Washington State Medicaid Transformation Project (MTP) demonstration

Section 1115 Waiver Quarterly Report (DY6 Q1)

Demonstration Year: 6 (January 1 to December 31, 2022)

Reporting Quarter: 1 (January 1 to March 31, 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.

In early 2021, Washington State requested an MTP one-year extension because of disruptions from the COVID-19 pandemic. CMS approved the request, and MTP will continue for a sixth year, which ends December 31, 2022.

During the six-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) 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), also called supportive housing and Individual Placement and Support (IPS), also called supported employment.
- SUD IMD waiver: treatment services, including short-term services provided in residential and inpatient treatment settings that qualify as an institution for mental diseases (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: January 1–March 31, 2022

This quarterly report summarizes MTP activities from the first quarter of 2022: January 1 through March 31. It details MTP implementation, including stakeholder education and engagement, planning and implementation, and development of policies and procedures.

Summary of quarter accomplishments

- The state continued work on a longer-term MTP application for renewal, with submission to CMS anticipated during Q3 of 2022. HCA shared renewal concepts with CMS during Q1 and will continue to engage CMS before and after submission.

- ACHs continued to distribute incentive funds to partnering providers through the financial executor (FE) portal. During the reporting period, ACHs distributed more than $18 million to partnering providers and organizations. The state distributed approximately $184,000 in earned incentive funds to IHCPs in Q1 for achievement of IHCP-specific Project milestones.

- As of March 31, 2022, nearly 13,000 clients have received services and supports from the MAC and TSOA programs. New enrollees in LTSS for this reporting period include 36 MAC dyads, 255 TSOA dyads, and 490 TSOA individuals.

- Within FCS, the total aggregate number of people enrolled in services as of March 31, 2022, included 4,757 in IPS and 6,854 in CSS. The total unduplicated number of enrollments at the end of this reporting period was 9,681.

MTP-wide stakeholder engagement

During the reporting period, HCA shared an announcement about Washington State's pursual of an MTP renewal. HCA also announced the release of new materials about the MTP renewal. These new materials explain what programs will continue, expand, or begin under the renewal:

- The about the MTP renewal provides in-depth detail on each renewal program. In addition, this document shares general information about Medicaid (Apple Health in Washington) and Section 1115 Medicaid demonstration waivers.

- The snapshot provides a quick summary of the renewal programs.

- The evolution of Initiative 1 shares what HCA, ACHs, and other partners will focus on in the renewal.

To reach a wider audience, especially communities where English may be a second language, HCA translated the "about the MTP renewal" and "snapshot" documents. These materials are available in Cambodian, Chinese, Korean, Laotian, Russian, Somali, Spanish, and Vietnamese languages. Visit the MTP renewal page to view these resources.

In addition, staff began planning for and coordinating the formal MTP renewal public comment period, which will occur next quarter. Activities included:

- Scheduling the virtual public hearings and securing presenters.

- Developing an infographic about the renewal application process.

- Creating a high-level PowerPoint presentation geared toward the public.

- Sharing MTP renewal resources and materials with ACHs and asking them to share with their networks and communities.

- Beginning the development of the Washington State Register notice, which will accompany the full public notice and other information on the [MTP renewal page](#), once the formal public comment period opens.

- Beginning the development of the public comment survey, which will be another option for people to share their feedback with HCA during the public comment period.

- Continuing monthly Tribal meetings to discuss renewal developments ahead of Roundtables and Tribal Consultation.

During the reporting period, HCA also updated several pages within the [MTP website section](#) to include updated information about the one-year extension of the current MTP waiver.

Statewide activities and accountability

Value-based purchasing (VBP)

HCA completed a series of strategy meetings to revisit VBP goals for 2022-2025, building on MTP and VBP priorities and focus areas. During these strategy meetings, staff also discussed the original purchasing goal of achieving 90 percent of state-financed health care in value-based payment arrangements by the end of 2021. In Q1 of demonstration year (DY) 6, HCA finalized a set of new purchasing goals and will begin sharing and vetting them internally.

