Washington State Medicaid Transformation Project (MTP) demonstration
Section 1115 Waiver Annual Report (DY4)/Quarterly Report (DY4 Q2)
Demonstration Year: 4 (January 1 to December 31, 2020)
Reporting Quarter: 2 (April 1 to June 30, 2020)

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Introduction

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

Over the five-year MTP period, Washington State will:

- Integrate physical and behavioral health purchasing and services to provide whole-person care. Whole-person care means care for the mind, body, and substance use disorder.
- Convert 90 percent of Medicaid provider payments to reward outcomes instead of volume of service.
- Support providers as they adopt new payment and care models.
- Improve health equity by implementing population health strategies.
- Provide targeted services to support the state's aging populations and their family caregivers, and address social determinants of health.
- Help our most vulnerable population get and keep stable housing and employment. Improve substance use disorder (SUD) treatment access and outcomes.

The state will accomplish these goals through these programs:

- Transformation through Accountable Communities of Health (ACHs) and Delivery System Reform Incentive Payment (DSRIP) program.
- Long-Term Services and Supports (LTSS): Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA).
- Foundational Community Supports (FCS): Community Support Services (CSS) and Supported Employment – Individual Placement and Support (IPS).
- SUD Program – treatment services, including short-term services provided in residential and inpatient treatment settings that qualify as an institution of mental disease (IMD).

Vision: a healthier Washington

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

Quarterly report: April 1–June 30, 2020

This quarterly report summarizes MTP activities from the second quarter of 2020: April 1 through June 30. It details MTP implementation, including stakeholder education and engagement, planning and implementation, and development of policies and procedures.

Summary of quarter accomplishments

- All initiatives successfully navigated COVID-19 disruptions while still providing quality service to clients and communities. A large amount of work was performed by staff, ACHs, and providers to streamline/virtualize services and ensure that COVID-19 disruptions had the least impact possible, and that resources focused on the most vulnerable.
- Within Initiative 1, value-based purchasing pay-for-reporting (P4R) and pay-for-performance (P4P) incentive funds were distributed in quarter (Q) 2 2020 based on 2018 P4P and 2019 P4R. All adoption targets were met by managed care organizations (MCOs) statewide and ACHs (regional).
- Initiative 2 served a total of 7,595 clients as of June 26, 2020.
- Within FCS (Initiative 3), the total aggregate number of people enrolled in services at the end of demonstration year (DY) 4 Q2 included 3,753 in IPS and 4,575 in CSS.
- HCA staff working on Initiative 4 continued to support the provider community, including weekly calls to disseminate information and provide technical assistance to providers undergoing the stressors of the pandemic.

MTP-wide stakeholder engagement

During this reporting period, HCA developed a communications plan and numerous communications about the Paying for Value surveys effort, which launches July 1, in Q3. HCA will send these surveys to both providers and plans (payers) to track progress toward the statewide goal of paying for value-based care, rather than volume of care.

At the beginning of this reporting period, HCA developed a one-page summary about our 1115 waiver amendment submittal to CMS. The one-pager summarized the purpose of HCA's request and outlined the key elements of the waiver amendment.

Statewide activities and accountability

Value-based purchasing (VBP)

VBP Roadmap

In Q2, HCA continued efforts to refine the VBP Roadmap and incorporate a long-term strategic vision. The VBP Roadmap describes HCA's VBP goals, purchasing and delivery system transformation strategies, innovation successes to date, and plans to accelerate the transition to value-based payment models. The roadmap establishes targets for VBP attainment and related DSRIP incentives for MCOs and ACHs.

Validation of financial performance measures

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

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

In collaboration with HCA, the IA released the VBP validation packets, including data entry templates and provider contract samplings for each MCO in June of 2020.

Statewide progress toward VBP targets

According to 2018 MCO financial performance measure data, MCOs and ACH regions are currently ahead of the annual, state-financed VBP targets. In addition to the reported financial data, HCA issued two annual Paying for Value surveys to:

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

HCA requires each MCO to respond to the annual survey to provide information and data on their non-Medicaid books of business in Washington State. HCA updated the survey template and plans to release the survey on July 1, 2020. Additionally, HCA developed and plans to release the provider survey through Survey Monkey on July 1, 2020.

Technical support and training

HCA continued working with an HCA consultant and internal leadership to refine the VBP Roadmap and integrate a long-term strategic vision.

Upcoming activities

- MCOs will complete the VBP validation templates, and work with the IA to address any discrepancies. In Q3, the IA will coordinate with HCA on the analysis and final reporting of MCO progress to date.
- Providers and health plans (including MCOs) will complete HCA's Paying for Value survey by August 31, 2020, and HCA will begin analyzing in Q3.
- HCA will continue to refine the VBP Roadmap and release a 2020 update in early Q4.

Integrated managed care (IMC) progress

In 2014, the Legislature directed a transition to integrate the purchasing of medical and behavioral health services for Apple Health (Medicaid) clients through an IMC system no later than January 1, 2020. Below are IMC-related activities for Q2.

IMC implementation concluded with the final three regions going live in January 2020. During this reporting period, HCA completed Early Warning System calls and participated in several regional provider meetings. In addition, a request for proposals was released to potentially add MCOs to regions with fewer than five MCOs in place.

Health information technology (HIT)

The 2020 HIT Operational Plan includes tasks in several categories that support MTP efforts, including:

- Electronic health records (EHRs)
- Mental health IMD waiver
- SUD HIT plan and prescription drug monitoring program (PMP)
- Enhancements
- Master person index
- Provider directory
- Payment models and sources
- Data and governance
- Health information exchange functionality
- Registries
- Adding clients and users to the Clinical Data Repository (CDR) and improving functions/quality
- Provider education
- Tribal engagement
- Behavioral health integration

During Q2, much of Washington State's efforts were focused on responding to COVID-19. During this time, Washington State advanced its HIT Operational Plan through the following activities:

- Adjusted telehealth payment policy to further enable providers to serve patients remotely.
- Supported the use of telehealth (audio-visual and audio-only) by:
    - Providing technical assistance and training to Medicaid providers, including behavioral health providers.
    - Requiring that MCOs cover telehealth (in addition to telemedicine).
- Secured 2,000 Zoom health care licenses, and made them available free of charge to Medicaid providers.
- Distributed approximately 6,000 smart phones (donated by cell phone companies) to Medicaid clients (including Tribal members and agencies that serve homeless individuals), and coordinated with two telephone companies to make 400 talk minutes and unlimited data available (texting and internet) per month.
- Made hundreds of loaner laptops available to providers to support their use of telehealth.
- HCA provided or contracted with the University of Washington's Harborview Behavioral Health Institute (BHI) to provide technical assistance, training, and other information to service providers, including behavioral health providers, about telehealth payment and clinical service delivery. BHI, with support from HCA:
    - Conducted a telehealth needs assessment to gather information about the telehealth needs of behavioral health clinicians and clients.
    - Established a Broadband Subcommittee to help address gaps in broadband across the state.
- Selected a master person index (MPI) expert vendor to develop a roadmap for MPI implementation.

- Successfully implemented an MPI proof of concept to aid the state's COVID-19 response: Supported contact tracing and reporting by adding contact and demographic data from the Medicaid repository to the Department of Health electronic lab reporting data.
- Disseminated quarterly provider feedback reports related to opioid use and prescribing patterns.
- Continued to explore how best to promote the adoption of certified EHR technology, including administering an environmental scan survey of EHR adoption and use.
- Continued the planning effort for an electronic consent management solution to facilitate exchange of sensitive health information, including SUD information.

To view the 2020 HIT Operational Plan and other related reports, visit the Medicaid HIT Plan page.

DSRIP program implementation accomplishments

ACH project milestone achievement

Semi-annual reporting

ACHs report on their MTP activities, project implementation, and progress on required milestones. These are outlined in the Project Toolkit. Semi-annual reports are submitted every six months and submissions were not due during this reporting period.

During Q2, ACHs continued to respond to COVID-19, including:

- Disseminating information on best practices so providers are up to date with treatment and care recommendations and statewide guidelines, as well as changes to billing requirements.
- Providing training and technical assistance on utilizing telehealth or telephone encounters instead of office visits.
- Helping to leverage COVID-19 capacity building investments to address business impacts of the pandemic for health and social services providers.
- Acting as a bridge between clinical efforts and community response and resources, making sure there is high-quality community care coordination.
- Providing support to programs critical to maintaining community health and resiliency, such as food banks, meal delivery services, community action agencies, local coalitions and other programs that support at-risk community members.
- Connecting community members to needed supports, such as housing, delivery of food or clothing, or other needs. This helps individuals and communities remain healthy and safe through local care coordination and connection mechanisms (e.g., 211 and/or other regional community information exchange systems).
- Ensuring maximization of investments via local, state, and federal resources. ACHs are well positioned to act as intermediaries based on their understanding of the needs of vulnerable community members and existing contractual relationships with providers.

