Washington State Medicaid Transformation Project (MTP) demonstration
Section 1115 Waiver Quarterly Report (DY6 Q3)
Demonstration Year: 6 (January 1 to December 31, 2022)
Reporting Quarter: 3 (July 1 to September 30, 2022)

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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, 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 (SDoH).
- Improve substance use disorder (SUD) treatment access and outcomes.

The state will accomplish these goals through these programs:

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

Vision: a healthier Washington

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

Quarterly report: July 1 – September 30, 2022

This quarterly report summarizes MTP activities from the third quarter of 2022: July 1 through September 30. It details MTP implementation, including stakeholder education and engagement, planning and implementation, and development of policies and procedures.

Summary of quarter accomplishments

- On July 15, 2022, the HCA and Department of Social and Health Services (DSHS) submitted the MTP 2.0 waiver renewal application following extensive public comment and tribal consultation.
- ACHs continued to distribute incentive funds to partnering providers through the financial executor (FE) portal. During the reporting period, ACHs distributed approximately $21 million to partnering providers and organizations. The state distributed over $38,000 in earned incentive funds to IHCPs in Q3 for achievement of IHCP-specific project milestones.
- As of September 30, 2022, more than 13,600 clients, in addition to their family caregivers, have received services and supports through the MAC and TSOA programs. New enrollees in LTSS for this reporting period include 24 MAC dyads, 157 TSOA dyads, and 272 TSOA individuals.
- Within FCS, the total aggregate number of people enrolled in services as of September 30, 2022, included 5,071 in IPS and 8,334 in CSS. The total unduplicated number of enrollments at the end of this reporting period was 11,222.

MTP-wide stakeholder engagement

During the reporting quarter, HCA continued its stakeholder engagement efforts:

- Announced the independent external evaluator's (IEE's) evaluation, which highlighted MTP's successes and areas of improvement for Washington State.
- Announced the state's MTP waiver renewal application submission to CMS. In addition to the announcement, HCA also updated the MTP renewal page with application materials and other resources.

Statewide activities and accountability

Value-based purchasing (VBP)

Paying for Value plan/payer survey

During the reporting period, HCA conducted the annual Paying for Value survey for plans/payers, which went from July 1–August 31. As part of the state's outreach efforts, HCA sent an announcement to health care plans and contacted plans directly.

The purpose of the Paying for Value survey is to:

- Assesses plan's participation in value-based purchasing arrangements.
- Tracks progress toward our statewide goal of paying for value-based care, rather than paying for volume of care.

The state's goal is to have 85 percent of state-financed health care in value-based payments by the end of 2021 and 90 percent by the end of 2022. As of 2020, Washington was at 77 percent.

HCA received 13 unique responses. Of those, 11 were returned from plans with which HCA contracts, along with PacificSource and Cigna (non-HCA-contracted respondents). HCA is analyzing the survey responses, which will help calculate HCA-contracted plan VBP performance.

Note: the state did not offer a survey for providers (as in past years) because of survey fatigue and similar surveys going to providers around the same time.

VBP Roadmap and Apple Health Appendix

The VBP Roadmap describes HCA's VBP goals, purchasing and delivery system transformation strategies, innovation successes to date, and plans to accelerate the transition into value-based payment models. The appendix, in accordance with the STCs, describes how MTP supports providers and managed care organizations (MCOs) to move along the value-based care continuum. The roadmap establishes targets for VBP attainment and related Delivery System Reform Inventive Payment (DSRIP) incentives for MCOs and ACHs.

In Q3, HCA developed a plan to update the VBP Roadmap, simplifying existing documents and creating new, more accessible materials for wider audiences. These updated materials are in development and will be published in Q4. HCA will also publish and submit to CMS our annual update to the Apple Health Appendix in Q4.

Validation of financial performance measures

HCA contracts with Myers and Stauffer LC (MSLC) to serve as the independent assessor (IA) for MTP. In this role, the IA functions as the third-party assessor of financial measures data submitted by MCOs as part of their contracts with HCA. HCA's contracts with the five MCOs 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. HCA continued to meet with MSLC in Q3 to conduct the 2022 validation process. HCA expects the IA to complete the process by the end of October 2022.

Statewide progress toward VBP targets

HCA sets annual VBP adoption targets for MCOs and ACH regions in alignment with HCA's state-financed purchasing goals. To track progress, HCA collects financial performance measure data from MCOs by ACH region through the VBP validation process and from commercial and Medicare payers and providers through an annual survey.

In Q3, HCA conducted the annual Paying for Value survey. This year, the state decided to conduct the plan/payer survey only (a change from previous years, in which HCA also conducted a survey for providers). HCA launched the Paying for Value survey for plans/payers on July 1, 2022, and closed it on August 31, 2022. Results will be analyzed in Q4 and shared widely with partners, stakeholders, and the public.

Technical support and training

No new activities in Q3.

Upcoming activities

- Complete MCO VBP validation process.
- Complete and publish the analysis of the Paying for Value survey
- Calculate 2021 VBP adoption by ACH, MCO, statewide managed care, and statewide HCA (MCO and Employee and Retiree Benefits programs) health care spend.

Integrated managed care (IMC) progress

In 2014, the Legislature directed a transition to integrate the purchasing of medical and behavioral health services for Apple Health (Medicaid) clients through an IMC system no later than January 1, 2020. Below are IMC-related activities for Q3 2022.

Since April 2021, HCA has maintained focus on measuring clinical integration and bi-directional care, with the assistance of most of the ACHs around the state. Ongoing collaboration has furthered these goals. In 2021, the Washington Integrated Care Assessment (WA-ICA) Initiative was launched to ensure that

outpatient practices have the necessary tools and support to continue to advance integration and bi-directional care. During Q3 of 2022, the WA-ICA Workgroup developed a strategic plan and set of recommendations that can be provided to practices. The goals for this work include advancing integrated care through coaching, education, training, and technical assistance (TA), and other assistance to practices; improving patient outcomes through further advancing the delivery of clinically integrated care; and identifying and implementing complementary, non-duplicative and coordinated roles for MCOs and ACHs to support practices.

During Q3, the first cohort of behavioral health and primary care outpatient practices completed the WA-ICA. HealthierHere, the ACH covering King County, has been contracted by other ACHs and MCOs to collect and analyze WA-ICA data. From those initial results, HealthierHere created a draft report summarizing the aggregated data from participating practices across the state, with further data review and evaluation planned. Discussions continued related to the identification of a long-term solution for data management, along with future contracting and funding with the anticipated approval of the MTP 2.0 renewal.

In addition, the Primary Care Transformation Model (PCTM) Workgroup decided to incorporate the WA-ICA into the Provider Accountabilities for the Behavioral Health Integration section of its draft PCTM document, further aligning these two statewide initiatives.

Health information technology (HIT)

The Health IT Operational Plan is composed of actionable deliverables to advance the health IT goals and vision articulated in the Health IT Strategic Roadmap. This work supports MTP in Washington State. The Health IT Roadmap and Operational Plan focuses on three phases of MTP work:

1. Design
2. Implementation and operations
3. Assessment

The activities for the 2022 Health IT Operational Plan include 42 deliverables and tasks in the following areas:

- Electronic health records (EHRs)
- Crisis Call Center and related activities
- MH IMD waiver
- Master Person Index (MPI)
- Provider directory
- Payment models and sources
- SDOH and LTC/Social Service Data Exchange
- CMS Interoperability Rules
- MTP Extension, and Waiver Renewal
- Clinical Data Repository (CDR)
- Tribal engagement

Activities and successes

During Q3 of 2022, the Health IT team engaged in the following activities:

- In coordination with the Washington State Department of Health (DOH), supported continued implementation planning for the nationally required 988 crisis call system and the more expansive

state requirements in E2SHB 1477 for a crisis call center hub system and the behavioral health integrated client referral system. Key activities include:
    - Finalizing the technical functional requirements required to meet federal and state laws, including gathering information from Vibrant Emotional Health (the administrator for the National Suicide Prevention Lifelines) regarding the Vibrant Unified Platform.
    - Drafting the required Final Technical and Operational Plan for the National 988 System: Crisis Call Center and Behavioral Health Integrated Referral System. The work involved collaboration with DOH, multiple divisions within HCA, and the Governor's Office.
    - In partnership with DOH, starting the review and comment process for the draft Final Technical and Operational Plan, seeking input from HCA and DOH leadership, tribal governments, crisis response and technology subcommittees, and state legislative committees.
    - Participating in discussions and presentations about alignment between the technical call infrastructures of 9-1-1 and 9-8-8 call lines.
    - Preparing and submitting decision packages requesting funds to support implementation of the Technical and Operational Plan.
- In consultation with McKinsey & Company and other state agencies, HCA staff worked with community-based organizations, health plans, ACHs, and safety net providers to contribute to a community information exchange (CIE) landscape review.
- Released a Request for Proposals (RFP) for the design and implementation of an electronic consent management (ECM) solution, including a formal question and answer process with prospective vendors.
- Launched the Health and Human Service Coalition (Coalition) Master Person Index (MPI) project, creating 5.2 million identities. The Coalition also launched an operational governance model to support administration of the Coalition MPI.
- Continued work with Apple's App Store to publish the MyHealthButton App in the provider directory and patient directory Application Programming Interfaces (APIs).
- Developed and submitted a decision package for EHRaaS for legislative review.
- Supported data collection and analysis of the WA-ICA, an on-going collaboration among the HCA, MCOs, and ACHs that assesses practice-level integration of physical and behavioral health care. A total of 374 practices submitted assessment results: 58 behavioral health organizations spanning 126 Sites and 28 primary care practices across 79 sites.
- HCA continues to explore the feasibility of using Medicaid claims and encounter data to accurately identify Medicaid primary care practices and out-patient behavioral health practices.
- Continues participation in in the steering committee of the Washington Care Coordination Workgroup.

DSRIP program implementation accomplishments

ACH project milestone achievement

Pay-for-reporting (P4R)

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

Next steps

HCA and ACHs continue to partner on the transition from DSRIP to the Taking Action for Healthier Communities (TAHC) program that will introduce focused strategies to address health equity through community-based care coordination (Community Hub model) and implementation of health-related services (HRS). In addition, HCA will continue to convene a task force that includes representatives from MCOs and ACHs to discuss roles and partnership opportunities to support the Community Hub model and HRS implementation.

Annual VBP milestone achievement by ACHs

Over the course of DY1–5, ACHs helped assess and support provider VBP readiness and practice transformation by connecting providers to training and resources. In DY6, ACHs transitioned VBP efforts to support communication with providers regarding the opportunity to participate in the WA-ICA program in DY6 and throughout the MTP renewal period. WA-ICA provides a standardized assessment of integrated care to support behavioral health and physical health providers advance along the continuum of integration.

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 **$21.2 million** to **192** partnering providers and organizations in support of project planning and implementation activities. The state distributed approximately **$38,628.00** in earned incentive funds to IHCPs in Q3 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

- The state has received the majority of DY5 pay-for-performance (P4P) rates. Those have been sent to the IA to start working on the achievement value totals for each region. The maternal and child health rates will be available in January 2023.
- For DY5, CMS approved a performance change from a two-year mixed performance criteria to a year-over-year, improvement-over-self methodology for all performance.
- The state has received all high-performance rates for the subset of high-performance metrics. Those have been sent to the IA for high-performance calculations. The state is currently working on outcomes related to regional high-performance scores.

Statewide results

The state is still gathering all data required to submit a statewide accountability report for DY5. The state expects to send CMS a final report in December 2022 for DY5 withheld earnings for quality improvement and value-based adoption results.

DSRIP program stakeholder engagement activities

- Early in the reporting period, HCA announced ACHs' earned incentives in the state's first P4R cycle. HCA changed from the previous semi-annual reporting (SAR) process to a streamlined, point-in-time reporting process for P4R reporting.
- HCA continued to engage in regular statewide and regional ACH discussions to share about the TAHC proposal, ongoing CIE planning, and other topics of interest.

DSRIP stakeholder concerns

Stakeholders continued to ask about the timeline for the MTP renewal and the state worked with stakeholders and partners to communicate the anticipated temporary extension to allow continuation of current programs during negotiations with CMS.

Upcoming DSRIP activities

- The state sent all ACHs copies of their P4P and high-performance rates for DY5 in October 2022.
- In Q4 the state will make public the 2021 regional performance rates/outcomes and 2022 ACH improvement targets.
- The state will send CMS the statewide accountability report in December 2022. Following CMS approval of the statewide accountability report, HCA will account for any withheld funds unearned and adjust ACH projected incentives accordingly.
- The state anticipates receiving the remainder of the P4P rates in January 2023. These are consistent with the release time for the maternal and child health metrics.

Tribal project implementation activities

Primary milestone: Started meeting with ACHs regarding tribal engagement in the first round of the MTP to learn from successes and challenges and draft a new Tribal Engagement and Collaboration policy for the MTP renewal.

Tribal partner engagement timeline

July 6: Second and final consultation on the MTP renewal application

July 11: Met with Northwest Portland Area Indian Health Board (NPAIHB) to discuss Behavioral Health Aides and Community Health Aides (BHAs/CHAs) State Plan Amendment (SPA)

July 11: Met internally to discuss CIE

July 13: Participated in the Tribal Partners Collaborative, hosted by Better Health Together (BHT)

July 27: Met with McKinsey & Company to discuss listening sessions regarding CIE

August 3: Met internally to discuss CIE

August 10: Participated in the Tribal Partners Collaborative, hosted by BHT

August 10: Hosted the first tribal listening session regarding CIE

August 11: Attended the film screen premier of Children of the Setting Sun presents Tribal Approaches to Wellness

August 15: Met with staff from BHT to discuss tribal relationships and build a stronger connection between the regional tribal liaison and the ACH

August 17: Hosted the second and final tribal listening session regarding CIE

August 22: Participated in the Northwest Washington Indian Health Board (NWWIHB) and North Sound Accountable Community of Health Tribal Alignment meeting

August 30: Met with NPAIHB to discuss BHAs/CHAs SPA

September 7: Participated in internal CIE planning meeting

September 7: Participated in discussion with CMS regarding renewal application

September 9: Met with Cascade Pacific Action Alliance (CPAA) to discuss tribal participation and make connections with regional tribal liaisons

September 15: Participated in the CIE Steering Committee

September 20: Met with North Sound ACH to discuss tribal participation and make connections with the regional tribal liaison

September 21: Participated in a CIE Planning meeting

September 21: Participated in HealthierHere's Network Partner Workgroup

September 23: Participated in the first TAHC Task Force

September 26-28: Participated in the American Indian Health Commission's State and Tribal Leaders Health Summit

LTSS implementation accomplishments

This section summarizes LTSS program development and implementation activities from July 1 through September 30, 2022. Key accomplishments for this quarter include:

- As of September 30, 2022, more than 13,600 clients, in addition to their family caregivers, have received services and supports through the MAC and TSOA programs. The average caseload for the quarter is 4,339 clients.
- The 1115 renewal application was submitted requesting an additional five years for MAC and TSOA programs.

Network adequacy for MAC and TSOA

In-home care worker shortages continue to be an issue across the state and the nation. The Area Agencies on Aging (AAAs) typically contract with qualified providers that will provide services across all waivers and programs. They seek a variety of service providers (like Housework and Errands and PERS) to bridge when personal care or respite workers are in short supply. AAAs continue to engage new providers of waiver services as well as maintaining and monitoring existing service contracts.

Assessment and systems update

The MAC/TSOA budget tool was tested and moved into the GetCare system this quarter. Additionally, ALTSA continued working with the GetCare vendor and the TCARE ® assessment vendor in preparation for the fall release and implementation of the updated caregiver assessment (TCARE 5.0) used for MAC and TSOA dyads.

Staff training

MAC and TSOA program managers for Home and Community Services remain committed to providing monthly statewide training webinars on requested and needed topics during 2022. Below are the webinar trainings that occurred during this quarter:

- July 20: Provided an overview of the upcoming changes to the TCARE ® caregiver assessment tool and an orientation to the use of the new MAC/TSOA budget management tool being developed in the GetCare system.
- Sept 23: Conducted the annual "What's Gained, What's Lost" webinar which provides case managers the tools necessary to support clients in deciding which LTSS program may best fit their needs.

The Estate Recovery training webinar was postponed until 2023 due to staff shortage within the Office of Financial Recovery.