Paying for Value surveys

In early February, HCA announced results from the Paying for Value surveys. Later that month, the agency held a webinar on the 2021 Paying for Value survey analysis webinar. Staff presented on survey results from health care plans (including commercial) and health care providers, which included VBP topics like:

- Health plan and provider participation in alternative payment models.

- Enablers and barriers to VBP adoption.

- Health equity programs and data collection.

- Impact of COVID-19 on VBP.

HCA also developed an [executive summary](#) of the survey results, which offers a comprehensive look at participation and experience in VBP, barriers and enablers to VBP adoption, 2021 survey conclusions, and more. This executive summary, along with the webinar slide deck and other resources, are available on the [VBP website section](#).

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 special terms and conditions (STCs), describes how MTP supports providers and MCOs to move along the value-based care continuum. The roadmap establishes targets for VBP attainment and related Delivery System Reform Incentive Payment (DSRIP) program incentives for MCOs and ACHs. There were no new activities for the VBP Roadmap or Apple Health Appendix in Q1.

Validation of financial performance measures

Washington State Medicaid Transformation Project demonstration
Approval period: January 9, 2017, through December 31, 2022

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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 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 will meet with MSLC in Q2 to kick-off the 2022 validation process.

Statewide progress toward VBP targets

HCA sets annual VBP adoptions 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. HCA completed the analysis of these data in Q4 of 2021 (DY5) and presented the findings in a webinar (stated above under "Paying for Value surveys").

Technical support and training

- No new activities in Q1

Upcoming activities

- HCA will begin preparation for the 2022 survey process and the MCO VBP validation process in Q2 of DY6.

Integrated managed care (IMC) progress

In 2014, Washington State legislation 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 Q1.

- Stabilizing the behavioral health provider network has continued to be a challenge because of the COVID-19 pandemic. However, significant behavioral health workforce gaps are now the bigger concern and ACHs and MCOs have been exploring and implementing strategies to mitigate these issues.

- Since April 2021, HCA has maintained focus in two areas specific to measuring clinical integration and bi-directional care, with the assistance of most of the ACHs around the state. Updates for this reporting period include:

  o HCA partnered with MCOs and ACHs to advance these recommendations and ongoing monitoring of these performance measures.

  o HCA, in partnership with ACHs, completed follow-up meetings in all 10 regions and concluded these meetings in the Q1 of 2022. These meetings were facilitated discussions with the regional providers, MCOs, ACHs, and behavioral health administrative service organizations (BH-ASOs). Ongoing monitoring and collaboration will continue to monitor these performance measures and advance improvements across the state.

In 2021, the state completed its research to identify a new clinical integration assessment tool to better support the advancement of bi-directional physical and behavioral health clinical integration in Washington State. The tool, called the Washington Integrated Care Assessment (WA-ICA) will be completed by outpatient behavioral and physical health practices to track progress and to serve as a roadmap for practice teams in advancing integration.

Domains and subdomains (evidence-based elements of bidirectional integration) on the WA-ICA include screenings, referrals, care management, and sharing treatment information. A complete list of the domains and more information about the tool is available on the [HCA site](#).

During Q4 of 2021, the WA-ICA Workgroup in consultation with the HCA, introduced methodology to identify practice cohorts and developed an implementation schedule. The workgroup continued to develop a comprehensive set of strategies for outreach and engagement, including launching a dedicated website section on the [HCA site](#) and holding a panel discussion at the 2021 HCA/ACH Learning Symposium.

Implementation will begin in July 2022 with an initial cohort of practices. Additional cohorts will begin to use the tool every six months, through July 2024.

During Q1 of 2022, the state continued to prepare for implementation with the first cohort of practices in July 2022 and planning for subsequent cohorts across the state. This included refinements to the WA-ICA tool and the development of a guidance document, FAQ, and other outreach and support materials.

