Washington State Medicaid Transformation Project (MTP) demonstration
Section 1115 Waiver Annual Report (DY4) / Quarterly Report (DY4 Q1)
Demonstration Year: 4 (January 1 to December 31, 2020)
Reporting Quarter: 1 (January 1 to March 31, 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 are targeted to improve the system's capacity to address local health priorities, deliver high-quality, cost-effective, and whole-person care, and create a sustainable link between clinical and community based services.

Over the five-year MTP period, Washington will:

- Integrate physical and behavioral health purchasing and services to provide whole-person care.
- Convert 90 percent of Medicaid provider payments to reward outcomes instead of volume of service.
- Support providers as they adopt new payment and care models.
- Improve health equity by implementing population health strategies.
- Provide targeted services to support the state's aging populations and address social determinants of health.
- 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 setting 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: January 1–March 31, 2020

This quarterly report summarizes MTP activities from the first quarter of 2020: January 1 through March 31. It details MTP implementation, including stakeholder education and engagement, planning and implementation, and development of policies and procedures.

On February 29, 2020, Washington State declared a state of emergency in response to COVID-19. This was followed by Governor Inslee's Stay Home, Stay Healthy order, which he announced on March 23, 2020. These actions, as well as other activities related to the pandemic response, affected much of Washington State's economy and health delivery system. All of MTP's initiatives were impacted by these activities, starting in mid-March.

Summary of quarter accomplishments

- After a rigorous independent assessment in Q1 2020, all nine ACHs demonstrated completion of milestones through the second half of 2019.
- The Tribal Coordinating Entity (the American Indian Health Commission of Washington State) submitted a report representing accomplishments and progress occurring in the second half of 2019 (DY3).
- The LTSS program served more than 6,800 clients as of March 27, 2020.
- The Research and Data Analysis Division (RDA) of the Washington State Department of Social and Health Services (DSHS) released a preliminary evaluation report on the FCS program. The report covers the first nine months of FCS implementation, from January to September 2018, and highlights promising results.
- HCA staff working on the SUD IMD waiver continued to support the provider community, including responding to issues that emerged due to COVID-19 and related concerns about residential treatment setting and telehealth. In addition, HCA staff explored potential services in isolation and quarantine settings.
- HCA moved quickly to respond to COVID-19 challenges, including the follow examples:
    - Submitted 1135, 1115, and MTP-related waiver requests to CMS.
    - Procured more than 2,000 Zoom for Healthcare licenses and is offering them free of charge to Medicaid physical and behavioral health providers for telehealth purposes.
    - Distributed several hundred loaner laptops to providers to help clients and providers stay connected through online appointments.
    - Distributed thousands of cell phones to Tribes, Medicaid clients, and individuals with behavioral health and long-term care needs.
    - Initiated rapid response calls to disseminate information and respond to emerging issues.
    - Issued regular guidance for providers related to telehealth service delivery and other COVID-19 developments.
    - HCA continues to convene and coordinate with an interagency workgroup regarding COVID-19 mitigation and recovery, stimulus funding, etc.

MTP-wide stakeholder engagement

To help people understand MTP, HCA created a one-pager during this reporting period. This publication describes MTP and its initiatives, and explains the waiver and how MTP is funded.

In February, HCA announced a promising preliminary report about the FCS program. HCA also continued to send out the Foundations newsletter, which is a monthly newsletter dedicated to Initiative 3. Currently, Foundations reaches more than 4,600 people, including subscribers interested in supportive housing, supported employment, and Tribal behavioral health providers.

Also in February, HCA released the Paying for Value surveys results. The Paying for Value surveys are two annual surveys, one sent to providers and one sent to plans (payers) that track progress toward the statewide goal of paying for value-based care, rather than volume of care. In both surveys, providers and payers noted progress on adopting value-based payment models.

To view all announcement and activities during this reporting period, please visit HCA's News page and Meetings and materials page.

Statewide activities and accountability

Value-based purchasing (VBP)

VBP Roadmap and Apple Health Appendix

The VBP Roadmap describes HCA's VBP goals, purchasing and delivery system transformation strategies, innovation successes to date, and the plans to accelerate the transition to value-based payment models. The appendix, as stipulated by the special terms and conditions (STCs), describes how MTP is supporting providers and MCOs to move along the value-based care continuum. The roadmap establishes targets for VBP attainment and related DSRIP incentives for MCOs and ACHs. In Q1, HCA continued sharing results from the 2019 MCO and ACH VBP achievement with ACHs.

Validation of financial performance measures

In DY1, HCA contracted with Myers and Stauffer LC to serve as the independent assessor (IA) for MTP. In this role, the IA assesses the financial measures data submitted by Managed Care Organizations (MCOs) as part of the MCO contracts with HCA. HCA's contracts with the five MCOs to establish parameters for the VBP assessment process. These parameters include the financial performance measures, the timelines under which MCOs must submit data, and the review process, which includes third-party validation.

The IA completed validation of statewide and regional financial measure data submitted by MCOs in DY3. HCA began preparing for the VBP validation process in Q1 of 2020, and scheduled check-ins with the IA for early Q4 to review "lessons learned" and begin preparations for the 2020 validation process. Next steps include updating the MCO templates and determining the sampling of provider contracts for each MCO.

Statewide progress toward VBP targets

According to 2017 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 VBP surveys to:

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

Responses were collected through August 31, 2019. During Q3, the state synthesized and analyzed results from the annual survey respondents. In Q4, a summary of key findings was made available to ACHs, stakeholders, and the public on the Paying for value page. In Q1 of 2020, HCA presented region-specific results from the survey to Olympic Community of Health, and has extended the offer to other ACHs.

Technical support and training

In Q1 of 2020, HCA continued efforts to develop a "VBP Toolkit" to serve as a collection of tools and resources available to providers. Included tools and resources serve a variety of purposes:

- Providing baseline education
- Developing necessary infrastructure and capabilities
- Creating roadmaps for practice transformation and payment reform adoption.

HCA distributed an updated toolkit to ACHs in Q1 of 2020 to support the provider community.

Upcoming activities

- HCA will work with the IA in continued preparation for the 2020 MCO VBP validation process.
- HCA will begin updating the health plan and provider Paying for Value Survey templates and prepare for the 2020 survey process.

Integrated managed care (IMC) progress

In 2014, the Legislature directed a transition to integrate the purchasing of physical 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 Q1.

- IMC went live in the final three regions, completing statewide implementation (Salish, Great Rivers, and Thurston-Mason regional service areas) on January 1, 2020 in alignment with statewide accountability expectations.
- Monitored IMC implementation in the 2020 go-live regions through participation in regional meetings and workgroups, regular check-in calls with each region, and data collected through each region's Early Warning System.
- Continued extensive stakeholder engagement with the regions implementing on January 1, 2020. This included participation in regional meetings and workgroups, development of IMC communications materials, and regular meetings with providers, MCOs, and behavioral health–administrative services organizations (BH-ASOs) to address IMC issues, concerns, and questions.
- Continued to monitor IMC implementation in the 2019 mid-adopter regions through regular participation in regional IMC workgroup meetings and through data collected for the North Sound regional Early Warning System.

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 (PDMP) enhancements
- Master Person Index (MPI)
- Provider directory
- Payment models and sources
- Data and Governance
- Health information exchange functionality
- Registries
- Adding clients to the Clinical Data Repository (CDR)
- Adding CDR users
- Adding CDR functions/quality
- Provider education
- Tribal engagement
- Behavioral health integration

During the first quarter of 2020, Washington State advanced its HIT Operational Plan through the following activities:

- HCA expanded its pre-existing telemedicine policies to cover telehealth services during the COVID-19 pandemic, and has held/participated in numerous webinars for providers and others. These webinars described telehealth services and how Medicaid will cover services using this technology.