Upcoming webinars include:

- Nov 16: Back to Basics – Purpose of Caregiver Programs
- Dec 14: Overview of ProviderOne (MMIS) – provider authorizations and payment adjustments

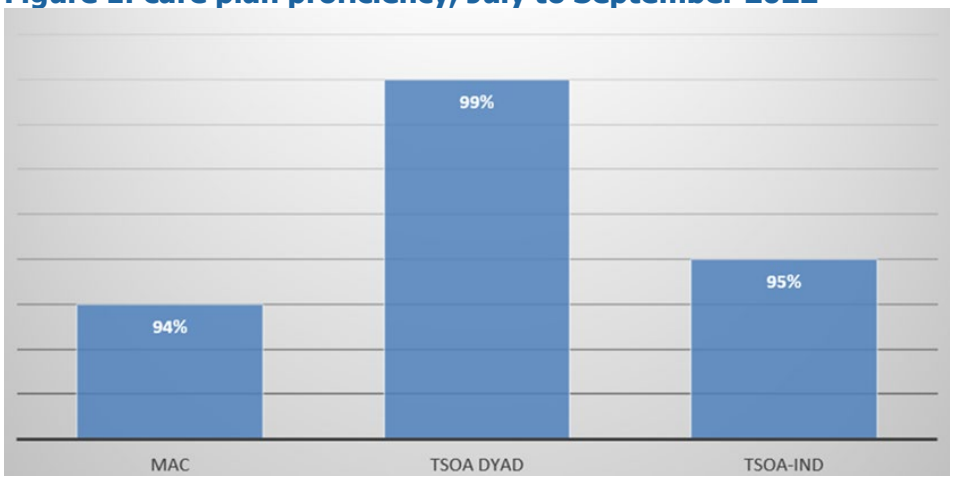
Data and reporting

Table 1: beneficiary enrollment by program

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of September 30, 2022	226	1319	3293
Number of new enrollees in quarter by program	24	157	272
Number of new person-centered service plans in quarter by program	7*	49**	95***
Number of beneficiaries self-directing services under employer authority**	0	0	0

*17 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.
** 106 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.
*** 168 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 will begin using individual providers after the Consumer Directed Employer is fully implemented for the 1915(c) and 1915(k) programs.

Figure 1: care plan proficiency, July to September 2022



The state continues to monitor care proficiency and is proud to report the AAAs' continued proficiency in timely completion of care plans for enrollees.

Tribal engagement

DSHS Aging and Long-Term Support Administration (ALTSA) met with a number of tribes to discuss Medicaid services and Initiatives 2 and 3 of the demonstration. Below are several engagement activities that occurred this quarter.

- July 2022: Shared MAC/TSOA LTSS brochures, information and contact information with Puyallup Tribe.
- August 2022: ALTSA attended meetings with other state partners and tribal partners to discuss MAC/TSOA eligibility and what "presumptive eligibility" looks like with TSOA.
- September 2022: Invited multimedia manager with DSHS to Indian Policy Advisory Council (IPAC) to discuss MAC/TSOA marketing and outreach videography.
- September 2022: Recognizing a need to broaden marketing and outreach materials that are culturally appropriate, ALTSA negotiated a contract to increase materials for use in multiple programs, including respite, kinship care and MAC/TSOA. Marketing materials are now being completed by copywriters. (Still working on materials)
- Planning meetings were scheduled this quarter to begin preparations for the Fall/Winter Tribal Summit to be held in December.

Washington State Tribes are still working under the emergency guidelines of the COVID-19 public health emergency (PHE) which has impacted all aspects of state, local and tribal government operations by means of face-to-face interaction. Most outreach is being done virtually.

Outreach and engagement

The state distributed a casting call to solicit Tribal members and their family caregivers who might be interested in being interviewed for an outreach video that will be used to promote caregiver programs.

Table 2: outreach and engagement activities by AAA

	July	August	September
	Number of events held		
Community presentations and information sharing	**53**	**38**	**30**

The volume and type of outreach activities continue to be impacted by COVID-19 and social distancing requirements.

Quality assurance

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

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

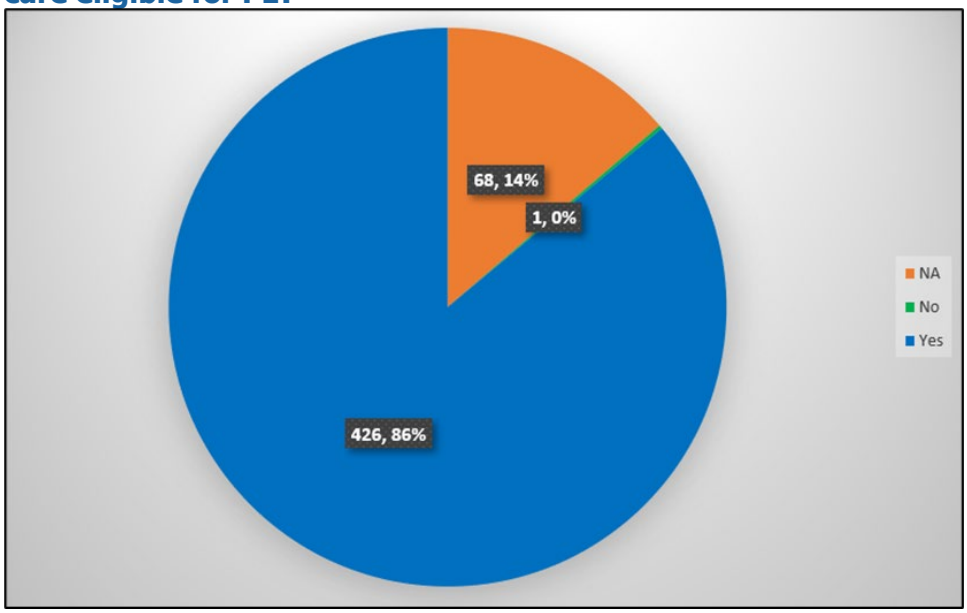


Figure 3: Question 2a: did the client remain eligible after the PE period?

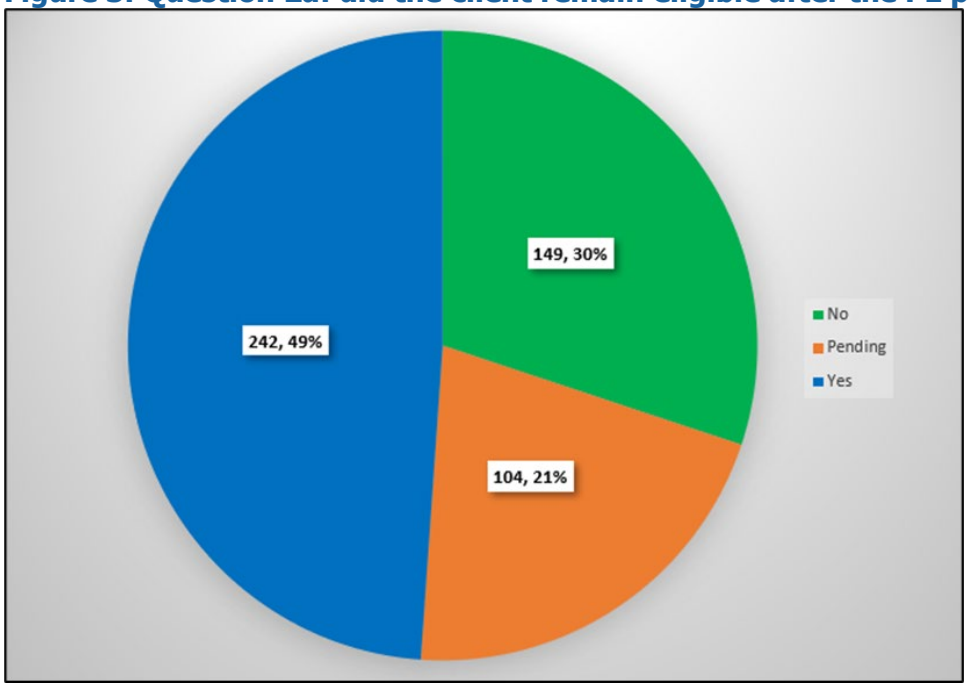
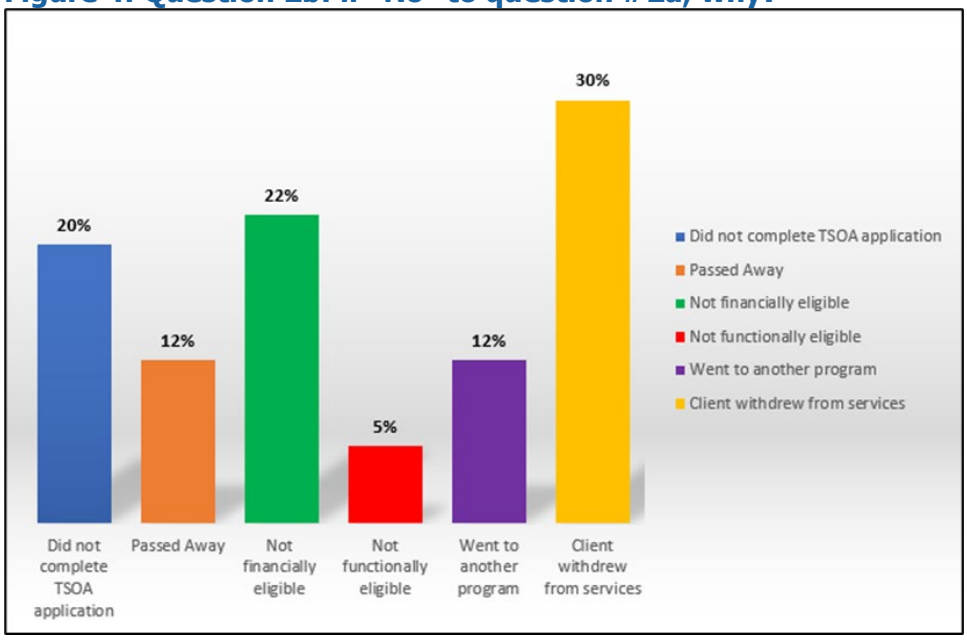