Next steps

Implementation of project activities is underway across the state, although many ACHs continue to adjust implementation plans and/or provider performance expectations to account for COVID-19 response efforts. ACHs will continue to inform the state about project progress by submitting updated implementation plans and/or project updates that reflect progress, barriers, and opportunities during the reporting period.

ACHs will also provide updates related to how ACHs are supporting partnering providers. Much of the work prior to COVID-19 is regaining momentum, although the state continues to encourage ACHs to pivot based on unanticipated COVID-19 related challenges and opportunities.

Annual VBP milestone achievement by ACHs

ACHs help assess and support provider VBP readiness and practice transformation by connecting providers to training and resources. ACHs continue to use a number of strategies to support regional providers in the transition to VBP, including suppporting behavioral health providers with the transition to IMC.

Financial executor (FE) portal activity

ACHs continue to distribute incentive funds to partnering providers through the FE portal. During the reporting quarter, ACHs distributed more than $23 million to 353 partnering providers and organizations in support of project planning and implementation activities. The state distributed approximately $600,809 in earned incentive funds to Indian Health Care Providers (IHCPs) in Q2 for achievement of IHCP-specific project milestones.

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

HCA and the FE implemented a change that allows ACHs to issue provider payments on a more frequent cadence to be more nimble during the COVID-19 pandemic.

HCA will continue to monitor the FE portal to make sure ACHs are distributing funds to partnering providers in a timely manner.

DSRIP measurement activities

HCA and the Center for Outcomes Research and Education (CORE) continue efforts to transition measure production and visualization from CORE to HCA. The Healthier Washington dashboard is a publicly available data resource that provides data on populations, health indicators and HEDIS measures for Washington State. The dashboard supports ACHs and partnering providers by providing actionable data on population health and social determinants of health. ACHs have been engaged in the transition and users have provided feedback regarding functionality and improvements to the dashboard.

What's going to change and when?

- CORE will provide HCA with transitional technical assistance through all of 2020.
- Engagement with all stakeholders, to include ACHs, began in February 2020.
- State of Washington (HCA and Department of Social and Health Service's Research and Data Analysis (RDA) Division) becomes the sole measure producers for all DSRIP measures, beginning July 2020.
- The current Healthier Washington Dashboard will sunset and the new dashboard goes live in January 2021.

State measurement support

HCA continues to provide technical assistance surrounding project P4R/P4P metrics, the DSRIP Measurement Guide, and metric technical specifications. HCA also continues to update documents to capture DSRIP program development, and participate in ACH-led calls and forums to address DSRIP performance and measurement questions. Related resources, such as the measurement guide, are available on the Medicaid Transformation metrics page.

DSRIP program stakeholder engagement activities

HCA continued to host a weekly Transformation Alignment Call (TAC) with ACHs, state partners, and others. HCA continued sending a weekly ACH email summarizing COVID-19-related communications HCA has sent out, along with other announcements and information from Washington State Department of Health, the Office of Governor, Joint Information Center, and others.

In addition, monthly MCO calls continued to discuss alignment opportunities and promote open communication. HCA has also created a workgroup with ACH executives to discuss strategies to better address social determinants of health, including potential investment strategies.

HCA engaged each ACH in a one-on-one discussion between HCA and the ACH. These conversations focused on sustainability planning related to priority DSRIP activities and investments, including the capacity that has been developed within the ACH organization and partnership.

DSRIP stakeholder concerns

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

Upcoming DSRIP activities

HCA will continue to coordinate with CMS and ACHs regarding adjustments due to the COVID-19 pandemic, including adjustments to P4R and P4P. The state continues to work with the IA and will issue modified semi-annual reporting guidance for the sixth reporting cycle to account for COVID-19 impacts.

HCA is synthesizing feedback from the one-on-one ACH calls and will be engaging ACHs in related conversations about sustainability planning, funding strategies, and the future of the ACHs in health system transformation. Themes and priorities from these conversations include: community-based care coordination, health equity, innovative financing strategies, continued VBP advancement to sustain transformation, and ACH roles post-MTP to support clinical-community linkages.

HCA will work with the IA to finalize the timeline and process associated with upcoming P4P and achievement value calculations. HCA will also finalize the statewide accountability report template for DY3 in preparation for submission to CMS in Q4.

Tribal project implementation activities

Primary milestone: IHCPs continued to draw down their IHCP-specific projects funds for incentives associated with the second half of DY3. Over $600,000 was distributed to IHCPs during Q2 DY4.

Tribal partner engagement timeline

ACHs and IHCPs focused primarily on responding to COVID-19 in their regions and Tribal areas. Engagement was more limited than usual because of pandemic response and associated constraints.

April 13:	Participated in the Behavioral Health Aide Advisory Workgroup, hosted by the Northwest Portland Area Indian Health Board (NPAIHB) on establishing this Community Health Aide Program (CHAP) provider.
April 13:	Distributed $480,648 to IHCPs for reporting on the second half of DY3.
April 14:	Discussed alternative payment methodology (APM) for traditional medicine with HealthierHere.
April 16:	Participated in Better Health Together's (BHT) Tribal Leadership meeting.
April 17:	Began discussion of electronic consent management and IHCPs, overlapping with the ongoing work regarding IHCPs and EHRs.
April 20:	HCA's Office of Tribal Affairs (OTA) co-hosted a regional Tribal coordination meeting (North Sound region), attended by HCA, MCO's tribal liaisons, the North Sound Behavioral Health Administrative Services Organization, and the North Sound ACH to better coordinate between the entities supporting health in the region.

April 21: OTA and MCO Tribal Liaison meeting.

April 22: OTA co-hosted a regional Tribal coordination meeting (King County region.)

April 28: Participated in a call with Centene to discuss managed care work with Tribes and IHCPs in other states and opportunities here in Washington.

April 28: Discussed traditional medicine with HealthierHere.

May 1: Discussed the intersection of data and Tribal health with OneHealthPort (the organization contracted for the CDR), including data sovereignty and its importance.

May 1: Discussed the Tribal federally qualified health center (FQHC) APM with individual IHCP.

May 6: Participated in the American Indian Health Commission for Washington State, the Tribal coordinating entity, Quarterly Delegate Meeting.

May 15: Discussed the Tribal FQHC APM with individual IHCP.

May 18: Participated in BHT's Tribal Leadership meeting.

May 19: Presented the Tribal FQHC APM for individual IHCP.

May 26: OTA and MCO Tribal Liaison meeting.

June 1: Distributed $120,161 to an IHCP for reporting on first and second half DY3.

June 4: Participated in a discussion on ACH funding model.

June 9: Participated in a discussion on the MPI, and implications for Tribes, IHCPs, and data sovereignty.

June 15: OTA co-hosted a regional Tribal coordination meeting (North Sound region).

June 15: OTA co-hosted a regional Tribal coordination meeting (Cascade Pacific Action Alliance region).

June 17: Participated in a North Sound ACH discussion on Trauma Informed Care and Psychology through an Indigenous Lens.

June 18: Participated in BHT's Tribal Leadership meeting.

June 18: Discussed additional funding for the CHAP at NPAIHB.

LTSS implementation accomplishments

This section summarizes LTSS program development and implementation activities from April 1 through June 30, 2020. Key accomplishments for this quarter include:

- Total number of clients served as of June 26 was 7,595.
- Clients continued to be served during the COVID -19 pandemic. Aging and Long-Term Support Administration (ALTSA) shifted to remote assessments, allowed remote personal care or respite when feasible, and provided enhanced provider rates in response to the pandemic.
- Completed data requirements for the integration of TCARE into the GetCare system and began system development.

Network adequacy for MAC and TSOA

Area Agencies on Aging (AAA) continued to maintain and execute provider contracts on behalf of Home and Community Services (HCS). At least one AAA engaged their local Tribes to contract for home-delivered meal services during this quarter.

Assessment and systems update

The state continued its development of integrating GetCare, the primary client management system, and TCARE, the evidence-based caregiver assessment tool, to streamline the workflow for case managers by eliminating redundant data entry and allow more efficient data collection from each system. The data is used for ongoing program management, and providing information that will be useful in developing program sustainability after the MTP waiver ends.