- The State procured more than 2,000 Zoom for Healthcare licenses and is offering them free of charge to Medicaid physical and behavioral health providers to facilitate the use of telehealth services.
- HCA has distributed several hundred HCA-issued loaner laptops to providers to help clients and providers stay connected through online appointments.
- HCA has distributed thousands of phones donated by cell phone companies through the state Military Department to Tribes, fee-for-service Medicaid clients, and individuals with behavioral health and long-term care needs. The phones have 400 talk minutes and unlimited data (texting and internet).
- HCA is supporting the Behavioral Health Institute (BHI) to provide training and technical assistance to behavioral health providers and their use of telehealth.
- Began a project to develop requirements for a consent management system.
- Advanced the state's MPI work by selecting a project manager and releasing a request for proposals for an MPI expert vendor to develop a roadmap for implementation.
- Disseminated quarterly provider feedback reports related to opioid use and prescribing patterns.
- Incorporated the HIT tasks in the mental health IMD waiver application to support the requirements in that waiver. HCA was not successful in securing state matching funds from the Legislature needed to support implementation of these requirements. As a result, implementation of the HIT tasks in the mental health IMD waiver are contingent on securing funding.
- Engaged MCOs and state staff in a workgroup to advance time and distance standards for provider networks. Activities under this workgroup were temporarily halted due to the urgency to respond to COVID-19 pandemic.
- Engaged MCOs and state staff in a workgroup to incorporate HIT in care coordination efforts. Activities under this workgroup were temporarily halted due to the urgency to respond to COVID-19 pandemic.

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 on a semi-annual cadence, as outlined in the Project Toolkit. Semi-annual reports are submitted every six months. The fourth set of semi-annual reports described ACH progress on projects from July 1 through December 31, 2019.

The IA reviewed the projects, determined milestone completion, and related eligibility for incentives. After a rigorous independent assessment in Q1 2020, all nine ACHs demonstrated completion of milestones through the second half of 2019. All ACH regions earned incentive funds to continue their health transformation efforts.

Next steps

Implementation of project activities is underway across the state, although many ACHs are adjusting 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.

DSRIP midpoint assessment

The STCs require an independent, midpoint assessment of DSRIP to systematically identify recommendations for improving individual ACHs and implementation of their Project Plans. During Q1, the IA collected public input and subsequently issued the final midpoint assessment report. The report highlights areas that will benefit from further statewide coordination (e.g., workforce and health information exchange) and establishes that there is clear and convincing evidence of statewide progress on health system capacity building and delivery system reform.

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.

All nine ACHs demonstrated completion of VBP pay-for-reporting (P4R) milestones through the second half of 2019. In addition, each ACH achieved the 2018 (DY2) regional VBP target of 50 percent based on validated MCO VBP attainment. VBP P4R and pay-for-performance (P4P) incentive funds will be distributed in Q2 2020.

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 $21.1 million to 295 partnering providers and organizations in support of project planning and implementation activities. The state distributed approximately $1 million in earned incentive funds to Indian Health Care Providers (IHCPs) in Q1 for achievement of IHCP-specific project milestones.

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

HCA and the FE implemented a change that allows ACHs to accrue interest in the FE portal, and ACHs began accruing interest in August 2019. The decision to allow interest accrual was in response to requests made by ACHs, as well as recognition that a portion of ACH earned incentives are likely to stay in the FE portal for a period of time due to allocation timelines and contract terms with partnering providers. This quarterly report includes the amount of interest earned for each ACH to date.

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

Since the beginning of MTP, HCA has contracted with Providence Health & Services – Center for Outcomes Research and Education (CORE) to support measure production and visualization of health care transformation measures, in partnership with state measure producers. CORE was selected as HCA's vendor for this work based on their experience and expertise in this area. ACHs' input as key stakeholders resulted in the creation of the Healthier Washington Measures Dashboard. The measures available on the dashboard are used to define and track ACH progress on key elements.

The contract with CORE included a plan for HCA to develop the necessary capabilities to take on the measure production and visualization work from CORE. HCA is now at that point, and transition work initiated at the start of 2020. CORE will work collaboratively with HCA throughout this year to ensure a smooth transition, with HCA assuming CORE's duties in a phased approach.

Both HCA and CORE are vested with this transition being as seamless as possible for ACHs. All parties are committed to ongoing rigorous quality assurance and metric evaluation. A new dashboard will be built by HCA with stakeholder input, focusing initially on the DSRIP measures (also known as P4P measures).

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 RDA) 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 monitor questions about project P4R/P4P metrics, the 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 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. In mid-March, HCA changed the format of this call to be more responsive to the COVID-19 response activities happening in ACH regions and at the state level. HCA also implemented a weekly ACH email distribution, which contains specific 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.

On January 14, HCA held a webinar on the midpoint assessment of the ACHs. The purpose of the webinar was to share high-level findings of DSRIP efforts and explain the process for the midpoint assessment. In addition to the webinar, HCA also provided a public comment period for people to share input on the IA's draft report of their midpoint assessment. The final report is available on the HCA website.

HCA also created a one-pager that describes MTP and ACHs, and outlines what ACHs are working on.

DSRIP stakeholder concerns

Near the end of Q1, ACHs began escalating concerns regarding DSRIP reporting and performance expectations due to COVID-19 impacts. ACHs are working to pivot activities and/or postpone implementation where appropriate, and the state will continue to partner with ACHs to navigate competing priorities and planning ahead on COVID-19 recovery efforts.

Upcoming DSRIP activities

The state will continue to coordinate with CMS and ACHs to find an appropriate path forward during the COVID-19 pandemic. Many new challenges and opportunities are emerging, and it will be important to pivot activities where appropriate, and capitalize on new windows of opportunity that may emerge (i.e., sustainability of innovations that were accelerated during COVID-19). That state is also beginning one-on-one conversations with each ACH beginning in Q2. This will provide an opportunity to look toward sustainability of DSRIP activities while also considering the unique opportunities and innovations that have emerged during this time.

The state will work with the IA to issue modified semi-annual reporting guidance for the fifth reporting cycle to account for COVID-19 impacts and current capacity limitations.

Tribal project implementation activities

The Tribal Coordinating Entity (the American Indian Health Commission of Washington State) submitted a report representing accomplishments and progress occurring in the second half of 2019 (DY 3). This report drew down half of the IHCP-specific projects funds ($1,862,500) for 2019. With the funds in the FE portal, individual IHCPs could report on their metrics and funds could be distributed. More than $1,000,000 was distributed to IHCPs.

Tribal partner engagement timeline

- January 7: HCA's Office of Tribal Affairs (OTA) co-hosted a regional tribal coordination meeting, attended by HCA's managed care team, MCO tribal liaisons, BH-ASOs, and ACHs to better coordinate between the entities supporting health in the regional service area (RSAs).
- January 10: OTA hosted the ACH Tribal Liaison standing call.
- January 27: Northwest Portland Area Indian Health Board (NPAIHB) presented to the ACHs on the Community Health Aide Program.
- February 2: OTA distributed $60,080 in earned incentives to IHCPs.
- February 3: OTA participated in a meeting between NPAIHB and Heritage University (Yakama Nation) regarding establishing a Behavioral Health Aide program at Heritage.
- February 10: OTA co-hosted a regional tribal coordination meeting and attended the North Sound ACH Tribal Alignment Committee.
- February 13: OTA co-hosted a regional tribal coordination meeting.
- February 20: OTA participated in Better Health Together's Tribal Leadership Meeting.
- February 24: HCA held tribal consultation on the IMD portion of the 1115 waiver.
- March 5: Met with Olympic Community of Health regarding building relationships with Tribes sharing the region.
- March 17: OTA distributed $781,052 in earned incentives to IHCPs.
- March 31: OTA distributed $180,243 in earned incentives to IHCPs.

LTSS implementation accomplishments

This section summarizes LTSS program development and implementation activities from January 1 through March 31, 2020. Key accomplishments for this quarter include:

- Total number of clients served as of March 27, 2020 is more than 6,800.
- Home and Community Services Division and Area Agencies on Aging (AAA) have spent most of the quarter exploring how to manage intakes, assessments, and service delivery for clients and families during the constraints related to the COVID-19 pandemic.