Figure 4: Question 2b: if "No" to question #2a, why?



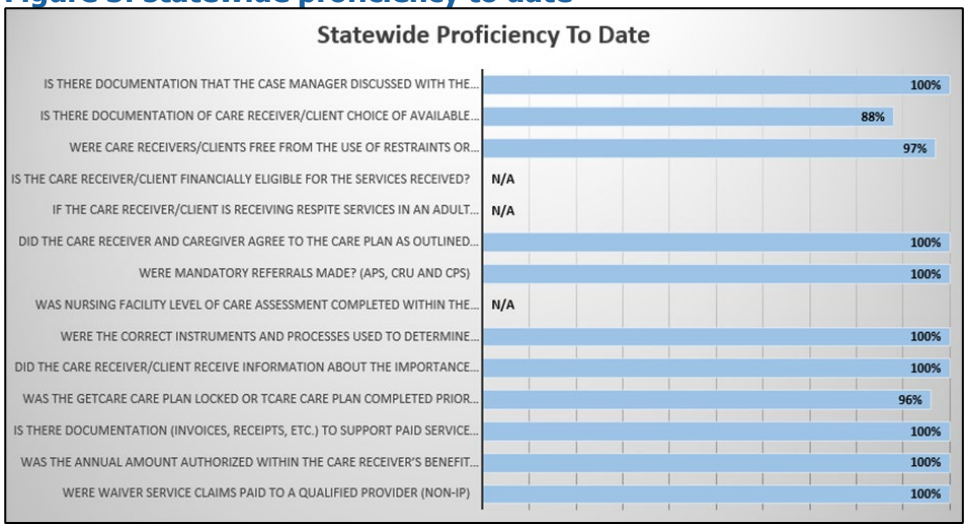
Note: These percentages represent the "No" population in the previous table (30%). For example, the 22% of PE clients found to be not financially eligible are 22% of the 30% illustrated in the Table for Question 2a.

2022 quality assurance results to date

HCS' Quality Assurance unit began the 2022 audit cycle in January this year and will conclude in November. The statewide compliance review of the MAC and TSOA performance measures is conducted with all 13 AAAs. An identical review process is applied in each AAA Planning and Service Area (PSA), using the same quality assurance tool and the same 19 performance measures.

The Quality Assurance team reviews a statistically valid sample of case records. The sample size in 2022 is 355 cases. This methodology is the same one used for the state's 1915(c) waivers and meets the CMS requirements for sampling. Each AAA's sample was determined by multiplying the percent of the total program population in that area by the sample size.

Figure 5: statewide proficiency to date



Note: "N/A" means this question did not pertain to anyone in the sample.
The state continues to meet or exceed the CMS minimum proficiency of 86% on all measures.

State rulemaking

ALTSA finished the rule making process this quarter to modify Washington Administrative Code (WAC) related to the upcoming release of TCARE 5.0, the evidence-based caregiver assessment tool used for MAC and TSOA dyads. Notice of final rulemaking was posted in the Washington State Register (WSR 22-18-004) and became effective September 25, 2022.

Upcoming activities

- Fall/Winter Tribal Summit will be held virtually the first week of December.
- In October, the state began collaborative work sessions with CMS related to the 1115 waiver renewal.
- During the next quarter, program and field staff will continue to develop policy and procedures related to the implementation of potential new services requested in the waiver renewal.

LTSS stakeholder concerns

Concerns were presented about the potential decrease in MAC and TSOA enrollments due to the increase in Personal Needs Allowance (PNA) for traditional LTSS programs. The state will be monitoring the MTP and traditional LTSS caseload changes in the next quarter related the PNA increase.

FCS implementation accomplishments

Initiative 3 provides evidence-based supportive housing and supported employment services to eligible Medicaid clients. This section summarizes the FCS program development and implementation activities from July 1 through September 30, 2022. Key accomplishments for the quarter include:

- The total aggregate number of people enrolled in FCS services at the end of DY6 Q3 was:
  - CSS: 8,334
  - IPS: 5,071
- There were 176 providers under contract with Amerigroup at the end of DY6 Q3, representing 478 sites throughout the state.

Note: CSS and IPS enrollment totals include 2,183 participants enrolled in both programs. The total unduplicated number of enrollments at the end of this reporting period was 11,222.

Network adequacy for FCS

Table 3: FCS provider network development

	July		August		September	
FCS service type	Contracts	Service locations	Contracts	Service locations	Contracts	Service locations
Supported Employment – Individual Placement Support (IPS)	37	78	36	77	36	77
Community Support Services (CSS)	19	45	20	46	20	46
CSS and IPS	117	351	120	355	120	355
Total	**173**	**474**	**176**	**478**	**176**	**478**

Client enrollment

Table 4: FCS client enrollment

	July	August	September
Supported Employment – Individual Placement and Support (IPS)	2,756	2,800	2,888
Community Support Services (CSS)	5,594	5,906	6,151
CSS and IPS	2,056	2,096	2,183
Total aggregate enrollment	**10,406**	**10,802**	**11,222**

Data source: RDA administrative reports

Table 5: FCS client risk profile

		Met HUD homeless criteria	Avg. PRISM risk score	Serious mental illness
July	IPS	614 (13%)	1.06	3,474 (72%)
	CSS	1,640 (21%)	1.36	5,163 (67%)
August	IPS	619 (13%)	1.08	3,504 (72%)
	CSS	1,715 (21%)	1.36	5,378 (67%)
September	IPS	640 (13%)	1.08	3,626 (72%)
	CSS	1,824 (22%)	1.34	5,537 (66%)

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

Table 6: FCS client risk profile continued

		Medicaid only enrollees*	MH treatment need	SUD treatment need	Co-occurring MH + SUD treatment needs flags
July	IPS	4,015	3,747 (93%)	2,475 (62%)	2,363 (59%)
	CSS	6,337	5,789 (91%)	4,667 (74%)	4,349 (69%)
August	IPS	4,084	3,792 (93%)	2,516 (62%)	2,388 (58%)
	CSS	6,647	6,032 (91%)	4,872 (73%)	4,520 (68%)
September	IPS	4,232	3,906 (92%)	2,580 (61%)	2,441 (58%)
	CSS	6,936	6,235 (90%)	5,043 (73%)	4,643 (67%)

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

Table 7: FCS client service utilization

		Medicaid only enrollees*	Long-term Services and Supports	Mental health services	SUD services (received in last 12 months)	Care + MH or SUD services
July	IPS	4,015	444 (11%)	2,945 (73%)	1,528 (38%)	373 (9%)
	CSS	6,337	658 (10%)	4,173 (66%)	2,810 (44%)	545 (9%)
August	IPS	4,084	476 (12%)	2,964 (73%)	1,547 (38%)	402 (10%)
	CSS	6,647	672 (10%)	4,310 (65%)	2,958 (45%)	543 (8%)
September	IPS	4,232	494 (12%)	3,021 (71%)	1,571 (37%)	415 (10%)
	CSS	6,936	710 (10%)	4,377 (63%)	3,015 (43%)	570 (8%)