Staff training

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

- May – review of mandatory forms/documents and their usage

Upcoming webinars include:

- July – overview of roles (case manager, financial worker, intake, etc.) related to enrollment and case management of participants in the MAC and TSOA programs.

Data and reporting

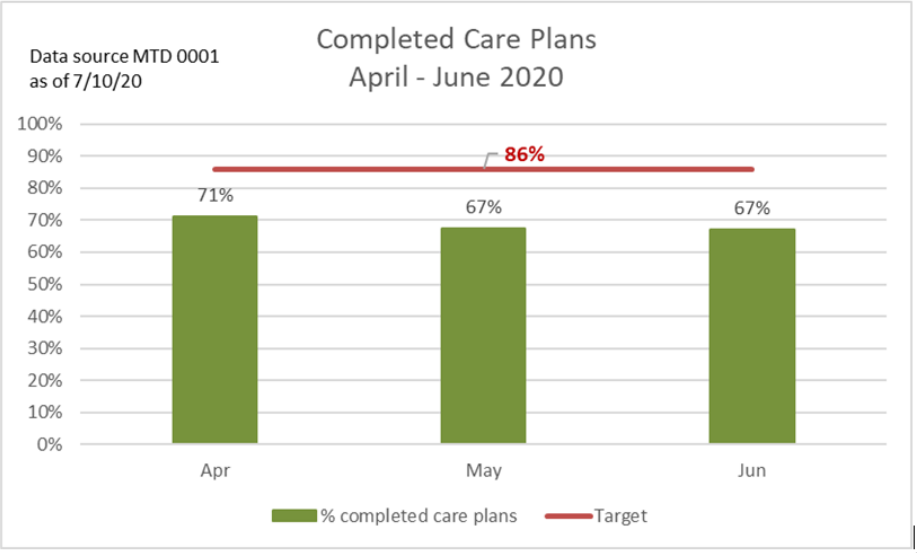
Table 1: beneficiary enrollment by program

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of June 30, 2020	220	2,466	4,674
Number of new enrollees in quarter by program	21	226	444
Number of new person-centered service plans in quarter by program	5*	63**	208***
Number of beneficiaries self-directing services under employer authority	0	0	0

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

The state continues to monitor timely completion of enrollees' care plans monthly and provide technical assistance to the AAAs as needed. Results of the care plan proficiency monitoring review are illustrated in the following table:

Table 2: completed care plans



Tribal engagement

Washington State continues to be in a state of emergency due to COVID-19, which has impacted all aspects of state, local, and Tribal government operations.

ALTSA met with a number of Tribes to discuss Medicaid services and MTP Initiatives 2 and 3. April 1 through June 30, 2020.

- Met with Indian Policy Advisory subcommittee to provide updates.
    - A new Aging and Disabilities Resource Center-COVID-19 contract was shared. Updates will be provided monthly, starting in May 2020. The American Indian Health Commission (AIHC) will be working with AAAs and Tribes to improve access to assessments and services, including caregiver services. AIHC will meet with all 29 federally recognized Tribes, 13 AAAs, and facilitate regional meetings to improve cultural competence, understanding, and pathways to services.
- No 7.01 planning meetings were held during this period due to Tribal closures.
- Regular contact was maintained through the ALTSA Tribal Affairs Unit with many Tribes. Tribes shared an increased need for caregiver supports and growing concern over isolation of Tribal elders due to COVID-19.
- Six Tribes adapted to social distancing requirements through their kinship navigator and respite programs to continue to provide support to Tribal members.
- Lummi Nation requested information and the Department of Social Health and Services provided a response on Permanent Supportive Housing, June 24, 2020.

Outreach and engagement

AAAs continued to explore creative ways to conduct outreach activities that promote caregiver programs this quarter, as a result of the COVID-19 stay–at-home order.

Table 3: outreach and engagement activities by AAA

	April	May	June
	Number of events held		
Community presentations and information sharing	20	16	15

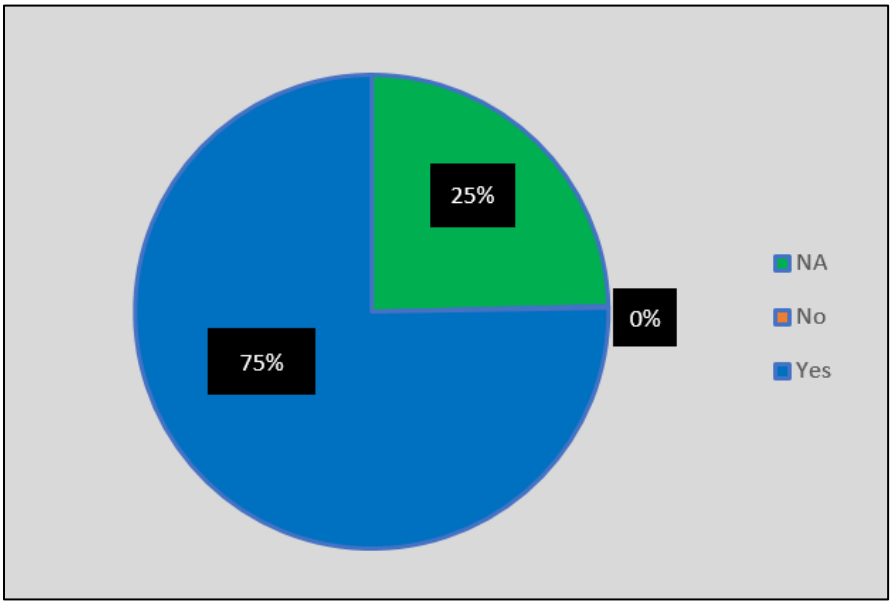
Limited outreach activities occurred due to COVID-19.. Some activities occurred, such as virtual meetings with hospital social worker and community partners. The AAAs also posted ads in local newspapers, participated in radio shows, and held virtual/telephonic support groups.

There has been no outreach and engagement activities completed by HCS headquarters for this quarter due to COVID-19.

Quality assurance

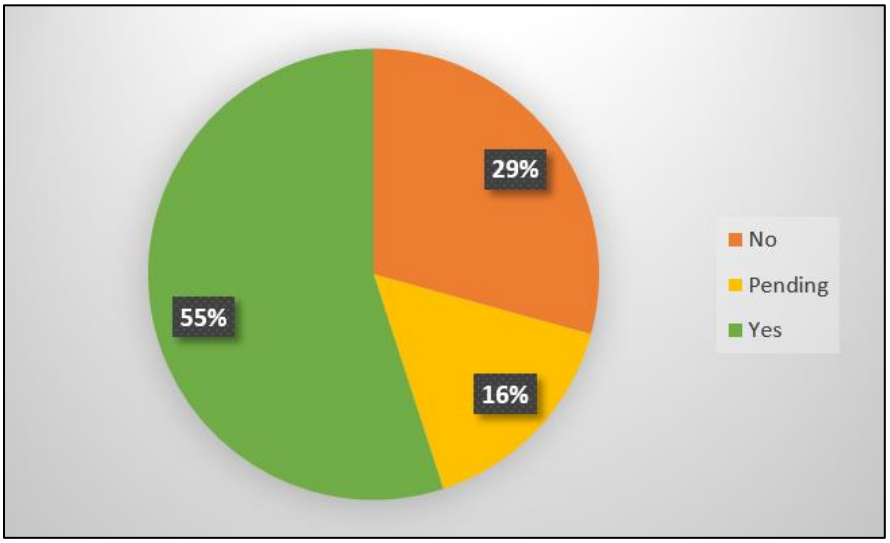
Results of the quarterly presumptive eligibility (PE) quality assurance review

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



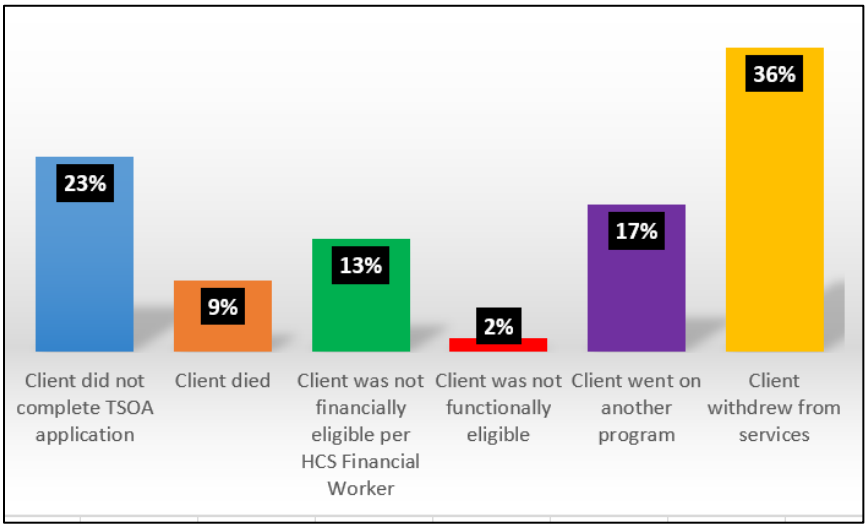
Note: the N/A represents clients who were part of the last quarter's review and the response to question #1 was "yes" but the response to question #2a was "pending."