Network adequacy for MAC and TSOA

AAAs continue to renew current provider contracts as well as executing new provider contracts for the purpose of maintaining and increasing the provider network. During the COVID-19 pandemic, the AAAs have been creative in finding ways of getting supplies to care providers and home delivered meal providers to keep contracted providers engaged with enrolled clients while still maintaining social distancing.

Assessment and systems update

During this quarter, the state continued the development of integrating GetCare, the primary client management system, and TCARE, the evidence-based caregiver assessment tool that streamlines the workflow for case managers by eliminating redundant data entry and allows more efficient data collection from each system.

Staff training

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

- January – Quality assurance process and audit questions review
- March – cancelled due to workload associated with COVID-19 pandemic
- New hires and supervisors attended TCARE process training throughout this quarter

Upcoming webinars include:

- May – review of mandatory forms/documents and their usage
- July – overview of roles (case manager, financial worker, intake, etc.) related to implementing MAC and TSOA

Data and reporting

Table 1: beneficiary enrollment by program

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of March 31, 2020	200	2,235	4,326
Number of new enrollees in quarter by program	28	310	562
Number of new person-centered service plans in quarter by program	6*	103**	223***
Number of beneficiaries self-directing services under employer authority	0	0	0

*19 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.
**165 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.
***318 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 and assist AAAs with compliance in timely completion of care plans for enrollees.

Outreach and engagement

Hospital outreach has continued at the local level for many AAAs. Additionally, in January, some AAAs placed an ad in their local movie theatres to promote caregiver programs, which has increased interest in the programs. AAAs have explored creative ways to conduct outreach activities promoting caregiver programs this quarter as a result of Governor Inslee's Stay Home, Stay Healthy order.

Table 2: outreach and engagement activities by AAA

	January	February	March
	Number of events held		
Community presentations and information sharing	23	47	8

Outreach activities occurred in a variety of settings, such as Community Resource Offices, hospital events, community resource fairs, hospital social worker meetings, MCO meetings, public library events, senior centers, and 55+ housing communities. The state also shared publications, sent out mailings, posted ads in local newspapers and on the radio, and held support groups, training and workshops for Q1.

Tribal engagement

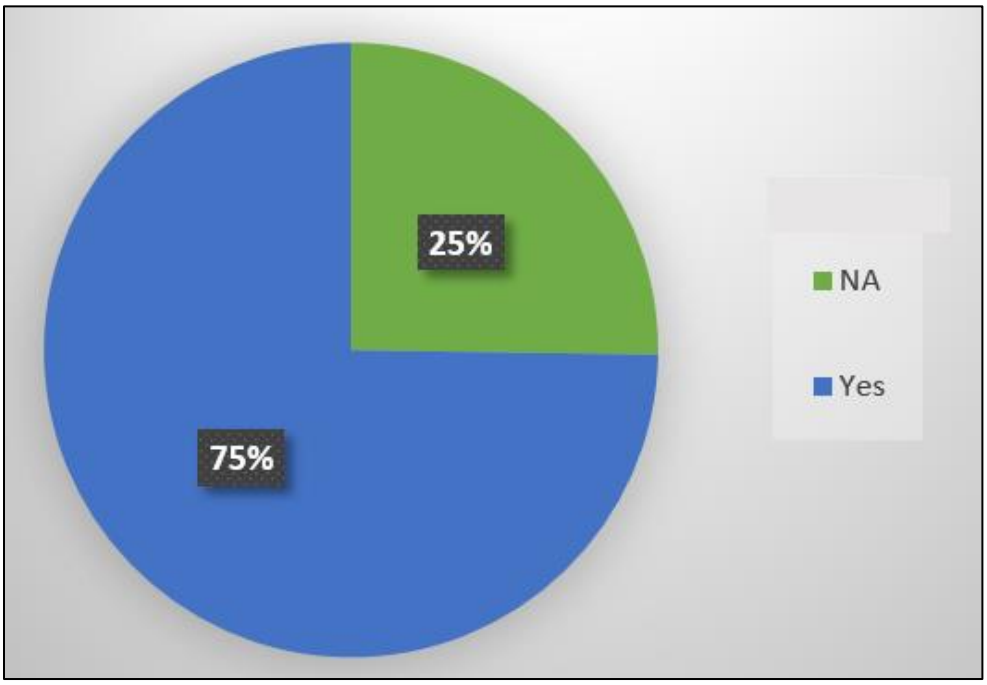
DSHS Aging and Long-Term Support Administration (ALTSA) met with a number of Tribes to discuss Medicaid services and Initiative 2 and 3 of MTP. Many of the conversations were focused on expanding tribal subject matter expertise in respite services and to increase tribal staff ability to assist with MAC/TSOA referrals. The Tribes contacted include Lummi Nation, Spokane Tribe of Indians, and Port Gamble S'Klallam Tribe. ALTSA also engaged with a number of Tribes in the 7.01 planning meetings to build tribal infrastructure and capacity for LTSS service delivery to tribal members.

Quality assurance

Presumptive eligibility review

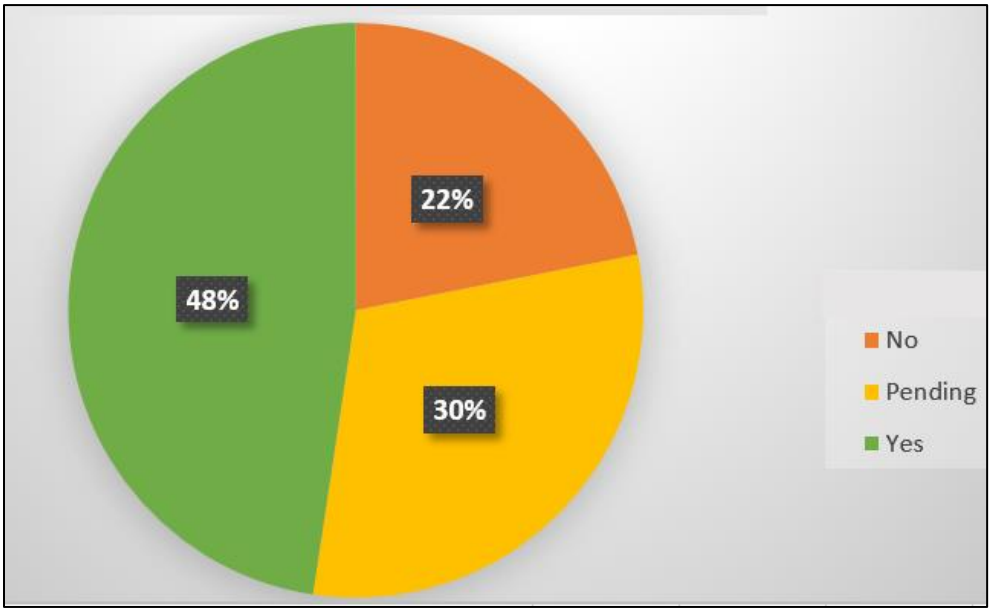
Below are the results of this quarter's review of presumptive eligibility (PE) decisions. The sample size is 100 percent of PE assessments during the quarter.

Table 3: Question 1: was the client appropriately determined to be nursing facility level of care eligible for PE?