(Aging CARE assessment in last 15 months)

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

Table 8: FCS client Medicaid eligibility

		CN blind/disabled (Medicaid only & full dual eligible)	CN aged (Medicaid only & full dual eligible)	CN family & pregnant woman	ACA expansion adults (nonadults presumptive)	Adults (nonadults presumptive) ACA expansion adults (SSI presumptive)	CN & CHIP children
July	IPS	1,454 (30%)	110 (2%)	513 (11%)	2,045 (42%)	548 (11%)	142 (3%)
	CSS	2,454 (32%)	380 (5%)	926 (12%)	2,558 (33%)	1,248 (16%)	84 (1%)
August	IPS	1,486 (30%)	116 (2%)	516 (11%)	2,077 (42%)	566 (12%)	135 (3%)
	CSS	2,547 (32%)	393 (5%)	1,000 (12%)	2,663 (33%)	1,319 (16%)	80 (1%)
September	IPS	1,535 (30%)	117 (2%)	533 (11%)	2,140 (42%)	600 (12%)	146 (3%)
	CSS	2,648 (32%)	407 (5%)	1,037 (12%)	2,770 (33%)	1,384 (17%)	88 (1%)

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

Quality assurance and monitoring activity

FCS staff continued to work with the third-party administrator (TPA) to monitor the implementation of FCS during Q3. No major concerns or issues were identified, and the TPA reported no grievances or appeals during the quarter. The cumulative enrollment increased month-over-month in each program, after seeing slight decreases at the end of DY5.

A good portion of work focused on identifying processes to reconnect enrollees due to changes in coverage. Because FCS is not an entitlement benefit, enrollment in the program is a manual process requiring weekly workflows to enroll and re-enroll (or "reconnect") eligible individuals to the program. Reconnecting involves a historical eligibility screening to identify gaps in coverage caused by changes in Medicaid type, incarceration, and other changes in the ProviderOne database that automatically disconnects an individual from FCS.

FCS training staff wrapped up the last fiscal year by completing the final fidelity review of contracted FCS providers. These reviews were completed virtually or hybrid over two or more days with a review team of HCA staff and FCS providers. The FCS training staff are also bringing on fidelity reviewers from other state agencies such as the Division of Vocational Rehabilitation to facilitate more cross-system collaboration. In late Q3, FCS training staff began a new cycle of fidelity reviews that will carry into Q4.

FCS staff also held two two-part fidelity reviewers training events that teach FCS providers and prospective reviewers evidence-based practices and help prepare them for participation on review panels. These fidelity reviews use a learning collaborative approach and FCS providers can receive incentives through SAMHSA block grants to become reviewers or host a review.

Lastly, FCS training staff held a six-part series on the evidence-based practice, Permanent Supportive Housing. Each training was accompanied by one-on-one technical assistance and all housing providers who scored 75% or lower on fidelity within the last two years during fidelity reviews were requested to attend.

Other FCS program activity

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

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

FCS staff attended and presented at several conferences during Q3: WA Conference on Ending Homelessness, Opioid Summit, Peer Pathways Conference, and Oregon's Health and Housing conference. Presentation topics included Discharge Planners Toolkit for reducing homelessness, community inclusion and the importance of collaboration, and several topics related to engaging provider networks.

The FCS program staff is growing thanks to significant investment by the state legislature during the 2022 legislative session. During Q3, two positions were filled: (1) a new state-funded position, FCS Quality and Alignment Specialist, which aims to support the development and implementation of new projects and initiatives, with a specific focus on quality improvement and project management and (2) program manager. Both positions were filled by current FCS team members, and the corresponding vacant positions are expected to be filled in Q4.

Upcoming activities

- Medicaid Academy: The first 6-week Medicaid Academy was offered to potential and current FCS providers in Q2 and will occur again in Q4. These Academies are targeted to executive leads, fiscal/finance leads, programmatic leads, and quality improvement leads within their agencies. Information presented will primarily benefit support agencies who are not yet set up as Medicaid billers, who have been having issues with billing to Medicaid, and those who are interested in becoming Medicaid billers.
- Supportive Housing Academy: Based on direct provider feedback, a series of four trainings aimed at increasing tenant feedback, clarifying roles and responsibilities, and increasing housing inventory was created and will be offered during Q4.
- FCS staff continue to meet regularly with the Department of Commerce on the planning and development of two programs:
    - Apple Health and Homes, a partnership between the Department of Commerce, DSHS, and the HCA focused on creating permanent supportive housing units for CSS-eligible individuals.
    - The expansion of the Housing and Essential Needs (HEN) program to create a bridge period of up to 9 months of additional rental support for IPS-enrolled individuals. Roughly 30% of IPS enrollees have a referral for and receive assistance from the HEN program.
- FCS staff will have several presentations at the Co-Occurring Disorder Conference that highlight an agency's ability to individualize support for participants through utilization of FCS.

FCS program stakeholder engagement activities

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

Table 9: FCS program stakeholder engagement activities

	July	August	September
	Number of events held		
Training and assistance provided to individual organizations	68	122	82
Community and regional presentations and training events	4	7	2
Informational webinars	8	10	7
Stakeholder engagement meetings	17	19	15
Total activities	**97**	**158**	**106**

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.

Q3 topics included:

- Stabilization services for aftercare in housing
- Best practices in job coaching
- Thoughtful engagement for homeless systems change
- Strengthening relationships with employers: beyond the initial meeting
- Case management approaches and best practices to address hoarding behaviors
- Overview of SAMHSA's core elements of Permanent Supportive Housing
- Recovery and returning to work
- Permanent Supportive Housing fidelity: Access to housing

FCS stakeholder concerns

- The FCS team continues to receive feedback regarding challenges with submitting claims from providers who are new to billing Medicaid. HCA is providing additional technical assistance on billing best practices and alignment with other Medicaid billing processes.
- FCS stakeholders have asked questions regarding the status of the waiver renewal and the plans for the continuation of the services. This is particularly prevalent among new providers interested in developing FCS services and programs within their agencies.

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 institution for mental diseases (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 July 1 through September 30, 2023. Accomplishments for the quarter include:

- In late September, Washington began issuing provider relief and workforce stabilization funds to behavioral health agencies. The $100 million workforce provider relief fund was appropriated in the 2022 Washington State supplemental community behavioral health budget and can be used for immediate workforce retention and recruitment costs incurred due to COVID-19, childcare stipends, or provider recruitment efforts.
    - Eligibility is based on the provider's history of services for Medicaid or low-income clients.
    - These funds will help to relieve the workforce pressure that has been experienced by so many of our behavioral health providers during the last two years.

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:

- No changes in implementation plan to report.

SUD HIT plan requirements

- HCA continued to coordinate internally and with DOH to support the development of the Technical and Operational Plan for the nationally required 988 crisis call system and enhanced Crisis Call Center Hub System and Behavioral Health Integrated Client Referral System required under state law (E2SBH 1477). The Crisis Call Center Hub System and Behavioral Health Integrated Client Referral System includes a focus on persons with SUD and MH needs. The technology systems and tools that are being considered include tools to support crisis call, response, and dispatch, and behavioral health referral and follow-up.
- HCA has developed options to consider for using about $1.5 million in state general funds appropriated for the use of health information technology and evaluations to support the 1115 demonstration waiver as it relates to IMDs.
- The HIT Team released an RFP for the design and implementation of an electronic consent management (ECM) solution. The first use case that this solution will focus on is the exchange of SUD information subject to 42 CFR Part 2.
- The HCA included language in Medicaid Managed Care contracts requiring that MCOs work with in-patient psychiatric hospitals and units that
    1. Have interoperable health IT to create and send admission, discharge, transfer (ADT) summaries using HIT standards on behalf of persons admitted/transferred to or discharged from these institutions.
    2. Do not have HIT to submit plans regarding the acquisition of needed HIT.

Evaluation design

No changes to report

Monitoring protocol

No changes to report

Upcoming activities

Co-Occurring Disorder conference

MH IMD waiver implementation accomplishments

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

This section summarizes MH IMD waiver development and implementation activities from July 1 through September 30, 2022.