Table 5: Question 2a: did the client remain eligible after the PE period?



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

Table 6: Question 2b: if "No" to question #2a, why?



2020 quality assurance results to date

HCS' Quality Assurance (QA) unit began the 2020 audit cycle in January and will end in October. The state's 2020 QA cycle was paused as of March 25, 2020, due to COVID-19 impacts, but resumed June 1, 2020. QA results for AAAs scheduled during this pause will be included in next quarter's report.

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

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

State rulemaking

There were no rulemaking activities this quarter.

Upcoming activities

- Continue development and testing of TCARE process integration into GetCare system (projected implementation date of September 15, 2020).
- July training webinar.
- The planned outreach and engagement activities by HCS for July through September include resuming work on producing a statewide marketing video and a Tribal-focused video, as well as distributing outreach materials to medical clinics and physicians.

LTSS stakeholder concerns

No stakeholder comments or concerns were noted this quarter.

FCS implementation accomplishments

This section summarizes the FCS program development and implementation activities from April 1 through June 30, 2020. Key accomplishments for the quarter include:

- Total aggregate number of people enrolled in FCS services at the end of DY4 Q2:
  - CSS: 4,575
  - IPS: 3,753
- There were 151 providers under contract with Amerigroup, FCS' third party administrator, at the end of DY4 Q2, representing 419 sites throughout the state.

Note: CSS and IPS enrollment totals include 1,329 participants enrolled in both programs. The total unduplicated number of enrollments at the end of this reporting period was 7,039.

The COVID-19 pandemic had significant impacts on FCS enrollments and services this quarter. In response to emergency orders, HCA began weekly calls with behavioral health and FCS provider agencies. Guidance based on CMS information was distributed to FCS providers to ensure individuals had access to services.

FCS service providers were encouraged to use telehealth services and HCA provided technical assistance, HIPAA-compliant Zoom licenses, as well as loaner laptops. Provider viability was tracked on a weekly basis and Amerigroup worked with FCS-contracted agencies to clean up outstanding claims to expedite payments. Even with all these efforts, approximately 40 providers have vocalized concerns over their financial viability to continue to provide FCS services.

HCA distributed thousands of donated phones to Washingtonians in need to access telehealth and community resources to better navigate services during COVID-19. FCS providers, homeless service providers, homeless outreach teams, and behavioral health outpatient facilities helped distribute phones.

Although many people benefitted from receiving these phones, FCS providers continue to emphasize the need for additional cell phones and/or other handheld devices and associated connectivity supports (e.g., minutes or broadband).

Network adequacy for FCS

Table 7: FCS provider network development

	April		May		June	
FCS service type	Contracts	Service locations	Contracts	Service locations	Contracts	Service locations
Supported Employment – Individual Placement Support (IPS)	34	76	34	76	33	74
Community Support Services (CSS)	20	46	20	46	21	49
CSS and IPS	97	306	97	306	97	296
Total	**151**	**428**	**151**	**428**	**151**	**419**

Client enrollment

Table 8: FCS client enrollment

	April	May	June (preliminary)
Supported Employment – Individual Placement and Support (IPS)	2,339	2,440	2,464
Community Support Services (CSS)	3,042	3,253	3,246
CSS and IPS	1,224	1,329	1,329
Total aggregate enrollment	**6,605**	**7,022**	**7,039**

Data source: RDA administrative reports

Table 9: FCS client risk profile

		Meet HUD homeless criteria	Avg. PRISM risk score	Serious mental illness
April	IPS	584 (16%)	1.05	2,739 (77%)
	CSS	1,146 (27%)	1.50	3,101 (73%)
May	IPS	629 (17%)	1.02	2,885 (77%)
	CSS	1,252 (27%)	1.47	3,287 (72%)
June (preliminary)	IPS	669 (18%)	1.02	2,897 (76%)
	CSS	1,310 (29%)	1.47	3,290 (72%)

HUD = Housing and Urban Development
PRISM = Predictive Risk Intelligence System (Risk ≥ 1.5 identifies top 10 percent of high-cost Medicaid adults; Risk ≥ 1.0 identifies top 19 percent of high-cost Medicaid adults)
Note: month-to-month changes are due to client enrollment mix, not program impact
Data source: RDA administrative reports

Table 10: FCS client risk profile continued

		Medicaid only enrollees*	MH treatment need	SUD treatment need	Co-occurring mental health+ SUD treatment need flags
April	IPS	3,053	2,884 (94%)	1,903 (62%)	1,821 (60%)
	CSS	3,561	3,345 (94%)	2,765 (78%)	2,622 (74%)
May	IPS	3,242	3,048 (94%)	2,025 (62%)	1,931 (60%)
	CSS	3,852	3,584 (93%)	2,975 (77%)	2,810 (73%)
June (preliminary)	IPS	3,253	3,051 (94%)	2,012 (62%)	1,916 (59%)
	CSS	3,844	3,565 (93%)	2,944 (77%)	2,771 (72%)

Data source: RDA administrative reports
*Does not include individuals who are dual-enrolled.

Table 11: FCS client service utilization

		Medicaid only enrollees*	Long-term Services and Supports	Mental health services	SUD services (received in last 12 months)	Care + mental health or SUD services
April	IPS	3,053	305 (10%)	2,465 (81%)	1,090 (36%)	261 (9%)
	CSS	3,561	464 (13%)	2,612 (73%)	1,509 (42%)	398 (11%)
May	IPS	3,242	312 (10%)	2,558 (79%)	1,091 (34%)	267 (8%)
	CSS	3,852	491 (13%)	2,727 (71%)	1,525 (40%)	409 (11%)
June (preliminary)	IPS	3,253	311 (10%)	2,509 (77%)	1,001 (31%)	262 (8%)
	CSS	3,844	492 (13%)	2,634 (69%)	1,387 (36%)	400 (10%)

(Aging CARE assessment in last 15 months)
Data source: RDA administrative reports
*Does not include individuals who are dual-enrolled.

Table 12: FCS client Medicaid eligibility

		CN blind/disabled (Medicaid only & full dual-eligible)	CN aged (Medicaid only & full dual-eligible)	CN family & pregnant woman	ACA expansion adults	CN & CHIP children
April	IPS	1,017 (29%)	81 (2%)	403 (11%)	415 (12%)	84 (2%)
	CSS	1,474 (35%)	241 (6%)	504 (12%)	644 (15%)	40 (1%)
May	IPS	1,068 (28%)	81 (2%)	438 (12%)	464 (12%)	85 (2%)
	CSS	1,562 (34%)	248 (5%)	559 (12%)	739 (16%)	42 (1%)
June (preliminary)	IPS	1,090 (29%)	83 (2%)	442 (12%)	465 (12%)	84 (2%)
	CSS	1,577 (34%)	249 (5%)	558 (12%)	759 (17%)	41 (1%)

ACA = Affordable Care Act
CHIP = Children's Health Insurance Program
CN = categorically needy
Data source: RDA administrative reports

Quality assurance and monitoring activity

COVID-19 has had a significant impact on current FCS participants and potential enrollees. As early as May, Amerigroup indicated a decrease in the number of assessments for potential FCS enrollees, which resulted in a decrease in the number of new enrollees in the program in Q2.

New enrollments for participants receiving CSS services have continued to outpace enrollments in IPS services, and participants enrolled to receive both IPS and CSS services remained fairly steady. The participants enrolled to receive both service are typically not "new" to FCS, and often transfer from either IPS or CSS throughout each month. RDA also indicated a decrease in the new enrollments in the program. In the six months prior to Q2, total enrollment had increased four percent, and more time is needed to fully understand the impacts of the pandemic on current enrollment trends.

In addition to the effects on enrollments, COVID-19 impacted FCS providers' ability to deliver services. Both IPS and CSS providers have indicated significant challenges maintaining steady service hours, and the state estimates roughly 40 percent of providers had to reduce or suspend services during Washington State's stay-at-home order.