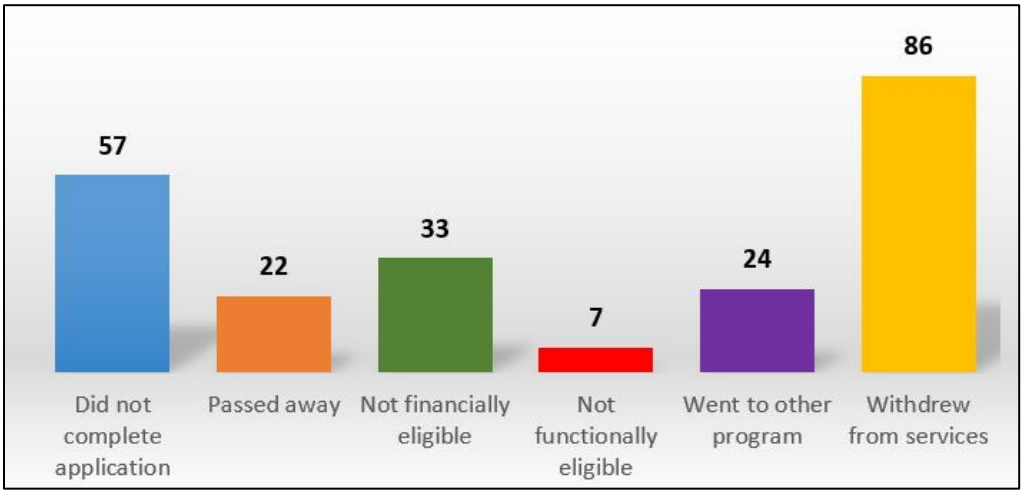
Note: the N/A represents clients who were part of the last quarter's review and the response to question #1 was "yes" but the response to question #2a was "pending".

Table 4: 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 5: Question 2b: if "No" to question #2a, why?



2020 quality assurance results to date

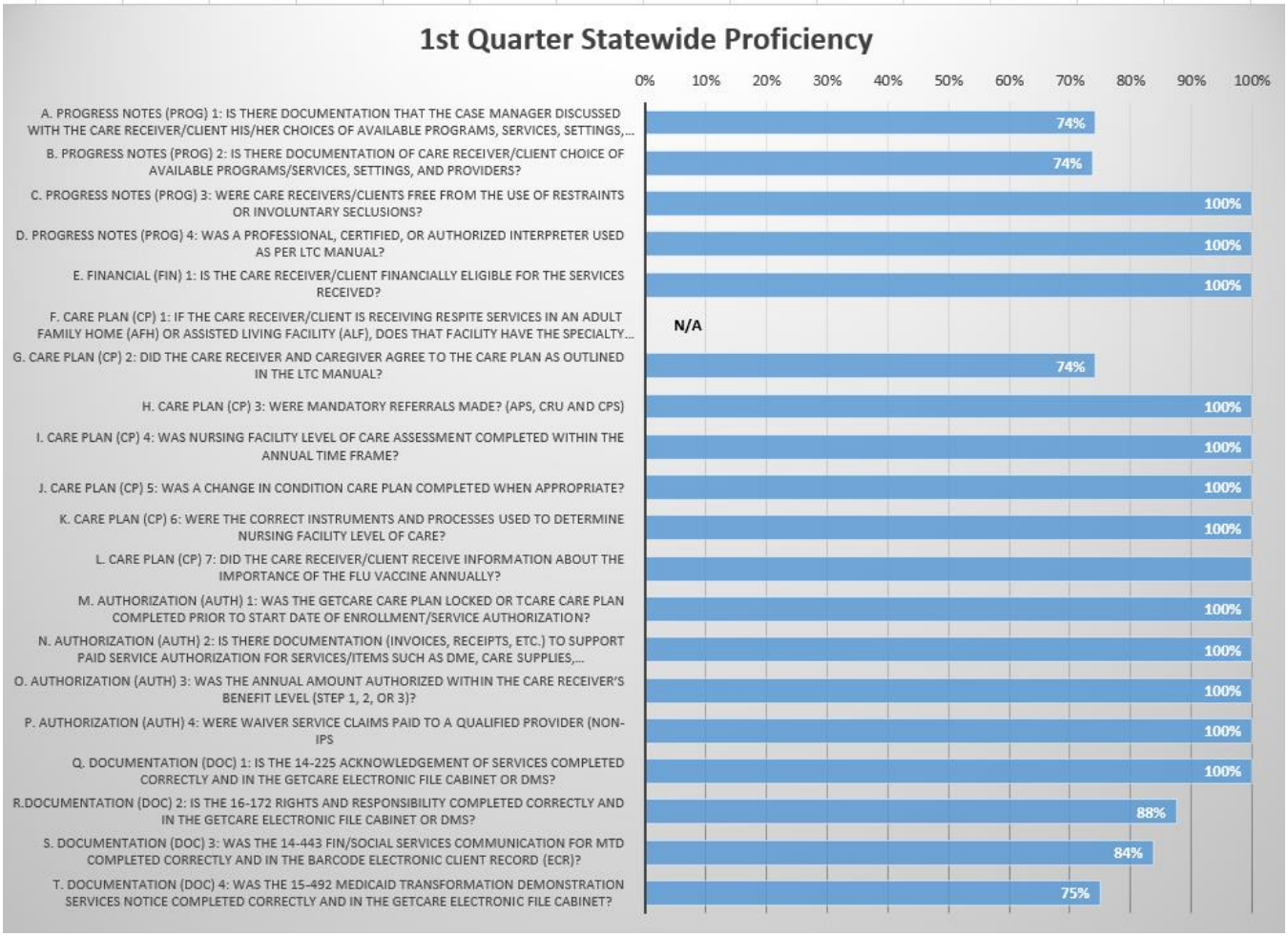
Home and Community Services' Quality Assurance unit began the 2020 audit cycle in January and will end in October. The statewide compliance review is conducted with all 13 AAAs. An identical review process is used in each AAA Planning and Service Area (PSA), using the same quality assurance tool and the same 19 questions. (See set of quality assurance questions below.) 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.

A statewide quality assurance webinar was conducted in early January to review the process and the 2020 quality assurance monitoring questions. The state's 2020 quality assurance cycle was paused as of March 25, 2020 due to COVID-19 impacts.

The comparison chart below reflects the statewide proficiency to date for each of the audit questions.

Table 6: statewide proficiency to date



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

State rulemaking

There was no rulemaking activity this quarter.

Upcoming activities

- Continue development and testing of TCARE process integration into GetCare system.
- Resume quality assurance activities when COVID-19 pandemic ends.

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 January 1 through March 31, 2020. Key accomplishments for Q1 quarter include:

- Total aggregate number of people enrolled in FCS services at the end of Q1:
  - CSS[1]: 4,073
  - IPS[2]: 3,713
- There were 148 providers under contract with Amerigroup at the end of the quarter, representing 421 sites throughout the state. Prior to the COVID-19 pandemic, the FCS provider network continued to grow and provide coverage over the entire state, with the exception of San Juan County.
- RDA released a preliminary evaluation report on the FCS program. The report covers the first nine months of FCS implementation, from January to September 2018. Key findings of the report include:
  - People enrolled in IPS services found employment at a higher rate, earned more money, and worked more hours.
  - CSS services helped people transition or begin to transition out of homelessness or housing instability.
  - There was promising reductions in emergency room visits and hospitalizations for people enrolled in CSS services.

Note: CSS and IPS enrollment totals include 1,038 participants enrolled in both programs. The total unduplicated number of enrollments at the end of this reporting period was 6,749.

Enrollment in CSS overtook enrollment in IPS for the first time. With the COVID-19 pandemic, this trend toward higher enrollment in CSS is likely to continue. In the first few weeks of the pandemic, IPS providers as a group appear more adversely affected than CSS providers.

Network adequacy for FCS

Table 7: FCS provider network development

	January		February		March	
FCS service type	Contracts	Service locations	Contracts	Service locations	Contracts	Service locations
Supported Employment – Individual Placement Support (IPS)	33	69	33	69	34	74
Community Support Services (CSS)	17	33	18	44	20	46
CSS and IPS	85	274	90	291	94	301
Total	**135**	**376**	**141**	**404**	**148**	**421**

The FCS provider network continued to expand in Q1, particularly with providers who deliver both CSS and IPS services.

As noted earlier in this report, Governor Inslee issued a Stay Home, Stay Healthy order in mid-March. FCS provides essential services to vulnerable populations, and so are not restricted under the order. However,

[1] Community Support Services (CSS) represents supportive housing.
[2] Supported Employment – Individual Placement Support (IPS) represents supported employment.

the practical impacts of the pandemic were immediate. Some providers decided to reduce or suspend FCS services by the end of March. As the next quarter begins, the state estimates that at least 40 percent of providers have reduced or suspended services, with IPS providers disproportionately impacted.