The [WA-ICA portal](#) is available on the Healthier Washington Collaboration Portal for providers and care teams. This portal will provide access to the tools and contain support materials for orientation to the tool as well as additional resources for advancing integration. The workgroup also began working on recommendations for how coaching and technical assistance will be provided to advance integration across the state.

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: design, implementation and operations, and assessment.

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

- Electronic health records (EHRs)

- MH IMD waiver

- SUD HIT Plan and Prescription Drug Monitoring Program (PDMP) enhancements

- Master Person Index (MPI)

- Provider directory

- Payment models and sources

- Data and governance

- Health information exchange (HIE) functionality

- Registries

- Clinical Data Repository (CDR)

- Tribal engagement

Q1 of 2022 focused heavily on planning for several health IT- related initiatives, including the:

- Nationally required 988 crisis call line and the related, and more expansive, State requirements for a Crisis Call Center Hub System and a Behavioral Health Integrated Referral System;

- Electronic Health Record as a Service (EHRaaS); and

- Electronic Consent Management Solution.

Activities and successes

During Q1 of 2022, the Health IT team engaged in the following activities:

- The Health IT team engaged in the following activities in preparation for the implementation of the 988 crisis call line and planning for the enhanced Behavioral Health Integrated Client Referral System:

  - HCA coordinated internally and with the Department of Health (DOH) to support implementation planning for the nationally required 988 crisis call system, and the more expansive state requirements for a Crisis Call Center Hub System and the Behavioral Health Integrated Client Referral System.

  - The draft Technical and Operational Plan required by Washington State law for these systems, developed by HCA in collaboration with DOH, was submitted to the Governor's Office and Washington State Legislature in Q1 2022 following review and comments by the Crisis Response Improvement Committee Strategy (CRIS) Committee and Technical Subcommittee.

  - HCA provided overviews of the Draft Technical and Operational Plan to the CRIS Technical and 988 Tribal subcommittees.

  - HCA gathered information from the following sources in Washington State regarding the technology used and needed to respond to people in crisis:

    - Behavioral health crisis providers

    - BH-ASOs

    - Regional Crisis Lines

    - National Suicide Prevention Lifeline Services

  - HCA gathered information from other states because of their 988 implementation related activities (e.g., Michigan, Georgia, Colorado, Arizona, Oklahoma, and Indiana.)

  - HCA began identifying the technical functional requirements to support the implementation of the Behavioral Health Integrated Client Referral System required by Washington State law.

  - HCA began interviews with technology vendors and seeing demonstrations of their products that could potentially support the functional requirements for the Crisis Call Center Hub and the Behavioral Health Integrated Client Referral Systems.

- The Health IT team requested proposals for and awarded a contract for a project manager. The project manager will help create a request for proposals (RFP) for the design and implementation of an electronic consent management (ECM) solution. The ECM solution will first focus on the exchange of SUD information, subject to 42 CFR Part 2.

- The Washington State Legislature approved the Governor's budget proposal requesting funds to support the implementation of the health IT requirements for the MH IMD waiver. HCA will begin

planning for the implementation of some the health IT tasks included in the 2022 Annual HIT Operational Plan.

- The Health and Human Services (HHS) Coalition MPI project completed a high-level design of the MPI integration layer. They are currently in the process of developing the integration layer and establishing integration connections. The state's ProviderOne system will be the first system to connect, anticipated in the fall of 2022. HCA is in the process of developing governance processes and a model for MPI operations. DOH completed their MPI connections to the Washington Disease Registry System (WDRS) at the end of February.

- HCA continues to work with the Apple and Google stores to get the MyHealthButton App published in the provider directory and patient directory Application Programming Interfaces (APIs).