Because IPS and CSS services are reimbursed by the third party administrator on a fee-for-service basis, the decrease of services posed significant challenges to providers' financial viability. In response, FCS program staff worked with the HCA Finance Division to establish new reimbursement rates for IPS and CSS services.

These increased rates were issued in two phases, including a higher rate for April, May, and June to help providers maintain their programs during a period of reduced services. A permanent rate increase of roughly seven percent will be effective July 1, 2020.

A large amount of work in Q2 was centered on the use of telehealth services as a result of the COVID-19 pandemic. In April, HCA began strongly encouraging FCS providers to deliver services using virtual technologies, either via telephone or via conferencing video platforms. HCA's Division of Behavioral Health and Recovery (DBHR) staff provided additional technical assistance to providers and held a webinar on the use of telehealth in behavioral health and recovery support services. Several other related projects are outlined in the HIT section.

HCA also completed the procurement of 15 contracts that incentivize SUD treatment providers to build IPS programs integrated with their other treatment services. This expansion includes Tribal partner service providers as well as five Medications for Opioid Use Disorders (MOUD) providers, who have historically not provided supported employment services for their participants in Washington State.

DBHR will be leveraging Substance Abuse Mental Health Services Administration (SAMHSA) block grant funding for these seed grants to hire and train staff, and develop policies and procedures around IPS services.

Other FCS program activity

In May, Greg Claycamp left the role of FCS program administrator to take a position at a local housing provider. Matt Christie, the former FCS program manager, was promoted to the administrator role, effective June 1. HCA plans to backfill the program manager position, which is crucial for providing operational and program data support, along with coordinating technical assistance activities and reporting needs.

Upcoming activities

The DBHR training staff moved all technical assistance trainings, conferences, and fidelity reviews to a virtual format. Along with the regularly scheduled monthly topical webinars and individual agency trainings, DBHR staff are scheduled to conduct 14 virtual fidelity reviews of both IPS and CSS providers across the state in Q3.

FCS staff use SAMHSA block grant funds to incentivize agencies to host a fidelity review or to join the learning collaborative by sending staff on fidelity reviews of other agencies. Prior to this process, agencies must attend a Fidelity Reviewers training event that explains the learning collaborative process, the principles of each evidence-based practice, and the activities included in the fidelity review.

As part of HCA's ongoing provider support work, the national technical assistance contractor, Corporation for Supportive Housing (CSH), will be providing direct technical assistance on business modeling and policies and procedures for eight CSS service providers throughout the state. CSH will also be conducting interviews of participants, employers, and landlords who have either enrolled in FCS or worked with participants. These interviews are part of a Photovoice project to highlight success stories and promote the value and impact of FCS services.

As part of HCA's efforts to expand IPS services to SUD treatment providers, various trainings are scheduled in Q3 to assist the onboarding of new providers.

HCA will host a FCS conference on September 15-16. A planning committee comprised of representatives from DBHR, ALTSA, and other program partners meet bi-weekly to coordinate work and develop content for the conference. HCA hosted two prior conferences that were focused on employment.

FCS program stakeholder engagement activities

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

Table 13: FCS program stakeholder engagement activities

	April	May	June
	Number of events held		
Training and assistance provided to individual organizations	74	43	48
Community and regional presentations and training events	7	8	9
Informational webinars	7	5	7
Stakeholder engagement meetings	23	9	16
Total activities	**111**	**65**	**80**

Training and assistance activities to individual organizations increased significantly since Q1. HCA, ALTSA, and Amerigroup provided an increasing amount of technical assistance to FCS providers to cope with the new direct service environment resulting from the COVID-19 pandemic. Last quarter, HCA, ALTSA, and Amerigroup moved all technical assistance and stakeholder engagement activities to a virtual format, which continued during this reporting period. HCA plans to continue this trend through the end of DY4.

Webinars are intended to inform, educate, and coordinate resources for FCS providers serving people who need housing and employment services, resources, and supports. Q2 topics included:

- The use of telehealth for behavioral health and recovery support service providers
- Physical and emotional needs of older adults in supportive housing (CSS)
- Job developers community of practice: job development during COVID-19
- Self-care and vicarious trauma
- Self-care and supporting staff during COVID-19
- Motivational interviewing
- Support vs service: laws around animals in housing
- Washington State Veterans and Military Families program
- Wellness strategies for career service providers
- Starting supported employment services in SUD programs
- Self-care in supportive housing (CSS)

Total attendance for HCA-led technical assistance activities reached 3,470 for the quarter, nearly three times the number of total attendees in Q1.

Figure 1: attendance of HCA-led technical assistance activities by training type

Five fidelity reviews were completed in Q2 by HCA's staff, including three reviews of CSS providers and two reviews of IPS providers. Fidelity reviews are designed as part of HCA's continuous quality improvement approach to implementing the evidence-based practices of IPS and CSS programs.

FCS stakeholder concerns

A number of FCS providers have raised questions around the sustainability of FCS services and MTP, given the challenges posed by the COVID-19 pandemic. HCA has heard from about 40 percent of contracted providers experiencing financial struggles related to the pandemic. These providers have had to temporarily pause FCS services, furloughed staff, or move FCS staff to other services to balance their reduced workload.

Amerigroup reported two providers who terminated contracts during the quarter due to financial challenges posed by the pandemic.

SUD IMD waiver implementation accomplishments

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

This section summarizes SUD IMD waiver development and implementation activities from April 1 through June 30, 2020. Accomplishments for the quarter include:

- The COVID-19 pandemic in Washington continued to ramp up during Q2 and significantly impacted implementation activities.
    - HCA took action to support telehealth and telemedicine services.
    - HCA initiated weekly calls to disseminate information and provide technical assistance to providers undergoing the stressors of the pandemic.
    - The state engaged with CMS regarding possible changes to the 1115 waiver in light of COVID.

Implementation plan

In accordance with the amended STCs, the state is required to submit an implementation plan for the SUD IMD waiver, incorporating six key milestones outlined by CMS. At the time of the waiver application, Washington met a number of these milestones in its provision of SUD services. Where the state did not meet the milestones, CMS was engaged to confirm appropriate adjustments. These changes, included in the state's SUD implementation plan, are described below:

- **Milestone 3c:** requirements that residential treatment facilities offer MOUD onsite or facilitate access offsite.
    - **Update:** implementation of Washington Administrative Code changes is on schedule. HCA emergency rulemaking went into effect on 4/23/2020 to satisfy this requirement.

SUD HIT plan requirements

HCA continued implementation of activities under the Section 1003 of the SUPPORT ACT grant award to develop a policy framework to enhance SUD treatment and recovery services. Activities include:

- Expanding the number of connections with PMPs across the United States.
- Launching the Aware platform for the Prescription Drug Monitoring Program.
- Updating prescribing metrics for the Chief Medical Officer reports that are distributed in collaboration with the Washington State Medical Association
- Gathering information on barriers to integrate PMP information into EHRs.

Evaluation design

There were no updates during this reporting period.

Monitoring protocol

Per discussion with CMS, due to a delay in receiving updated technical specifications for the Monitoring Protocol metrics, the state will not be submitting a Monitoring Workbook this quarter. The state will resume reporting next quarter and will include the current quarter's results (if given sufficient time to incorporate updated technical specifications).

Upcoming activities

There were no updates during this reporting period.

Quarterly expenditures

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

Table 14: DSRIP expenditures

	Q1	Q2	Q3	Q4	DY4 Total	Funding source
	January 1–March 31	April 1–June 30	July 1–September 30	October 1–December 31	January 1–December 31	Federal financial participation
ACH						
Better Health Together	$5,144,786	$4,852,757				$4,998,772
Cascade Pacific Action Alliance	$4,677,079	$4,443,414				$4,560,247
Elevate Health	$6,547,910	$6,080,780				$6,314,345
Greater Columbia	$10,289,572	$9,355,513				$9,822,543
HealthierHere	$2,338,539	$2,396,707				$2,367,623
North Central	$7,015,618	$6,490,122				$6,752,870
North Sound	$1,870,831	$1,987,366				$1,929,099
Olympic Community of Health	$5,612,494	$5,262,097				$5,437,296
SWACH	$3,273,955	$3,215,390				$3,244,673
Indian Health Care Providers	$1,862,500	$0				$931,250

Table 15: LTSS and FCS service expenditures

	Q1	Q2	Q3	Q4	DY4 Total
	January 1–March 31	April 1–June 30	July 1–September 30	October 1–December 31	January 1–December 31
Tailored Supports for Older Adults (TSOA)	$2,323,728	$3,684,643			
Medicaid Alternative Care (MAC)	$56,452	$79,469			
MAC and TSOA not eligible	$465	$1,236			
FCS	$2,637,290	$9,434,315			

Financial and budget neutrality development issues

Financial

Below are the counts of member months eligible to receive services under MTP. Member months for non-expansion adults are updated retrospectively, based on the current caseload forecast council (CFC) medical caseload data. March 2020 through June 2020 member months for non-expansion adults are forecasted caseload figures from CFC.