- July 2022: The 90/180-day civil commitment bed program is now contracted with 16 community facilities for a total of 196 beds outside of our state hospitals.
- September 2022: Successful award process for reissued Commerce residential treatment facility funding for King County region, was awarded to Connection Solutions.
- In late September, Washington began issuing provider relief and workforce stabilization funds to behavioral health agencies. The $100 million workforce provider relief fund was appropriated in the 2022 Washington State supplemental community behavioral health budget and can be used for immediate workforce retention and recruitment costs incurred due to COVID-19, childcare stipends, or provider recruitment efforts.
    - Eligibility is based on the provider's history of services for Medicaid or low-income clients.
    - These funds will help to relieve the workforce pressure that has been experienced by so many of our behavioral health providers during the last two years.

Implementation plan

Updates on the state requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge:

- MCO contract changes in effect as scheduled in January 2022
- WAC changes effective as of May 25, 2022

Updates on the strategies to improve state tracking of availability of inpatient and crisis stabilization beds:

- Work continues on the statewide bed tracking system which has been incorporated into improvements in crisis system infrastructure in the wake of E2SBH 1477 crisis system legislation and implementation of the 988 behavioral health emergency line.

MH HIT plan requirements

This quarter, HCA initiated contracts related to the MH waiver HIT plan requirements. These contracts include work on:

- Activities found under the SUD HIT plan requirements section.

Evaluation design

No changes to report

Monitoring protocol

No changes to report

Upcoming activities

No activities to report

Quarterly expenditures

The following table reflects quarterly expenditures for DSRIP, LTSS, and FCS during DY6 (2022).

Table 10: DSRIP expenditures

	Q1	Q2	Q3	Q4	DY6 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
Better Health Together	$0	$9,103,699	$0			$4,551,850
Cascade Pacific Action Alliance	$0	$9,462,549	$0			$4,731,275
Elevate Health	$0	$12,361,357	$0			$6,180,679
Greater Columbia	$0	$11,373,483	$0			$5,686,742
HealthierHere	$0	$19,146,935	$0			$9,573,468
North Central	$0	$5,344,126	$0			$2,672,063
North Sound	$0	$12,980,082	$0			$6,490,041
Olympic Community of Health	$0	$4,219,193	$0			$2,109,597
SWACH	$0	$5,803,354	$0			$2,901,677
Indian Health Care Providers	$0	$939,500	$0			$479,750

Table 11: MCO-VBP expenditures

	Q1	Q2	Q3	Q4	DY6 Total
MCO-VBP	January 1–March 31	April 1–June 30	July 1–September 30	October 1–December 31	January 1–December 31
Amerigroup WA	$0	$573,406.00	$0		$573,406.00
CHPW	$0	$1,623,416.00	$0		$1,623,416.00
CCW	$0	$1,393,036.00	$0		$1,393,036.00
Molina	$0	$2,714,859.00	$0		$2,714,859.00
United Healthcare	$0	$1,695,283.00	$0		$1,695,283.00

Table 12: LTSS and FCS service expenditures

	Q1	Q2	Q3	Q4	DY6 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)	$1,759,393	$7,049,254	$5,724,026		$14,532,673
Medicaid Alternative Care (MAC)	$50,791	$201,047	$169,460		$421,298
MAC and TSOA not eligible	$0	$281	$264		$545
FCS	$3,047,246	$6,125,131	$6,015,533		$15,187,910

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. Actual caseload data for non-expansion adults is available through June 2022. July 2022 through September 2022 member months for non-expansion adults are forecasted caseload figures from CFC.

Table 13: member months eligible to receive services

Calendar month	Non-expansion adults only	SUD Medicaid disabled	SUD Medicaid non-disabled	SUD newly eligible	SUD AI/AN	SMI Medicaid Disabled IMD	SMI Medicaid non-disabled IMD	SMI Newly eligible IMD	SMI AI/AN
Jan-17	376,304	0	0	0	0				
Feb-17	375,200	0	0	0	0				
Mar-17	374,730	0	0	0	0				
Apr-17	373,582	0	0	0	0				
May-17	373,126	0	0	0	0				
Jun-17	373,031	0	0	0	0				
Jul-17	372,119	0	0	0	0				
Aug-17	371,854	0	0	0	0				
Sep-17	370,589	0	0	0	0				
Oct-17	370,394	0	0	0	0				
Nov-17	370,223	0	0	0	0				
Dec-17	370,250	0	0	0	0				
Jan-18	370,288	0	0	0	0				
Feb-18	368,915	0	0	0	0				
Mar-18	368,724	0	0	0	0				
Apr-18	367,462	0	0	0	0				
May-18	367,826	0	0	0	0				
Jun-18	367,106	0	0	0	0				
Jul-18	366,849	5	19	91	10				
Aug-18	366,250	8	17	95	44				

Sept-18	365,254	4	19	80	44				
Oct-18	365,253	4	22	93	47				
Nov-18	364,787	3	27	93	34				
Dec-18	364,238	4	17	96	23				
Jan-19	364,165	34	133	411	37				
Feb-19	362,484	31	115	391	40				
Mar-19	362,138	42	144	398	45				
Apr-19	361,667	56	136	473	38				
May-19	361,154	43	125	483	49				
June-19	360,392	65	150	573	54				
Jul-19	360,821	65	197	676	55				
Aug-19	360,397	66	243	744	49				
Sep-19	359,951	75	214	779	44				
Oct-19	359,433	73	237	884	36				
Nov-19	358,530	81	190	812	44				
Dec-19	358,828	58	213	940	51				
Jan-20	359,246	32	129	531	44				
Feb-20	359,155	24	125	478	44				
Mac-20	360,830	33	133	484	45				
Apr-20	364,286	42	109	383	21				
May-20	366,704	25	97	376	29				
Jun-20	369,457	46	157	553	46				
Jul-20	372,116	25	84	335	32				
Aug-20	374,923	51	218	711	38				
Sep-20	377,117	65	208	680	47				
Oct-20	379,094	52	191	756	44				
Nov-20	380,001	54	179	761	27				
Dec-20	381,492	65	172	784	24	43	33	146	3
Jan-21	382,650	16	59	222	31	1	2	188	13
Feb-21	382,698	25	89	298	18	0	0	206	11
Mar-21	384,028	21	85	318	26	1	0	230	14
Apr-21	385,347	25	96	368	14	0	2	190	18
May-21	386,537	31	85	313	27	1	2	203	16
Jun-21	387,584	17	33	157	21	0	3	204	16
Jul-21	389,166	25	102	369	19	271	178	602	16
Aug-21	391,206	19	90	323	20	250	176	562	13
Sep-21	392,635	16	85	324	15	241	177	602	12
Oct-21	393,961	16	81	277	11	256	198	619	15
Nov-21	395,893	14	78	300	14	248	224	608	19
Dec-21	396,519	6	46	214	13	237	221	623	12
Jan-22	398,105	1	14	77	5	237	234	623	13
Feb-22	399,376	15	97	365	6	220	248	597	13
Mar-22	400,929	20	116	412	20	234	238	665	10
April-22	403,102	23	110	384	10	193	164	445	7
May-22	404,529	26	104	380	7	196	216	570	4
Jun-22	406,667	19	78	318	3	175	159	493	1
Jul-22	409,667	3	19	136	0	49	30	140	0
Aug-22	411,956								
Sep-22	414,118								
Total	25,965,408	1,569	5,487	20,499	1,465	2,853	2,505	8,516	226

Budget neutrality

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

Designated state health programs (DSHP)

HCA has continued to contract with Myers & Stauffer to perform an independent audit based on agreed-upon procedures to validate the accuracy of DSHP claims reported on the CMS-64 for calendar year (CY) 2021. Expected completion of the review is June 30, 2023.

Overall MTP development and issues

Operational/policy issues

No operational or policy issues were identified in Q2 2022. The state continued to advance decision packages for forthcoming legislative authorization to continue MTP in anticipation of the renewal approval.

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 IEE quarterly rapid cycle report was delivered on September 14, 2022, in compliance with the contracted deliverable timeline. This report covers July 1, 2022, through September 30, 2022. It presents findings regarding Washington state's Medicaid system performance through June 2021, including key performance indicators in 10 measurement domains as well as an examination of equity and disparities among specific populations within measurement domains:

Quantitative analysis of Medicaid data

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

Qualitative analysis

- The qualitative team continues to analyze previously collected qualitative data. These analyses will be included in the final evaluation report.
- The qualitative team is actively coding and analyzing data from the final round of ACH interviews. These interviews questioned leaders about their reflections on their prior work and their plans for sustainability. The team meets weekly to listen to audio recordings, analyze transcripts, and refine the codebook.
- The qualitative team submitted an IRB amendment in preparation for the final round of provider organization interviews. While waiting for approval, the qualitative team is identifying potential interviewees in each ACH region and developing an interview guide.