Given the number of small, non-traditional providers who participate in the FCS network, HCA is concerned that providers may determine FCS services are not viable during the pandemic and won't resume services as restrictions ease.

Consistent with federal guidance, HCA is supporting implementation of telehealth by our FCS providers. Initial steps include:

- Weekly provider calls, in which HCA updates providers on telehealth implementation and the response to COVID-19, and answers provider questions.
- A series of webinars introducing telehealth, followed by specific topics (deeper dives)
- HIPAA-compliant Zoom licenses.
- Loaner laptops for providers.
- Cell phones for FCS participants.

Within existing authority, HCA is assessing our capacity to temporarily increase payment rates for CSS and IPS services to maintain provider viability.

HCA is also requesting greater flexibility from CMS through the 1115 waiver amendment to tailor provider and client supports. Pending CMS approval, this may include capacity retention payments to FCS providers and flexible supportive resources for FCS participants.

Client enrollment

Table 8: FCS client enrollment

	January	February	March (preliminary)
Supported Employment – Individual Placement and Support (IPS)	2,428	2,659	2,675
Community Support Services (CSS)	2,729	2,962	3,036
CSS and IPS	953	1,008	1,038
Total aggregate enrollment	**6,110**	**6,629**	**6,749**

Data source: RDA administrative reports

Table 9: FCS client risk profile

		Meet HUD homeless criteria	Avg. PRISM risk score (preliminary)	Serious mental illness
January	IPS	487 (14%)	.94	2,593 (77%)
	CSS	925 (25%)	1.45	2,666 (72%)
February	IPS	525 (14%)	.95	2,790 (76%)
	CSS	1,007 (25%)	1.44	2,860 ((72%)
March	IPS	538 (14%)	.95	2,847 (77&)
	CSS	1,071 (26%)	1.43	2,946 (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.
Note: RDA reports that PRISM risk scores for this quarter are preliminary and will be revised.
Data source: RDA administrative reports

Table 10: FCS client risk profile continued

		Medicaid only enrollees*	MH treatment need	SUD treatment need	Co-occurring MH + SUD treatment need flags
January	IPS	2,872	2,735 (95%)	1,671 (58%)	1,610 (56%)
	CSS	3,013	2,855 (95%)	2,334 (71%)	2,228 (74%)
February	IPS	3,126	2,945 (94%)	1,799 (58%)	1,712 (55%)
	CSS	3,266	3,071 (94%)	2,508 (77%)	2,376 (73%)
March	IPS	3,160	2,967 (94%)	1,798 (57%)	1,708 (54%)
	CSS	3,353	3,133 (93%)	2,550 (76%)	2,401 (72%)

MH = mental health
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 (MH) services	SUD services (received in last 12 months)	Care + MH or SUD services
January	IPS	2,872	276 (10%)	2,292 (80%)	921 (32%)	238 (8%)
	CSS	3,013	412 (14%)	2,185 (73%)	1,245 (41%)	344 (11%)
February	IPS	3,126	302 (10%)	2,421 (77%)	956 (31%)	256 (8%)
	CSS	3,266	437 (13%)	2,290 (70%)	1,291 (40%)	357 (11%)
March	IPS	3,160	308 (10%)	2,405 (76%)	921 (29%)	256 (8%)
	CSS	3,353	446 (13%)	2,284 (68%)	1,263 (38%)	359 (11%)

(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
January	IPS	951 (28%)	77 (2%)	388 (11%)	391 (12%)	84 (2%)
	CSS	1,333 (36%)	227 (6%)	414 (11%)	580 (16%)	20 (1%)
February	IPS	1,041 (28%)	82 (2%)	419 (11%)	410 (11%)	93 (3%)
	CSS	1,438 (36%)	241 (6%)	449 (11%)	603 (15%)	26 (1%)
March	IPS	1,069 (29%)	86 (2%)	420 (11%)	415 (11%)	92 (2%)
	CSS	1,494 (37%)	248 (6%)	457 (11%)	605 15%)	26 (1%)

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

Quality assurance and monitoring activity

RDA completed its first substantive evaluation of the FCS program, with results publicly shared during this reporting period. **"The Foundational Community Supports Program: Preliminary Evaluation Findings"** compares outcomes for FCS enrollees during the first nine months of the program (Jan-Sept 2018) for several key measures to outcomes for a similar population of Medicaid participants not enrolled in FCS. The report and graphs are available on the HCA site. For this nine-month period, RDA reports the following key findings:

IPS key findings

- Uniformly positive impacts on employment, earnings, and hours for both HCA and ALTSA populations.
- Magnitude of employment effects are relatively modest.
- No statistically significant impacts on emergency department (ED) or inpatient (IP) services utilization.

CSS key findings

- Significant or promising positive impacts on transitions out of homelessness for both HCA and ALTSA populations.
- Promising reductions in ED utilization and IP utilization for the non-ALTSA population.
- No positive impact on ED, IP, or nursing facility utilization for ALTSA clients.

The state finds these initial results encouraging and note at least two factors that may indicate even stronger positive findings in future evaluations:

- First, the report evaluates "enrolled" participants, rather than "engaged." About 30 percent of enrolled participants didn't actually receive a service during this period.
- Second, the report evaluates impact during a period when many providers were new to IPS and CSS, and fidelity to these evidenced-based practices was probably not rigorous.

RDA anticipates completing a second evaluation that includes the next six months of service (October 2018–March 2019) and separate outcomes for "engaged" participants. That evaluation will likely be completed this summer.

Washington's MTP independent external evaluator, Oregon Health and Science University's Center for Health Systems Effectiveness (CHSE) also released a baseline report on MTP. CHSE identified Initiative 3 (FCS) providing services to help the most vulnerable Medicaid members gain and keep housing and employment. Its goals include improving social outcomes linked to health, improving health care quality, and reducing health care spending.

- Enrollment in CSS and IPS increased steadily in the program's first two years.
- A lack of FCS service providers in rural areas and a lack of affordable housing across the state presents challenges for the program.
- Although FCS services could potentially be used to support ACH health improvement projects, most ACHs were unaware of opportunities to connect the initiatives.

Other FCS program activity

HCA's Division of Behavioral Health and Recovery's continuous quality improvement approach to implementing the evidence-based practices of Permanent Supportive Housing (PSH) and Individual Placement and Support (IPS) included a number of fidelity reviews of contracted FCS providers as outlined below.

2019 fidelity reviews

- Eighteen fidelity reviews were held in 2019: nine permanent CSS fidelity reviews and nine IPS fidelity reviews.
    - Some highlights of the PSH fidelity reviews include an average score of 20.5 out of 28. Most common recommendations were focusing on forming strong relationships with local landlords and creating policies and procedures that outlined how to provide participant choice and separation of roles.
    - Highlights of the IPS/Supported Employment fidelity reviews include an average score of 92 out of 125. A sampling of recommendations include how to better document follow-up supports and how to ensure services are individualized.

2020 fidelity reviews

HCA plans to hold 21 new baseline fidelity reviews and 17 follow-up reviews (agencies that had a baseline review last year).

FCS trainers have created virtual fidelity reviews during the COVID-19 pandemic. The first reviews are happening now and the trainers will use the information gathered from these first reviews to continually improve how the state provides virtual fidelity reviews.

Upcoming activities

- DBHR will hold a webinar focused on delivering recovery supports services via telehealth on April 4, 2020, to give guidance to providers during the COVID-19 pandemic.
- HCA staff will meet with internal stakeholders to identify how to expand FCS services to more Tribal partners.
- DBHR started and will continue to hold weekly calls with providers during the COVID-19 pandemic for information and support.
- HCA, ALTSA, and Amerigroup will hold a call with all FCS providers to give guidance and information on our response to the COVID-19 pandemic.
- HCA staff will be holding online fidelity reviewers trainings on April 28 and 29, 2020.

HCA will release a request for applications that will incentivize SUD providers to start providing IPS services under the FCS program.