SUD member months are based on the state's ProviderOne system. At this time, SUD member month's data is only available through February 2020.

Table 16: member months eligible to receive services.

Calendar month	Non-expansion adults only	SUD Medicaid disabled	SUD Medicaid nondisabled	SUD newly eligible	SUD American Indian/Alaska Native
Jan-17	376,343	0	0	0	0
Feb-17	375,234	0	0	0	0
Mar-17	374,734	0	0	0	0
Apr-17	373,544	0	0	0	0
May-17	373,052	0	0	0	0
Jun-17	372,926	0	0	0	0
Jul-17	372,000	0	0	0	0
Aug-17	371,708	0	0	0	0
Sep-17	370,427	0	0	0	0
Oct-17	370,203	0	0	0	0
Nov-17	370,002	0	0	0	0
Dec-17	369,989	0	0	0	0
Jan-18	370,006	0	0	0	0
Feb-18	368,573	0	0	0	0
Mar-18	368,401	0	0	0	0
Apr-18	367,161	0	0	0	0
May-18	367,525	0	0	0	0
Jun-18	366,826	0	0	0	0
Jul-18	366,570	2	3	11	8
Aug-18	365,995	6	1	18	17
Sept-18	365,014	3	3	11	18
Oct-18	365,015	4	3	9	24
Nov-18	364,559	2	1	17	27
Dec-18	363,994	4	4	12	15
Jan-19	363,951	4	18	65	22
Feb-19	362,214	13	23	110	27
Mar-19	361,871	7	25	96	29
Apr-19	361,412	6	29	92	35
May-19	360,907	4	29	82	42
June-19	360,143	5	25	57	31
Jul-19	360,599	2	22	57	34
Aug-19	360,165	1	29	28	32
Sep-19	359,730	10	32	77	26
Oct-19	359,200	0	0	0	0
Nov-19	358,773	0	0	0	0
Dec-19	358,586	0	0	0	0

Jan-20	358,746	2	31	83	27
Feb-20	357,791	3	28	60	25
Mac-20	357,664	0	0	0	0
Apr-20	365,856	0	0	0	0
May-20	370,753	0	0	0	0
Jun-20	375,633	0	0	0	0
Total	15,388,906	100	462	1491	570

Budget neutrality

HCA adopted CMS's budget neutrality monitoring tool and has been using Performance Management Database and Analytics system to upload quarterly spreadsheets. HCA continues to monitor budget neutrality, and given the adjustments made to the methodology and program reductions, HCA is currently projected to meet budget neutrality over the lifetime of the project.

Designated state health programs (DSHP)

Last year, HCA procured a contract with Myers & Stauffer to perform an independent audit on DSHP expenditures. Myers and Stauffer completed their independent review as of June 30, 2020, and are in the process of finalizing a report for HCA.

Overall MTP development and issues

Operational/policy issues

Implementation activities continue to be underway for all initiatives. However, COVID-19 has been a significant disruption to MTP activities. Providers, ACHs, and other implementation partners have been working hard to adapt to new pandemic realities while serving clients and communities.

In spite of this new landscape, MTP activities continue, and we have been grateful for streamlined reporting and measurement options offered by CMS. Sustainability of programs and investments post-MTP is also a priority for the state. HCA is currently preparing the appropriate materials tied to legislative action to support appropriations for MTP continuation in the coming biennium.

Consumer issues

The COVID-19 pandemic has highlighted the need for additional support related to wireless connectivity through cell phone/tablets and broadband/minutes. This is a critical dependency for MTP initiatives to continue serving clients and promoting access. The state has made progress on this effort and continues to explore options for improving broadband connectivity and access to cell phones or other devices (including data/minutes).

MTP evaluation

The MTP independent external evaluator (IEE), Oregon Health Sciences University, Center for Health Systems Effectiveness, continued its active engagement. During this reporting period, key activates included delivery of the Rapid-Cycle Monitoring Report, and the Final Baseline Evaluation Report and Issue Brief (referenced in the DY4 Q1 quarterly report).

Rapid-Cycle Monitoring Report

The Eighth Rapid-Cycle Monitoring Report was delivered on June 26, 2020, in compliance with the contracted deliverable timeline. The report notes the following activities during this reporting period:

- Delivery of the final Baseline Evaluation Report and Issue Brief discussed above. The initial report was delivered on March 31, 2020. Follow up activity for this reporting period included incorporation of state agency feedback on the initial report, finalization of the issue brief, and incorporation of the nine ACHs.
- Preparation for the Interim Report, due to be delivered in December 2020. This activity includes detailed analysis plans for MTP Initiatives 1-4.
- Work with HCA and RDA to finalize data requirements for the Interim Report.
- Submission of a study amendment request with the Washington State Institutional Review Board to reflect updated data requirements and plans for the next round of key informant interviews.
- Review of ACH-specific information to be prepared for evaluation of ACH project-specific target populations.
- Additional outreach to ACH representatives to obtain their feedback on target populations, so the evaluation's quantitative evaluation reflects the Medicaid populations that ACHs are serving with their projects.
- Development of analytic summaries and contextual information about each of the eight health improvement projects in ACH regions.
- Continued key informant interviews with representatives from ACHs, state agencies, and MCOs.

These activities will continue in the upcoming reporting period, with progress reported in the next Rapid-Cycle Monitoring Report.

Baseline Evaluation Report and Issue Brief

The IEE's final Baseline Evaluation Report and Issue Brief describe the Washington State Medicaid system's status and readiness for transformation as of 2019. The final report incorporated individual case summaries for each of the nine ACHs.

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

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

The baseline report is very extensive, including quantitative results, key findings, and opportunities and challenges. It concludes with the following recommendations to support the state in meeting its MTP goals:

- Provide clarity on sustainability and expectations for ACHs beyond 2021.
- Provide ACHs with specific strategies and guidance on health information exchange (HIE) and community information exchange.
- Clarify the roles ACHs can potentially play to advance workforce strategies.
- Evaluate ways to connect MTP initiatives and facilitate connections.
- Enhance VBP reporting to track dollars directly tied to quality and efficiency.

The Issue Brief accompanying the baseline report presents a concise summary of MTP, the IEE's findings, and the key recommendations delivered in the full report. Key findings cross Initiatives 1-3.

Upcoming related activities

During the next reporting period, HCA will continue activities related to the Baseline Evaluation Report. These include:

- Implementation of a communications plan for report distribution.
- Assessment of opportunities to align report findings and recommendations with sustainability planning efforts across MTP initiatives.
- Identification of action items related to the report's findings.

Summary of additional resources, enclosures, and attachments

Additional resources

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

Summary of attachments

- Attachment A: State contacts
- Attachment B: Financial Executor Portal Dashboard, Q2 2020
- Attachment C: 1115 SUD Demonstration Monitoring Report – Part B
- Attachment D: MAC and TSOA quality assurance questions

Attachment A: state contacts

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

Area	Name	Title	Phone
MTP and quarterly reports	Chase Napier	Manager, Medicaid Transformation, Policy, HCA	360-725-0868
DSRIP program	Chase Napier	Manager, Medicaid Transformation, Policy, HCA	360-725-0868
LTSS program	Kelli Emans	Integration Unit Manager, DSHS	360-725-3213
FCS program	Melodie Pazolt	BH Programs and Recovery Support Services Section Manager, DBHR, HCA	360-725-0487
SUD IMD waiver	David Johnson	Federal Programs Manager, DBHR,HCA	360-725-9404

For mail delivery, use the following address:

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

Attachment B: Financial Executor Portal Dashboard, Q2 2020

This table shows all funds earned and distributed through the FE portal through June 30, 2020.