Key findings from the latest rapid-cycle report

- The performance measures in this report provide an ongoing look at how the COVID-19 PHE in Washington State may have impacted health care access and quality among Medicaid members. After notable initial impacts, we are beginning to see evidence of recovery within several domains. Specifically, access to periodontal exams and wellness visits for children over the age of three improved during this period. We continued to see positive trends for other types of care that can be

delivered virtually, including medication management for mental health and chronic conditions, such as diabetes and heart disease.

- We previously reported a dramatic downward trend in rates of care received in emergency departments and acute hospital settings, attributed to barriers to access resulting from the public health emergency. This trend has reversed. While still markedly lower than the previous year, we now see a subtle uptick in care in these settings.
- Finally, we continue to note disparities in health care access and quality among subpopulations examined in this report. Black members were less likely to receive follow-up care after an emergency department visit for alcohol or other drug use and were less likely to receive appropriate treatment for an opioid use disorder than other groups. American Indian/Alaska Native members experienced markedly worse access to well-child visits, cancer screenings, and care related to chronic conditions, alongside higher Emergency Department visit rates. Members with a serious mental illness were more likely to experience homelessness.

Upcoming IEE activities:

- Produce the 16th rapid cycle report
- Carry out ongoing MTP analysis
- Analyze Quantitative Data, including Administrative and Survey Data
- Update measures and models with post demonstration year final data, leading up to final report

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, Q3 2022
- Attachment C: 1115 SUD Demonstration Monitoring Workbook – Part A
- Attachment D: 1115 SUD Demonstration Monitoring Report – Part B
- Attachment E: 1115 SMI/SED Demonstration Monitoring Workbook – Part A
- Attachment F: 1115 SMI/SED Demonstration Monitoring Report – Part B

Attachment A: state contacts

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

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

For mail delivery, use the following address:

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

Attachment B: Financial Executor Portal Dashboard, Q3 2022

View this table on the HCA website, which shows all funds earned and distributed through the FE portal through September 30, 2022.

Attachment C: 1115 SUD Demonstration Monitoring Workbook – Part A

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

Attachment D: 1115 SUD Demonstration Monitoring Report – Part B

1. 1115-SUD Demonstration-Monitoring-Report-Trend Narrative Reporting

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. Medical assistance including opioid use disorder (OUD)/substance use disorder (SUD) benefits that would otherwise be matchable if the beneficiary were not residing in an IMD.

2. Executive Summary

- Metrics appearing in this attachment portray the months of January through March of 2022.In general treatment service trends stabilized although with a continued slight trend downward. Please note that this measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.

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

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
1.2 Assessment of Need and Qualification for SUD Services			
1.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.	The monthly number of Medicaid beneficiaries with an SUD diagnosis has fluctuated slightly and continues to be trending downward slightly in more recent months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#3: Medicaid beneficiaries with SUD diagnosis (monthly)
☒ The state has no metrics trends to report for this reporting topic.	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#4: Medicaid beneficiaries with SUD diagnosis (annual)
	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#5: Medicaid beneficiaries treated in an IMD for SUD
1.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) The target population(s) of the demonstration.**			

☐ ii) The clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration.			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to assessment of need and qualification for SUD services.			
☒ The state has no implementation update to report for this reporting topic.			
2.2 Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)			
2.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1.	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received any SUD treatment has fluctuated slightly and continues to be trending downward slightly in more recent months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#6: Any SUD Treatment
	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received SBIRT has fluctuated slightly but has remained fairly stable. Research within the state has highlighted some barriers to billing for SBIRT, including but not limited to staff turnover and uncertainty around reimbursement. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#7: Early Intervention
	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received outpatient SUD treatment has fluctuated slightly and continues to be trending downward slightly in more recent months. Note: This	04/01/2019 – 06/30/2019	#8: Outpatient Services

	measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.		
	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received residential and inpatient SUD treatment has fluctuated slightly continues to be trending downward slightly in more recent months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#10: Residential and Inpatient Services
	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received withdrawal management SUD treatment has fluctuated slightly and continues to be trending downward slightly in more recent months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#11: Withdrawal Management
	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received MAT SUD treatment has fluctuated slightly and continues to be trending downward slightly in more recent months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#12: Medication Assisted Treatment
☒ The state has no metrics trends to report for this reporting topic.	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#36: Average Length of Stay in IMDs

2.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) Planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g., outpatient services, intensive outpatient services, medication assisted treatment, services in intensive residential and inpatient settings, medically supervised withdrawal management).** **☐ ii) SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and medication assisted treatment services provided to individuals in IMDs.**			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 1.			
☒ The state has no implementation update to report for this reporting topic.			
3.2 Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)			
3.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 2.			

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

greater than 2 percent related to Milestone 3.			
☒ The state has no trends to report for this reporting topic.			
☐ The state is not reporting metrics related to Milestone 3.			
4.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards.** **☐ ii) State review process for residential treatment providers' compliance with qualifications standards.** **☐ iii) Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site.**			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 3.			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state is not reporting metrics related to Milestone 3.			

5.2 Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)			
5.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4.	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#13: SUD provider availability
☒ The state has no trends to report for this reporting topic.	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#14: SUD provider availability – MAT
5.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ Planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care.**			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 4.			
☒ The state has no implementation update to report for this reporting topic.			
6.2 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)			
6.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 5.			
☒ The state has no trends to report for this reporting topic.	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2017 – 12/31/2017	#15: Initiation and

			Engagement of Alcohol and Other Drug Treatment
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2018 – 12/31/2018	#18: Use of Opioids at High Dosage in Persons without Cancer (modified by State)
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2018 – 12/31/2018	#21: Concurrent Use of Opioids and Benzodiazepines (modified by State)
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2018 – 12/31/2018	#22: Continuity of Pharmacotherapy for Opioid Use Disorder (modified by State)

6.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD.** **☐ ii) Expansion of coverage for and access to naloxone.**			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 5.			
☒ The state has no implementation update to report for this reporting topic.			
7.2 Improved Care Coordination and Transitions between Levels of Care (Milestone 6)			
7.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 6.			
☒ The state has no trends to report for this reporting topic.	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2017 – 12/31/2017	#17(1): Follow-Up after Emergency Department Visit for Alcohol or Other Drug Dependence

	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2017 – 12/31/2017	#17(2): Follow-Up after Emergency Departmen t Visit for Mental Illness
7.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ Implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports.**			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 6.			
☒ The state has no implementation update to report for this reporting topic.			
8.2 SUD Health Information Technology (Health IT)			
8.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its Health IT metrics.			
☒ The state has no trends to report for this reporting topic.	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2017 – 06/30/2018	Q1: PDMP Statewide Fatal Drug Overdoses – All, All

			Opioids, Heroin, Prescription Opioids (excluding synthetic opioids), Synthetic Opioids (not Methadone)
	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	Q2: Substance Use Disorder Treatment Penetration Rate
	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	Q3: Foundational Community Supports Beneficiaries with Inpatient or Residential SUD Services
8.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to:			

☐ i) How health IT is being used to slow down the rate of growth of individuals identified with SUD. **☐ ii) How health IT is being used to treat effectively individuals identified with SUD.** **☐ iii) How health IT is being used to effectively monitor "recovery" supports and services for individuals identified with SUD.** **☐ iv) Other aspects of the state's plan to develop the health IT infrastructure/capabilities at the state, delivery system, health plan/MCO, and individual provider levels.** **☐ v) Other aspects of the state's health IT implementation milestones.** **☐ vi) The timeline for achieving health IT implementation milestones.** **☐ vii) Planned activities to increase use and functionality of the state's prescription drug monitoring program.**			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Health IT.			
☒ The state has no implementation update to report for this reporting topic.			