FCS program stakeholder engagement activities

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

Table 13: FCS program stakeholder engagement activities

	January	February	March
	Number of events held		
Training and assistance provided to individual organizations	48	45	50
Community and regional presentations and training events	10	11	8
Informational webinars	6	3	5
Stakeholder engagement meetings	8	18	6
Total activities	**72**	**77**	**69**

Training and assistance activities to individual organizations continued to increase this quarter.

Webinars are intended to inform, educate, and coordinate resources for FCS providers serving people who need housing and employment services, resources, and supports. Q1 topics included:

- Creating and maintaining personal and professional boundaries
- Supervisor training
- Landlord outreach- intimate relationships in supportive housing
- Golden thread series: assessments
- Landlord mitigation
- Criminal backgrounds and housing
- Dependable strengths – assessment tool
- Golden thread series: progress notes
- What to disclose to landlords
- Job development and time management

With the onset of the COVID-19 pandemic and Governor Inslee's Stay Home, Stay Healthy order, HCA, ALTSA, and Amerigroup shifted all technical assistance and stakeholder engagement activities to a virtual format. HCA started providing technical assistance to providers focused on delivering FCS services via telehealth.

FCS stakeholder concerns

Amerigroup reported no provider grievances or appeals during the quarter. One provider terminated its FCS contract during the quarter.

Some providers continue to report frustration with initial claims denials by Amerigroup. HCA is working with Amerigroup, providers, and our own internal systems to reduce initial denials. Accepted claims appear to be consistently paid by Amerigroup within contract parameters.

As noted, a substantial number of providers are now reporting severe financial distress related to the COVID-19 pandemic. HCA is working with these providers in the ways described above.

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 January 1 through March 31, 2020. Activities for the quarter include:

- The COVID-19 pandemic has impacted the SUD treatment system this quarter, including:
    - An outbreak of cases in a long-term care facility in Kirkland, Washington that brought national attention to safety issues in residential settings.
    - From the beginning of March, providers were dealing with a new reality due to concerns over containing and managing the spread of COVID.
- Providers are now trying to figure out and address:
    - Concerns over spread in residential treatment facilities.
    - Measures to provide services via telehealth.
    - How to provide services to patients in isolation and quarantine settings.
    - Impacts to medications for opioid use disorder (MOUD) and Opiate Substitution Treatment (OST) programs.

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 on-site or facilitate access offsite.
    - **Update:** implementation of Washington Administrative Code (WAC) changes is on schedule. While Department of Health (DOH) has been busy responding as the lead agency to the COVID-19 pandemic, they assure us their rulemaking continues and emergency WAC updates will be in place by July 1, 2020.

- **Milestone 6:** the state will require residential and outpatient providers to improve coordination between levels of care. A sub-workgroup was formed and meets regularly. HCA expects to have the requirement in the July 1, 2020, managed care contracts.
    - **Update:** MCO contracts for January 2020 are now in effect with this requirement. While HCA believes WAC language currently meets this milestone, DOH staff will also factor these expectations into current rulemaking projects.

SUD HIT plan requirements

HCA continues to coordinate internally and with DOH to support implementation of the HIT Plan requirements related to the Prescription Drug Monitoring Program (PDMP) and related requirements using funds made available through the Partnership Act/SUPPORT Act.

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 in the state. Activities include gathering and analyzing information about the current state of SUD treatment and recovery services, and gaps and barriers that need to be addressed to enhance SUD treatment and recovery services in Washington State.

Information collection activities include gathering information through surveys, subject matter expert interviews, and focus group discussions on how HIT and EHRs are used and how to strengthen the HIT infrastructure for care coordination and analytics.

Evaluation design

There were no updates during this reporting period.

Monitoring protocol

There were no updates during this reporting period.

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					$2,572,393
Cascade Pacific Action Alliance	$4,677,079					$2,338,540
Elevate Health	$6,547,910					$3,273,955
Greater Columbia	$10,289,572					$5,144,786
HealthierHere	$2,338,539					$1,169,270
North Central	$7,015,618					$3,507,809
North Sound	$1,870,831					$935,416
Olympic Community of Health	$5,612,494					$2,806,247
SWACH	$3,273,955					$1,636,978
Indian Health Care Providers	$1,862,500					$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				$2,323,728
Medicaid Alternative Care (MAC)	$56,452				$56,452
MAC and TSOA not eligible	$465				$465
FCS	$2,637,290				$2,637,290

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. November 2019 and March 2020 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 non-disabled	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	8	51	142	36
Nov-19	358,773	7	37	97	36
Dec-19	358,586	6	34	121	34

Jan-20	358,746	2	31	83	27
Feb-20	357,791	3	28	60	25
Mac-20	357,664	0	0	0	0
Total	14,271,553	99	428	1245	545

Budget neutrality

HCA adopted CMS's budget neutrality monitoring tool and has been using a Performance Management Database and Analytics system to upload quarterly spreadsheets. On March 20, 2020, HCA received approval of Washington State's budget neutrality corrective action plan related to unanticipated Medicaid LTSS wage increases in recent years.

Note: these wage increases did not come from Initiative 2 of MTP, also called LTSS, but from long-term services and supports that are part of the overall Medicaid program.

The approved corrective action plan resolves the projected budget neutrality exceedance. The prior projected exceedance was not a result of MTP spending or Medicaid-related policies, but was related to significant cost drivers in the state's Medicaid LTSS costs over the last several years. The increase in costs are related to state and city minimum wage laws, collective bargaining agreements with individual providers and adult family homes, and U.S. Department of Labor's home care overtime rule. The approved plan includes two main components:

- **Adjustment to the budget neutrality methodology,** which address the unexpected Medicaid LTSS cost increases by removing these costs from the baseline calculation.
- **Programmatic reductions**, which will limit Initiatives 2 and 3 in expanding some services in the final years of MTP.

Designated state health programs

No updates to report.

Overall MTP development and issues

Operational/policy issues

Implementation activities are underway for all initiatives. There are no significant operational or policy issues to report for this quarter, with the exception of the context provided throughout this report related to COVID-19.

Consumer issues

The state has not experienced any major consumer issues for DSRIP, FCS, LTSS, or the SUD IMD waiver during this reporting quarter, other than general inquiries about benefits available through MTP.

MTP evaluation

The MTP independent external evaluator, CHSE, continued its active engagement. During this reporting period, key activities included the following:

- **Submission of a revised sixth Rapid-Cycle Monitoring Report** on April 13, 2020.This report highlighted key findings for the first three ACHs where site visits and and key informant interviews were completed in 2019. Several technical errors were identified in those highlights. CHSE worked directly with leadership from all three of those ACHs to correct the errors and submitted a revised report. The final report (from December 31, 2019, but revised in April)) is now available on the HCA website.

- **Delivery of a draft Baseline Report on March 31, 2020**, in compliance with contracted timeline. This report describes the performance of Washington's health system and readiness for transformation as of 2019. It includes a narrative report and quantitative data appendix. The report was distributed to executive leads for all MTP initiatives. HCA's contract manger will coordinate with CHSE on any feedback received from initiative leads.

  CHSE will submit the final report on May 29, 2020, which will be accompanied by brief and detailed case summaries for all nine ACHs. A copy of the final report and description of follow-up activities will be included in the next quarterly report.

- **The seventh Rapid-Cycle Monitoring Report** was delivered on a slightly delayed schedule (negotiated by HCA and CHSE) because of COVID-19. The report was delivered on April 17, 2020, and notes the following activities in the January 1-March 31, 2021 reporting period:
  - Foundational activities for future analysis and data synthesis continued.
  - CHSE finalized data analysis, data visualizations, and narrative for the Baseline Report.
  - Case summary checking began on the individual ACH case summaries for feedback on factual aspects of the summaries, that will be delivered with the final Baseline report.
  - CHSE developed a plan for sampling primary care practices and hospitals across Washington for participation in qualitative interviews.
  - Qualitative and quantitative teams met to maximize coordination across those two disciplines and research questions.