- The state continues to work on the funding needed for licensing and lead organization services for the cloud based EHR solution, called EHRLite. The EHR Lite is a technology tool that provides a limited set of functionality compared to a certified EHR solution. EHRLite will be made available statewide to behavioral health, rural health, Tribal health, and long-term care providers seeking to implement an EHR solution. Pending the availability of funds, the EHRLite Pilot will be expanded.

- HCA, in collaboration with ACHs and MCOs, continued preparing for the initial implementation in July 2022 of the WA-ICA by outpatient primary care and behavioral health providers. During Q1 of 2022:
  - MCOs, ACHs, and HCA identified HealthierHere (an ACH) as the entity to receive and analyze WA-ICA assessment results and generate reports for providers, MCOs, and HCA for clinical integration.
  - The WA-ICA Communication Workgroup continued to develop and refine a methodology to identify the Medicaid-participating outpatient primary care and behavioral health practices that will be invited to complete the WA-ICA.
  - The workgroup continued to coordinate internally to align activities of the WA-ICA with the Multiple Payer Primary Care Initiative.
  - The workgroup continued planning for the initial July 2022 implementation of the WA-ICA

- HCA continued participation and collaboration in the Steering Committee for the Washington Care Coordination Workgroup. The Workgroup is comprised of ACHs, MCOs, HCA, and Collective Medical (a technology vendor). The Steering Committee explored opportunities and barriers to advance health information exchange using Collective Medical tools on behalf of persons who receive behavioral health services. The workgroup recommended three webinars for behavioral health agencies:
  - Collective Medical 101 – Refresher Training
  - Collective Medical Confidentiality and 42 CFR Part 2
  - Sustainable Practices for Using Collective Medical

DSRIP program implementation accomplishments

ACH project milestone achievement
Semi-annual reporting

ACHs report on their MTP activities, project implementation, and progress on required milestones. This is outlined in the [Project Toolkit](#). Semi-annual reports are submitted every six months. The most recent set of ACH semi-annual reports (SARs) were submitted on January 31, 2022, for the July 1–December 31, 2021 reporting period. After and independent assessment of performance by MSLC, it was determined that each ACH earned full credit for the SARs. In addition, the DY6 extension includes modified reporting requirements in place of SARs. The first DY6 report template was released by MSLC in February 2022.

Next steps

ACHs will submit the first DY6 report in April 2022 using the templated provided by MSLC. Payment for this report is anticipated by the end of Q2 2022.

HCA and ACHs continue to coordinate on the transition from implementation and continuous improvement to scale and sustainability strategies. In addition, HCA and ACHs are partnering closely on the overall transition of DSRIP and the design of new strategies within the longer-term MTP renewal application. Specifically, ACHs are contributing to the design of the Taking Action for Healthier Communities (TAHC) program that will introduce focused strategies on addressing health equity through community-based care coordination and new implementation of health-related services.

Annual VBP milestone achievement by ACHs

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

- HCA shared ACH progress in supporting provider VBP readiness through a webinar in Q1 (as stated above in "Paying for Value survey").

FE portal activity

ACHs continue to distribute incentive funds to partnering providers through the FE portal. During the reporting period, ACHs distributed more than $18 million to partnering providers and organizations in support of project activities. The state distributed approximately $184,000 in earned incentive funds to IHCPs in Q1.

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

DSRIP measurement activities

HCA submitted performance measure results to the IA for DY4. The IA will calculate the achievement values and determine the incentive amounts earned by each ACH. Achievement values are anticipated to be released in Q2 of this year.

CMS approved HCA's request for updates to measurement requirements that will apply to DY5 and DY6 performance. The updates impact pay-for-performance (P4P), high-performance pool (HPP), and statewide accountability quality improvement score (QIS) performance measurement.

One of the changes allows the state to adjust performance measurement from a two-year baseline gap to a year-over-year gap (i.e., 2020 will serve as the baseline for 2021 and 2021 as the baseline for 2022). In addition, all metrics for DY5 and DY6 will move from a gap-to-goal (GTG) methodology to improvement-over-self (IOS).