	Total	Better Health Together	Cascade Pacific Action Alliance	Elevate Health	Greater Columbia	HealthierHere	North Central	North Sound	Olympic Community of Health	SWACH	IHCP-specific projects
Funds earned by ACH											
2A: bi-directional integration of physical and behavioral health through care transformation	$223,773,554.88	$25,352,900.48	$18,109,210.96	$27,657,705.84	$37,362,169.27	$58,711,977.35	$8,267,249.96	$22,817,607.31	$9,361,069.79	$16,133,663.92	$0.00
2B: community-based care coordination	$81,357,610.55	$17,430,118.60	$12,450,085.57	$19,014,673.74	$0.00	$0.00	$5,683,733.48	$15,687,105.14	$0.00	$11,091,894.02	$0.00
2C: transitional care	$59,015,214.26	$0.00	$7,356,869.25	$0.00	$15,178,380.13	$23,851,740.35	$3,358,569.88	$9,269,654.65	$0.00	$0.00	$0.00
2D: diversion interventions	$16,431,160.08	$0.00	$0.00	$0.00	$0.00	$0.00	$3,358,569.88	$9,269,654.65	$3,802,935.55	$0.00	$0.00
3A: addressing the opioid use public health crisis	$27,971,696.50	$3,169,113.29	$2,263,651.92	$3,457,214.31	$4,670,270.27	$7,338,997.57	$1,033,406.27	$2,852,201.66	$1,170,134.02	$2,016,707.19	$0.00
3B: reproductive and maternal/child health	$7,857,483.25	$0.00	$2,829,565.40	$0.00	$0.00	$0.00	$0.00	$3,565,251.33	$1,462,666.52	$0.00	$0.00
3C: access to oral health services	$3,016,751.51	$0.00	$4,527,302.84	$0.00	$0.00	$0.00	$0.00	$2,139,150.00	$877,601.51	$0.00	$0.00
3D: chronic disease prevention and control	$55,943,389.99	$6,338,223.58	$4,527,302.84	$6,914,427.64	$9,340,541.54	$14,677,995.13	$2,066,812.54	$5,704,403.32	$2,340,268.03	$4,033,415.37	$0.00
Integration incentives	$68,111,492.00	$8,301,872.00	$0.00	$9,321,788.00	$10,183,916.00	$14,888,792.00	$5,781,980.00	$10,831,088.00	$0.00	$8,802,056.00	$0.00
VBP incentives	$5,850,000.00	$650,000.00	$650,000.00	$650,000.00	$650,000.00	$650,000.00	$650,000.00	$650,000.00	$650,000.00	$650,000.00	$0.00
IHCP-specific projects	$14,704,000.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$ 14,704,000.00
Bonus pool/high-performance pool	$6,308,649.00	$0.00	$1,455,842.00	$0.00	$0.00	$0.00	$1,455,842.00	$1,941,123.00	$1,455,842.00	$0.00	$0.00
Interest accrual	$870,392.43	$90,187.31	$41,358.22	$74,940.46	$144,747.19	$274,144.94	$61,490.81	$82,041.45	$11,164.17	$90,317.88	$0.00
TOTAL	**$571,211,394.45**	**$61,332,415.26**	**$49,683,886.16**	**$67,090,749.99**	**$77,530.024.4**	**$120,393,647.34**	**$31,717,654.82**	**$84,809,280.51**	**$21,131,681.59**	**$42,818,054.38**	**$14,704,000.00**
Funds distributed by ACH											
Administration	$23,997,629.65	$1,840,262.03	$335,981.00	$3,900,000.00	$2,181,786.00	$6,117,865.95	$954.61	$8,356,788.69	$14,081.37	$1,250,000.00	$0.00
Community health fund	$20,090,305.19	$2,929,314.40	$2,358,557.00	$4,000,000.00	$1,550,532.70	$0.00	$10,082.10	$8,641,818.99	$0.00	$600,000.00	$0.00
Health systems and community capacity building	$42,340,003.41	$8,751,751.00	$2,452,957.91	$6,697,570.00	$5,972,421.17	$2,189,079.73	$1,993,892.89	$11,071,910.81	$309,587.00	$2,350,832.90	$550,000.00
Integration incentives	$21,589,115.48	$2,930,000.00	$0.00	$4,871,933.00	$8,258,466.39	$4,831,974.43	$58,421.66	$553,320.00	$0.00	$85,000.00	$0.00
Project management	$6,706,375.43	$0.00	$1,903,385.00	$0.00	$890,500.00	$0.00	$706,236.26	$2,885,254.17	$196,000.00	$125,000.00	$0.00
Provider engagement, participation, and implementation	$94,193,094.93	$11,871,954.49	$9,676,084.00	$4,015,450.00	$8,375,062.00	$12,128,815.00	$3,136,515.75	$20,832,173.72	$9,420,555.97	$1,700,000.00	$13,036,484.00
Provider performance and quality incentives	$38,079,801.45	$0.00	$8,065,968.00	$12,544,452.80	$2,883,276.00	$5,343,517.17	$2,250,363.48	$0.00	$0.00	$6,992,224.00	$0.00
Reserve/contingency fund	$5,823,289.00	$570,835.00	$1,474,098.00	$0.00	$0.00	$0.00	$0.00	$1,720,000.00	$2,058,356.00	$0.00	$0.00
Shared domain 1 incentives	$116,237,321.00	$12,786,104.50	$11,623,733.00	$13,948,477.50	$16,273,226.00	$25,572,210.50	$5,811,865.00	$17,435,598.50	$4,649,493.00	$8,136,613.00	$0.00
TOTAL	**$369,056,935.54**	**$41,680,221.42**	**$37,890,763.91**	**$49,977,883.3**	**$46,385,270.26**	**$56,183,462.78**	**$13,968,331.75**	**$71,496,864.88**	**$16,648,073.34**	**$21,239,669.90**	**$13,586,484.00**
Total funds distributed to date	$369,056,935.5	$41,680,221.42	$37,890,673.91	$49,977,883.3	$46,385,270.26	$56,183,462.78	$13,968,331.75	$71,496,864.88	$16,648,073.34	$21,239,669.90	$12,985,675.00
Total funds available for distribution	$202,154,458.91	$19,652,193.84	$11,793,212.25	$17,112,866.69	$31,144,754.14	$64,210,184.56	$17,749,323.07	$13,312,415.63	$4,483,608.25	$21,578,384.48	$1,117,516.00
% of total funds distributed	**64.61 %**	**67.96 %**	**76.26%**	**74.49%**	**59.83%**	**46.67 %**	**44.04%**	**84.30 %**	**78.78 %**	**49.60%**	**92.40 %**
Administration	6.50 %	4.42 %	0.89 %	7.80 %	4.70 %	10.89 %	0.01 %	11.69 %	0.08 %	5.89 %	0.00 %
Community health fund	5.44 %	7.03 %	6.22 %	8.00 %	3.34 %	0.00 %	0.07 %	12.09 %	0.00 %	2.82 %	0.00 %

Health systems and community capacity building	11.47 %	21.00 %	6.47%	13.40 %	12.88 %	3.90 %	14.27 %	15.49 %	1.86 %	11.07 %	4.05 %
Integration incentives	5.85 %	7.03 %	0.00 %	9.75 %	17.80 %	8.60 %	0.42 %	0.77 %	0.00 %	0.40 %	0.00 %
Project management	1.82 %	0.00 %	5.02 %	0.00 %	1.92 %	0.00 %	5.06 %	4.04 %	1.18 %	0.59 %	0.00 %
Provider engagement, participation, and implementation	25.20 %	28.48 %	25.54 %	8.03 %	18.06 %	21.59 %	22.45 %	29.14 %	56.59 %	8.00 %	95.95 %
Provider performance and quality incentives	10.32 %	0.00 %	21.29 %	25.10 %	6.22 %	9.51 %	16.11 %	0.00 %	0.00 %	32.92 %	0.00 %
Reserve/contingency fund	1.58 %	1.37 %	3.89 %	0.00 %	0.00 %	0.00 %	0.00 %	2.41 %	12.36%		0.00 %
Shared domain 1 incentives	31.50 %	30.68 %	30.68 %	27.91 %	35.08 %	45.52 %	41.61 %	24.39 %	27.93 %	38.31 %	0.00 %
TOTAL	**100.00 %**	**100.00 %**	**100.00 %**	**100.00 %**	**100.00 %**	**100.00 %**	**100.00 %**	**100.00 %**	**100.00 %**	**100.00 %**	**100.00 %**

Attachment C: 1115 SUD Demonstration Monitoring Report – Part B

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

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

2. Executive Summary

Per discussion with CMS, due to a delay in receiving updated technical specifications for the Monitoring Protocol metrics, the state will not be submitting a Monitoring Workbook this quarter. The state will resume reporting next quarter and will include the current quarter's results (if given sufficient time to incorporate updated technical specifications).