9.2 Other SUD-Related Metrics			
9.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to other SUD-related metrics.	The rate of emergency department utilization for SUD has remained relatively stable over the last 6 months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#23: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries
	The rate of inpatient stays for SUD has remained relatively stable over the last 6 months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries
☒ The state has no trends to report for this reporting topic.	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#25: Readmissions Among Beneficiaries with SUD
	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2017 – 06/30/2018	#26: Overdose Deaths (count)
	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2017 – 06/30/2018	#27: Overdose

			Deaths (Rate)
	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2017 – 12/31/2017	#40: Access to Preventive /Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD.
9.2.2 Implementation Update			
☐ The state expects to make other program changes that may affect metrics related to other SUD-related metrics.			
☒ The state has no implementation update to report for this reporting topic.			
10.2 Budget Neutrality			
10.2.1 Current status and analysis			
☐ If the SUD component is part of a broader demonstration, the state should provide an analysis of the SUD-related budget neutrality and an analysis of budget neutrality. Describe the status of budget neutrality and an analysis of the budget neutrality to date.			
10.2.2 Implementation Update			
☐ The state expects to make other program changes that may affect budget neutrality			

☒ The state has no implementation update to report for this reporting topic.			
11.1 SUD-Related Demonstration Operations and Policy			
11.1.1 Considerations			
☐ States should highlight significant SUD (or if broader demonstration, then SUD-related) demonstration operations or policy considerations that could positively or negatively affect beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.			
☒ The state has no related considerations to report for this reporting topic.			
11.1.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) How the delivery system operates under the demonstration (e.g., through the managed care system or fee for service).** **☐ ii) Delivery models affecting demonstration participants (e.g., Accountable Care Organizations, Patient Centered Medical Homes).**			

☐ **iii) Partners involved in service delivery.**			
☒ **The state has no implementation update to report for this reporting topic.**			
☐ **The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities.**			
☒ **The state has no implementation update to report for this reporting topic.**			
☐ **The state is working on other initiatives related to SUD or OUD.**			
☒ **The state has no implementation update to report for this reporting topic.**			
☐**The initiatives described above are related to the SUD or OUD demonstration (States should note similarities and differences from the SUD demonstration).**			
☒ **The state has no implementation update to report for this reporting topic.**			
12. SUD Demonstration Evaluation Update			
12.1. Narrative Information			
☐ **Provide updates on SUD evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. See report template instructions for more details.**			

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

implementation plan, or monitoring protocol, based on expected or upcoming implementation changes.			
☒ The state has no updates on general requirements to report for this reporting topic.			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) The schedule for completing and submitting monitoring reports.** **☐ ii) The content or completeness of submitted reports and/or future reports.**			
☒ The state has no updates on general requirements to report for this reporting topic.			
☐ The state identified real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation			
☒ The state has no updates on general requirements to report for this reporting topic.			
13.1.2 Post-Award Public Forum			
☐ If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for			

the period during which the forum was held and in the annual report.			
☒ No post-award public forum was held during this reporting period and this is not an annual report, so the state has no post-award public forum update to report for this topic.			
14.1 Notable State Achievements and/or Innovations			
14.1 Narrative Information			
☐ Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD (or if broader demonstration, then SUD related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.			
☒ The state has no notable achievements or innovations to report for this reporting topic.			

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

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

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

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

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

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

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

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

State		Washington
Demonstration name		Washington State Medicaid Transformation Project No. 11-W-00304/0
Approval date for demonstration		January 9, 2017
Approval period for SMI/SED		November 6, 2020-December 31, 2022
Approval date for SMI/SED, if different from above		November 6. 2020
Implementation date of SMI/SED, if different from above		December 23, 2020
SMI/SED (or if broader demonstration, then SMI/SED -related) demonstration goals and objectives		This demonstration amendment will provide authority for the state to receive FFP for delivering treatment to Medicaid beneficiaries diagnosed with SMI while they are short-term residents in settings that qualify as IMDs, primarily to receive treatment for SMI. The goal of this amendment is for the state to maintain and enhance access to mental health services, and continue delivery system improvements to provide more coordinated and comprehensive treatment for beneficiaries with SMI. With this approval, beneficiaries will have access to a continuum of services at new settings that, absent this amendment, would be ineligible for payment for most Medicaid enrollees.

2. Executive Summary

- Metrics trends are currently not available as we await updated specifications and work through some critical issues on data definitions.

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

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

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

☐ ii) Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers ☐ iii) State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers within 72 hours post discharge ☐ iv) Strategies to prevent or decrease the lengths of stay in EDs among beneficiaries with SMI or SED (e.g., through the use of peers and psychiatric consultants in EDs to help with discharge and referral to treatment providers) ☐ v) Other State requirements/policies to improve care coordination and connections to community based care			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 2.			
☒ The state has no implementation update to report for this reporting topic.			
3.2 Access to Continuum of Care, Including Crisis Stabilization (Milestone 3)			
3.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 3.			
☒ The state has no trends to report for this reporting topic.			

3.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) State requirement that providers use an evidenced-based, publicly available patient assessment tool to determine appropriate level of care and length of stay ☐ ii) Other state requirements/policies to improve access to a full continuum of care including crisis stabilization			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 3.			
☒ The state has no implementation update to report for this reporting topic.			
4.2 Earlier Identification and Engagement in Treatment, Including Through Increased Integration (Milestone 4)			
4.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4.			
☒ The state has no trends to report for this reporting topic.			
4.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) Strategies for identifying and engaging beneficiaries in treatment sooner (e.g., with supported education and employment) ☐ ii) Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment			

☐ iii) Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED ☐ iv) Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 4.			
☒ The state has no implementation update to report for this reporting topic.			
5.2 SMI/SED Health Information Technology (Health IT)			
5.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its health IT metrics.			
☒ The state has no trends to report for this reporting topic.			
5.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) The three statements of assurance made in the state's health IT plan ☐ ii) Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider and/or physician/mental health provider to community based supports			

☐ iii) Electronic care plans and medical records ☐ iv) Individual consent being electronically captured and made accessible to patients and all members of the care team ☐ v) Intake, assessment and screening tools being part of a structured data capture process so that this information is interoperable with the rest of the health IT ecosystem ☐ vi) Telehealth technologies supporting collaborative care by facilitating broader availability of integrated mental health care and primary care ☐ vii) Alerting/analytics ☐ viii) Identity management			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make the following program changes that may affect metrics related to health IT.			
☒ The state has no implementation update to report for this reporting topic.			
6.2 Other SMI/SED-Related Metrics			
6.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than two 2 percent related to other SMI/SED-related metrics.			
☒ The state has no trends to report for this reporting topic.			

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

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

☐ i) Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, and observation/assessment centers, with a coordinated community crisis response that involves law enforcement and other first responders ☐ ii) Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model			
☒ The state has no implementation update to report for this reporting topic.			
9.2 Budget Neutrality			
9.2.1 Current Status and Analysis			
☐ If the SMI/SED component is part of a broader demonstration, the state should provide an analysis of the SMI/SED-related budget neutrality and an analysis of budget neutrality as a whole. Describe the current status of budget neutrality and an analysis of the budget neutrality to date.			
9.2.2 Implementation Update			
☐ The state expects to make the following program changes that may affect budget neutrality.			
☒ The state has no implementation update to report for this reporting topic.			
10.1 SMI/SED-Related Demonstration Operations and Policy			
10.1.1 Considerations			
☐ States should highlight significant SMI/SED (or if broader demonstration, then			

SMI/SED-related) demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SMI/SED demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.			
☒The state has no related considerations to report for this topic.			
10.1.2 Implementation Update			
☐ The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities.			
☒ The state has no implementation update to report for this reporting topic.			
☐The state is working on other initiatives related to SMI/SED.			
☒The state has no implementation update to report for this reporting topic.			
☐The initiatives described above are related to the SMI/SED demonstration as described (States should note similarities and differences from the SMI/SED demonstration).			
☒The state has no implementation update to report for this reporting topic.			
Compared to the demonstration design and operational details, the state expects to make the following changes to:			

☐ i) How the delivery system operates under the demonstration (e.g. through the managed care system or fee for service) ☐ ii) Delivery models affecting demonstration participants (e.g. Accountable Care Organizations, Patient Centered Medical Homes) ☐ iii) Partners involved in service delivery ☐ iv) The state Medicaid agency's Memorandum of Understanding (MOU) or other agreement with its mental health services agency			
☒The state has no implementation update to report for this reporting topic.			
11 SMI/SED Demonstration Evaluation Update			
11.1. Narrative Information			
☐ Provide updates on SMI/SED evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. See report template instructions for more details.			
☒ The state has no SMI/SED demonstration evaluation update to report.			
☐Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.			
☒The state has no SMI/SED demonstration evaluation update to report.			

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

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

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

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