  The report includes a detailed description of provider organization interview sample selection and the CHSE iterative sampling strategy. The next monitoring report will be available on the Medicaid Transformation resources page in April 2020.

Summary of additional resources, enclosures, and attachments

Additional resources

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

Summary of attachments

- Attachment A: State contacts
- Attachment B: Financial Executor Portal Dashboard, Q1 2020
- Attachment C: 1115 SUD Demonstration Monitoring Workbook – Part A
- Attachment D: 1115 SUD Demonstration Monitoring Report – Part B
- Attachment E: 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	360-725-0868
DSRIP program	Chase Napier	Manager, Medicaid Transformation	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	360-725-0487
SUD IMD waiver	David Johnson	Federal Programs Manager, DBHR	360-725-9404

For mail delivery, please use the following address:

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

Attachment B: Financial Executor Portal Dashboard, Q1 2020

This table shows all funds earned and distributed through the FE portal through March 31, 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	$204,504,273.88	$23,169,745.48	$16,549,815.96	$25,276,083.84	$34,144,889.27	$53,656,251.35	$7,555,352.96	$20,852,769.31	$8,554,981.79	$14,744,383.92	$0.00
2B: community based care coordination	$74,351,853.55	$15,929,199.60	$11,378,000.57	$17,377,307.74	$0.00	$0.00	$5,194,303.48	$14,336,278.14	$0.00	$10,136,764.02	$0.00
2C: transitional care	$53,933,375.26	$0.00	$6,723,364.25	$0.00	$13,871,360.13	$21,797,851.35	$3,069,360.88	$8,471,438.65	$0.00	$0.00	$0.00
2D: diversion interventions	$15,016,262.08	$0.00	$0.00	$0.00	$0.00	$0.00	$3,069,360.88	$8,471,438.65	$3,475,462.55	$0.00	$0.00
3A: addressing the opioid use public health crisis	$25,563,036.50	$2,896,219.29	$2,068,727.92	$3,159,511.31	$4,268,110.27	$6,707,031.57	$944,419.27	$2,606,596.66	$1,069,373.02	$1,843,047.19	$0.00
3B: reproductive and maternal/child health	$7,180,870.25	$0.00	2,585,909.40	$0.00	$0.00	$0.00	$0.00	$3,258,245.33	$1,336,715.52	$0.00	$0.00
3C: access to oral health services	$2,756,976.51	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,954,946.00	$802,030.51	$0.00	$0.00
3D: chronic disease prevention and control	$51,126,066.99	$5,792,434.58	$4,137,453.84	$6,319,021.64	$8,536,221.54	$13,414,063.13	$1,888,837.54	$5,213,193.32	$2,138,746.03	$3,686,095.37	$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	$2,700,000.00	$300,000.00	$300,000.00	$300,000.00	$300,000.00	$300,000.00	$300,000.00	$300,000.00	$300,000.00	$300,000.00	$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	$866,467.22	$90,187.31	$41,358.22	$74,940.46	$144,747.19	$270,219.73	$61,490.81	$82,041.45	$11,164.17	$90,317.88	$0.00
TOTAL	$527,123,323.24	$56,479,658.26	$45,240,472.16	$61,828,652.99	$71,449,244.40	$111,034,209.13	$29,320,947.82	$78,319,158.51	$19,144,315.59	$39,602,664.38	$14,704,000.00
Funds distributed by ACH											
Administration	$23,828,531.26	$1,672,118.25	$335,891.00	$3,900,000.00	$2,181,786.00	$6,117,865.95	$0.00	$8,356,788.69	$14,081.37	$1,250,000.00	$0.00
Community health fund	$19,988,051.95	$2,929,314.40	$2,358,557.00	$4,000,000.00	$1,469,550.51	$0.00	$10,082.10	$8,620,547.94	$0.00	$600,000.00	$0.00
Health systems and community capacity building	$35,174,376.81	$7,428,451.00	$1,428,507.91	$6,578,095.00	$4,560,267.17	$946,220.34	$1,653,144.91	$9,903,023.84	$110,000.00	$2,016,666.64	$550,000.00
Integration incentives	$20,432,940.55	$2,930,000.00	$0.00	$4,871,933.00	$7,191,840.89	$4,742,425.00	$58,421.66	$553,320.00	$0.00	$85,000.00	$0.00
Project management	$6,636,687.03	$0.00	$1,903,385.00	$0.00	$890,500.00	$0.00	$653,483.86	$2,868,318.17	$196,000.00	$125,000.00	$0.00
Provider engagement, participation, and implementation	$87,783,189.31	$10,049,421.99	$7,564,164.00	$3,895,200.00	$7,463,848.00	$11,858,815.00	$3,107,397.49	$20,482,458.72	$9,226,209.11	$1,700,000.00	$12,435,675.00
Provider performance and quality incentives	$31,374,640.71	$0.00	$6,328,350.00	$10,405,952.80	$1,963,505.00	$5,343,517.17	$1,778,481.74	$0.00	$0.00	$5,554,834.00	$0.00
Reserve/contingency fund	$3,194,098.00	$0.00	$1,474,098.00	$0.00	$0.00	$0.00	$0.00	$1,720,000.00	$0.00	$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	**$344,649,836.62**	**$37,795,410.14**	**$33,016,685.91**	**$47,599,658.30**	**$41,994,523.57**	**$54,581,053.96**	**$13,072,876.76**	**$69,940,055.86**	**$14,195,783.48**	**$19,468,113.64**	**$12,985,675.00**
Total funds distributed to date	$344,649,836.62	$37,795,410.14	$33,016,685.91	$47,599,658.30	$41,994,523.57	$54,581,053.96	$13,072,876.76	$69,940,055.86	$14,195,783.48	$19,468,113.64	$12,985,675.00
Total funds available for distribution	$182,473,486.62	$18,684,248.12	$12,223,786.25	$14,228,994.69	$29,454,720.83	$56,453,155.17	$16,248,071.06	$8,379,102.65	$4,948,532.11	$20,134,550.74	$1,718,325.00

% of total funds distributed	**65.38 %**	**66.92 %**	**72.98 %**	**76.99 %**	**58.78 %**	**49.16 %**	**44.59 %**	**89.30 %**	**74.15 %**	**49.16 %**	**88.31 %**
Administration	6.91 %	4.42 %	1.02 %	8.19 %	5.20 %	11.21 %	0.00 %	11.95 %	0.10 %	6.42 %	0.00 %
Community health fund	5.80 %	7.75 %	7.14 %	8.40 %	3.50 %	0.00 %	0.08 %	12.33 %	0.00 %	3.08 %	0.00 %
Health systems and community capacity building	10.21 %	19.65 %	4.33 %	13.82 %	10.86 %	1.73 %	12.65 %	14.16 %	0.77 %	10.36 %	4.24 %
Integration incentives	5.93 %	7.75 %	0.00 %	10.24 %	17.13 %	8.69 %	0.45 %	0.79 %	0.00 %	0.44 %	0.00 %
Project management	1.93 %	0.00 %	5.76 %		2.12 %	0.00 %	5.00 %	4.10 %	1.38 %	0.64 %	0.00 %
Provider engagement, participation, and implementation	25.47 %	26.59 %	22.91 %	8.18 %	17.77 %	21.73 %	23.77 %	29.29 %	64.99 %	8.73 %	95.76 %
Provider performance and quality incentives	9.10 %	0.00 %	19.17 %	21.86 %	4.68 %	9.79 %	13.60 %	0.00 %	0.00 %	28.53 %	0.00 %
Reserve/contingency fund	0.93 %	0.00 %	4.46 %	0.00 %	0.00 %	0.00 %	0.00 %	2.46 %	0.00 %		0.00 %
Shared domain 1 incentives	33.73 %	33.83 %	35.21 %	29.30 %	38.75 %	46.85 %	44.46 %	24.93 %	32.75 %	41.79 %	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 Workbook – Part A

This is the second workbook submitted as part of the CMS approved SUD Monitoring Protocol. This workbook contains historical reporting on the baseline reporting period (07/01/2017–06/30/2018) through the first year of waiver implementation (07/01/2018–06/30/2019). Per CMS' instructions, a separate tab was created for each quarter of reporting (see table below).