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

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
1.2 Assessment of Need and Qualification for SUD Services			
1.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.			
☒ The state has no metrics trends to report for this reporting topic.			
1.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) The target population(s) of the demonstration ☐ ii) The clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to assessment of need and qualification for SUD services			
☒ The state has no implementation update to report for this reporting topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
2.2 Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)			
2.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1			
☒ The state has no metrics trends to report for this reporting topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
2.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) Planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g. outpatient services, intensive outpatient services, medication assisted treatment, services in intensive residential and inpatient settings, medically supervised withdrawal management) ☐ ii) SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and medication assisted treatment services provided to individuals in IMDs			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 1			
☒ The state has no implementation update to report for this reporting topic.			
3.2 Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)			
3.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 2			
☐ The state has no trends to report for this reporting topic.			
☒ The state is not reporting metrics related to Milestone 2.			

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

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

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
5.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ Planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 4			
☒ The state has no implementation update to report for this reporting topic.			
6.2 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)			
6.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 5			
☒ The state has no trends to report for this reporting topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
6.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD ☐ ii) Expansion of coverage for and access to naloxone			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 5			
☒ The state has no implementation update to report for this reporting topic.			
7.2 Improved Care Coordination and Transitions between Levels of Care (Milestone 6)			
7.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 6	No trends to report for Follow-Up after Emergency Department Use for Alcohol or Other Drug Dependence or for Mental Illness (only one measurement year available).		
☒ The state has no trends to report for this reporting topic.			
7.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ Implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 6			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
☒ The state has no implementation update to report for this reporting topic.			
8.2 SUD Health Information Technology (Health IT)			
8.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its Health IT metrics			
☒ The state has no trends to report for this reporting topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
8.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) How health IT is being used to slow down the rate of growth of individuals identified with SUD ☐ ii) How health IT is being used to treat effectively individuals identified with SUD ☐ iii) How health IT is being used to effectively monitor "recovery" supports and services for individuals identified with SUD ☐ iv) Other aspects of the state's plan to develop the health IT infrastructure/capabilities at the state, delivery system, health plan/MCO, and individual provider levels ☐ v) Other aspects of the state's health IT implementation milestones ☐ vi) The timeline for achieving health IT implementation milestones ☐ vii) Planned activities to increase use and functionality of the state's prescription drug monitoring program			
☒ The state has no implementation update to report for this reporting topic.			
☒ The state expects to make other program changes that may affect metrics related to Health IT	*COVID-19 outbreaks have necessitated use of telemedicine and telehealth services.*		
☐ The state has no implementation update to report for this reporting topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
9.2 Other SUD-Related Metrics			
9.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to other SUD-related metrics			
☒ The state has no trends to report for this reporting topic.			
9.2.2 Implementation Update			
☐ The state expects to make other program changes that may affect metrics related to other SUD-related metrics			
☒ The state has no implementation update to report for this reporting topic.			
10.2 Budget Neutrality			
10.2.1 Current status and analysis			
☐ If the SUD component is part of a broader demonstration, the state should provide an analysis of the SUD-related budget neutrality and an analysis of budget neutrality as a whole. Describe the current status of budget neutrality and an analysis of the budget neutrality to date.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
10.2.2 Implementation Update			
☐ The state expects to make other program changes that may affect budget neutrality			
☒ The state has no implementation update to report for this reporting topic.			
11.1 SUD-Related Demonstration Operations and Policy			
11.1.1 Considerations			
☐ States should highlight significant SUD (or if broader demonstration, then SUD-related) demonstration operations or policy considerations that could positively or negatively affect beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.	*COVID-19 and related infection risk concerns are likely to impact how services are accessed and provided.* *Residential and face to face services will likely be depressed due to lockdown orders and social distancing protocols.*		
☐ The state has no related considerations to report for this reporting topic.			
11.1.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) How the delivery system operates under the demonstration (e.g. through the managed care system or fee for service) ☐ ii) Delivery models affecting demonstration participants (e.g. Accountable Care Organizations, Patient Centered Medical Homes) ☐ iii) Partners involved in service delivery			
☒ The state has no implementation update to report for this reporting topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
☐ The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state is working on other initiatives related to SUD or OUD			
☒ The state has no implementation update to report for this reporting topic.			
☐The initiatives described above are related to the SUD or OUD demonstration (States should note similarities and differences from the SUD demonstration)			
☒ The state has no implementation update to report for this reporting topic.			
12. SUD Demonstration Evaluation Update			
12.1. Narrative Information			
☐ Provide updates on SUD evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. See report template instructions for more details.			
☒ The state has no SUD demonstration evaluation update to report for this reporting topic.			
☐ Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.			
☒ The state has no SUD demonstration evaluation update to report for this reporting topic.			
☐ List anticipated evaluation-related deliverables related to this demonstration and their due dates.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
☐ The state has no SUD demonstration evaluation update to report for this reporting topic.			
13.1 Other Demonstration Reporting			
13.1.1 General Reporting Requirements			
☐ The state reports changes in its implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol			
☒ The state has no updates on general requirements to report for this reporting topic.			
☐ The state anticipates the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes			
☒ The state has no updates on general requirements to report for this reporting topic.			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) The schedule for completing and submitting monitoring reports ☐ ii) The content or completeness of submitted reports and/or future reports			
☒ The state has no updates on general requirements to report for this reporting topic.			
☐ The state identified real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation			
☒ The state has no updates on general requirements to report for this reporting topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
13.1.2 Post-Award Public Forum			
☐ If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual report.			
☒ No post-award public forum was held during this reporting period and this is not an annual report, so the state has no post-award public forum update to report for this topic.			
14.1 Notable State Achievements and/or Innovations			
14.1 Narrative Information			
☐ Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD (or if broader demonstration, then SUD related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.			
☒ The state has no notable achievements or innovations to report for this reporting topic.			

Attachment D: MAC and TSOA quality assurance questions

These questions are also available on the HCA website.

1. **PROGRESS NOTES (PROG) 1:** Is there documentation that the case manager discussed with the care receiver/client his/her choices of available programs, services, settings, and providers?
2. **PROGRESS NOTES (PROG) 2:** Is there documentation of care receiver/client choice of available programs/services, settings, and providers?
3. **PROGRESS NOTES (PROG) 3:** Were care receivers/clients free from the use of restraints or involuntary seclusions?
4. **PROGRESS NOTES (PROG) 4:** Was a professional, certified, or authorized interpreter used as per LTC Manual?
5. **FINANCIAL (FIN) 1:** Is the care receiver/client financially eligible for the services received?
6. **CARE PLAN (CP) 1:** If the care receiver/client is receiving respite services in an adult family home (AFH) or assisted living facility (ALF), does that facility have the specialty designation required to meet the needs of the care receiver/client?
7. **CARE PLAN (CP) 2:** Did the care receiver and caregiver agree to the Care Plan as outlined in the LTC Manual?
8. **CARE PLAN (CP) 3:** Were mandatory referrals made? (APS, CRU and CPS)
9. **CARE PLAN (CP) 4**: Was nursing facility level of care assessment completed within the annual time frame?
10. **CARE PLAN (CP) 5**: Was a change in condition care plan completed when appropriate?
11. **CARE PLAN (CP) 6**: Were the correct instruments and processes used to determine nursing facility level of care?
12. **CARE PLAN (CP) 7**: Did the care receiver/client receive information about the importance of the flu vaccine annually?
13. **AUTHORIZATION (AUTH) 1:** Was the GetCare care plan locked or TCARE care plan completed prior to start date of enrollment/service authorization?
14. **AUTHORIZATION (AUTH) 2:** Is there documentation (invoices, receipts, etc.) to support paid service authorization for services/items such as DME, care supplies, environmental modifications/minor home repairs, ramps, lift chair, and assistive/adaptive equipment?
15. **AUTHORIZATION (AUTH) 3:** Was the annual amount authorized within the care receiver's benefit level (Step 1, 2, or 3)?
16. **AUTHORIZATION (AUTH) 4:** Were waiver service claims paid to a qualified provider (non-IPs
17. **DOCUMENTATION (DOC) 1:** Is the 14-225 Acknowledgement of Services completed correctly and in the GetCare electronic file cabinet or DMS?
18. **DOCUMENTATION (DOC) 2:** Is the 16-172 Rights and Responsibility completed correctly and in the GetCare Electronic File Cabinet or DMS?
19. **DOCUMENTATION (DOC) 3:** Was the 14-443 Fin/Social Services Communication for MTD completed correctly and in the Barcode electronic client record (ECR)?
20. **DOCUMENTATION (DOC) 4:** Was the 15-492 Medicaid Transformation Demonstration Services Notice completed correctly and in the GetCare electronic file cabinet?