below: Contingent on funding, technical solutions to match a child's electronic medical records to a parent's electronic medical records, the use of an agency master person index, and implementation of needed data governance policies; the state envisions a future where a child's and parent's electronic medical records could be linked to provide safe and efficient care.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: The following high-level deliverables will be needed to achieve the stated goal of tag or linking a child's medical records with their respective parent/caretaker's medical record: • Issue a request for proposal for master person index expert consultants to develop a roadmap. • Develop implementation roadmap. • Identify funding sources for implementation. • Establish system and data governance processes. • If necessary, procure tools to implement the identified solution. • Implement the identified solution per the guidance of the master person index roadmap. • Connect electronic health record or other health information technology to the master person index via FHIR transactions.
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* The state continues to support and expand the use of and content in the statewide clinical data repository. The state is exploring the feasibility of a statewide electronic health record/rural HER particularly for providers that do not have/use certified electronic health records (e.g., behavioral health providers). As described above, contingent on funding, the state is supporting enhancements to its Health IT information

	infrastructure that will support the capture of additional clinical information and work to develop and use a master person index.
	Future State: Describe the future state of the health IT functionalities outlined below: Contingent on funding, the state envisions a future where information across all episodes of care is linked to the correct patient and available when and where needed to support and improve service delivery at the point of care.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: See actions needed described above.

Section 3: Relevant documents

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

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

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