Table 17: tabs for each quarter of reporting

Tab Name	Type of reporting for SUD IMD waiver	Calendar dates for reporting period	CMS-constructed monthly metric measurement periods	CMS-constructed annual metric measurement periods	Established quality metric measurement periods
Report - metrics reporting	Current waiver reporting period	01/01/2020 03/31/2020	07/01/2019 – 09/30/2019	07/01/2018 – 06/30/2019	N/A
Report - metrics reporting - A	Baseline reporting period	01/01/2018 – 03/31/2018	07/01/2017 – 09/30/2017	N/A	N/A
Report - metrics reporting - B	Baseline reporting period	04/01/2018 – 06/30/2018	10/01/2017 – 12/31/2017	N/A	01/01/2017 – 12/31/2017*
Report - metrics reporting - C	Baseline reporting period	07/01/2018 – 09/30/2018	01/01/2018 – 03/31/2018	N/A	N/A
Report - metrics reporting - D	Baseline reporting period	10/01/2018 – 12/31/2018	04/01/2018 – 06/30/2018	07/01/2017 – 06/30/2018	N/A
Report - metrics reporting - E	Waiver reporting period	01/01/2019 – 03/31/2019	07/01/2018 – 09/30/2018	N/A	N/A
Report - metrics reporting - F	Waiver reporting period	04/01/2019 – 06/30/2019	10/01/2018 – 12/31/2018	N/A	01/01/2018 – 12/31/2018
Report- metrics reporting - G	Waiver reporting period	07/01/2019 – 09/30/2019	01/01/2019 – 03/31/2019	N/A	N/A

*Some established quality metrics not reported for the CY2017 at this time.

NOTE: The full workbook will be submitted as a separate attachment to CMS. A public workbook (which does not contain the full workbook) is available on the HCA website.

Attachment D: 1115 SUD Demonstration Monitoring Report – Part B

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

State	*Washington State*
Demonstration name	*Washington State Medicaid Transformation Project No. 11-W-00304/0*
Approval date for demonstration	*January 9, 2017*
Approval period for SUD	*July 1, 2018-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

Trends remained largely stable.

Emergency department utilization for persons with a diagnosis of opiate use disorder continues on a downward trend.

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

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
1.2 Assessment of Need and Qualification for SUD Services			
1.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.	The number of Medicaid beneficiaries with a substance use disorder was stable with with no changes greater than 2% from the prior quarter	7/1/2019-9/30/2019	#3: Medicaid beneficiaries with SUD diagnosis (monthly)
☐ 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	Overall the number of Medicaid beneficiaries with an SUD diagnosis who received any form of SUD treatment in a given month remained stable compared with the prior quarter..	07/01/2019-09/30/2019	#6: Any SUD Treatment
	The number of SBIRT screenings dropped slightly from the previous quarter.	07/01/2019-09/30/2019	#7: Early Intervention
	The number of Medicaid beneficiaries who received an outpatient SUD services increased slightly. The proportion of outpatient service use among Medicaid beneficiaries in the various subpopulations (age breakouts, dually eligible for Medicaid/Medicare, pregnant, involved in the criminal justice system) remained stable with a slight drop in the number of youth. However, the proportion of outpatient service utilization among Medicaid beneficiaries with an OUD diagnosis rose by approximately 2% in the most recent month reported.	07/01/2019-09/30/2019	#8: Outpatient Services
	The absolute number of Medicaid beneficiaries who received a residential or inpatient service remained stable from the initial baseline month (July 2017) to the most recently reported month (September 2019). The proportion of service utilization among most subpopulations fluctuates from one month to the next, but overall remains consistent.	07/01/2019-09/30/2019	#10: Residential and Inpatient Services
	Use of withdrawal management services increased from the initial baseline month (July 2017) through December 2018 and decreased in use since then to levels consistent with the initial baseline month.	07/01/2019-09/30/2019	#11: Withdrawal Management
	The use of medication assisted treatment (MAT) steadily increased from the initial baseline month (July 2017) to the most recently reported month (September 2019). This is largely driven by the increased in the number of Medicaid beneficiaries with opioid use disorder utilizing MAT.	07/01/2019-09/30/2019	#12: Medication Assisted Treatment
☐ 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			
☒ 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	Overall, the rate of emergency department utilization for SUD in WA remained relatively stable from July 2017 through September 2019. However, the rate for persons with a diagnosis of OUD continues a downward trend over the same time.	07/01/2019-09/30/2019	#23: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries
	Overall, the rate of inpatient stays for SUD in WA increased slightly from July 2017 to September 2019. However, the rates for persons with a diagnosis of OUD appear to be on a downward trend over the same time.	07/01/2019-09/30/2019	#24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries
☐ 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.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
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.			
10.2.2 Implementation Update			
☐ The state expects to make other program changes that may affect budget neutrality			
☒ The state has no implementation update to report for this reporting topic.			
11.1 SUD-Related Demonstration Operations and Policy			
11.1.1 Considerations			
☒ States should highlight significant SUD (or if broader demonstration, then SUD-related) demonstration operations or policy considerations that could positively or negatively affect beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.	*The Coronavirus pandemic manifested in Washington starting this quarter. The impacts are difficult to gauge given data lags, however, concerns over COVID-19 will have an impact on all parts of the SUD service continuum. Infection control protocols necessitated by COVID-19 will result in services moving to telehealth whenever possible. Inpatient and residential settings will also be impacted by unit configuration, social distancing, and PPE availability.*		
☒ The state has no related considerations to report for this reporting topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
11.1.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) How the delivery system operates under the demonstration (e.g. through the managed care system or fee for service) ☐ ii) Delivery models affecting demonstration participants (e.g. Accountable Care Organizations, Patient Centered Medical Homes) ☐ iii) Partners involved in service delivery			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state is working on other initiatives related to SUD or OUD			
☒ The state has no implementation update to report for this reporting topic.			
☐The initiatives described above are related to the SUD or OUD demonstration (States should note similarities and differences from the SUD demonstration)			
☒ The state has no implementation update to report for this reporting topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
12. SUD Demonstration Evaluation Update			
12.1. Narrative Information			
☐ Provide updates on SUD evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. See report template instructions for more details.			
☒ The state has no SUD demonstration evaluation update to report for this reporting topic.			
☐ Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.			
☒ The state has no SUD demonstration evaluation update to report for this reporting topic.			
☐ List anticipated evaluation-related deliverables related to this demonstration and their due dates.			
☒ The state has no SUD demonstration evaluation update to report for this reporting topic.			
13.1 Other Demonstration Reporting			
13.1.1 General Reporting Requirements			
☐ The state reports changes in its implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol			
☒ The state has no updates on general requirements to report for this reporting topic.			
☐ The state anticipates the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes			
☒ The state has no updates on general requirements to report for this reporting topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) The schedule for completing and submitting monitoring reports ☐ ii) The content or completeness of submitted reports and/or future reports			
☒ The state has no updates on general requirements to report for this reporting topic.			
☐ The state identified real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation			
☒ The state has no updates on general requirements to report for this reporting topic.			
13.1.2 Post-Award Public Forum			
☐ If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual report.			
☒ No post-award public forum was held during this reporting period and this is not an annual report, so the state has no post-award public forum update to report for this topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
14.1 Notable State Achievements and/or Innovations			
14.1 Narrative Information			
☐ Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD (or if broader demonstration, then SUD related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.			
☒ The state has no notable achievements or innovations to report for this reporting topic.			

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

The IET-AD, FUA-AD, FUM-AD, and AAP measures (metrics #15, 17 (1), and 17 (2), and 32) are Healthcare Effectiveness Data and Information Set ("HEDIS®") measures that are owned and copyrighted by the National Committee for Quality Assurance ("NCQA"). NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications.

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

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

Attachment E: MAC and TSOA quality assurance questions

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?