Statewide results

The STCs outline DSRIP statewide accountability requirements, and the DSRIP Measurement Guide defines the statewide accountability measurement methodology. Starting in DY3, Washington State committed to improvement and achievement of these core components:

- Quality improvement (QI): improvement and attainment of quality targets across a set of performance metrics.

- VBP adoption: improvement and attainment of defined statewide VBP adoption targets.

The QI model determines the statewide performance across the quality metrics set. To reach achievement satisfaction, the state must score a 0.2 or higher. For DY4, the state scored 1.0, so the state earned 100 percent.

VBP adoption performance (to achieve the Health Care Payment & Learning Action Network (HCP-LAN) categories 2C-4B) is set at 85 percent for DY4. For the state to receive full VBP incentives for statewide accountability, MCOs need to collectively meet that target. If not, the improvement score (IS) methodology will be used to determine total incentives earned for DY4.

In January 2022, after reviewing HCA's [2020 statewide accountability report](#), CMS confirmed that Washington State achieved 100 percent of the at-risk funding. The state earned 100 percent of the quality improvement performance and missed the VBP adoption performance target. This target was set at 85 percent, and the state achieved 82 percent.

DSRIP program stakeholder engagement activities

During the reporting period, HCA:

- Met with Artemis (a contractor working with all nine ACHs) to begin preliminary planning for the 2022 HCA/ACH Learning Symposium. Next year, HCA and ACHs will call this event the "Learning Collaborative."

- Announced [2020 statewide and regional performance results for ACHs](#).

- Engaged with and informed ACHs on MTP renewal activities, and asked ACHs to share the resources and materials from the [MTP renewal page](#) with their networks and communities.

- Began developing a health equity community outreach strategy, which involves ACHs, for the MTP renewal public comment period. Using their convening and community influence, ACHs are beginning to engage with their communities to seek input on the MTP renewal and its programs. Washington State wants to receive feedback from communities and individuals who may be impacted by the state's transformation efforts, including MTP.

- Began planning Tribal Consultation and Roundtable meetings with Tribal partners.

DSRIP stakeholder concerns

Q1 of 2022 included significant stakeholder engagement, in partnership with ACHs, to discuss the upcoming MTP renewal application and public comment process. Stakeholders remain engaged in the

development of the MTP renewal and support or recognize the need for proposing innovative programs and policies that have the potential to improve the health of individuals and communities.

Upcoming DSRIP activities

Following approval of the DY6 extension, the state will continue to work with CMS on several requested adjustments to reporting, performance, and funds flow. Revised protocols were submitted to CMS and are expected to be finalized in Q2 2022.

The state and ACHs will continue to collaborate on the MTP five-year renewal in Q2 2022. This includes close partnership on community engagement and gathering feedback from the formal public comment period.

Weekly engagement with ACHs will continue and the focus will shift from concept design for the MTP renewal to DSRIP transition and renewal operational planning. HCA envisions convening a workgroup that includes ACH and MCOs to discuss the MTP renewal strategies around SDOH payment and community-based care coordination. The MTP renewal will require closer partnership between MCOs and ACHs, including clear roles that leverage each group's strengths to advance health equity and innovation.

Tribal project implementation activities

- **Primary milestone:** Initial development of the concept of a statewide Native Hub for the MTP renewal application.

Tribal partner engagement timeline

- January 4: participated in internal meeting regarding MTP renewal application timeline and public engagement

- January 10: met internally to discuss potential funding models under a renewed MTP

- January 10: participated in internal meeting regarding MTP renewal application timeline and public engagement

- January 11: Participated in internal meeting regarding the health-related social needs (HRSN)

- January 12: HCA hosted follow-up consultation on the concept of including Dental Health Aide Therapists in the MTP renewal application

- January 18: participated in internal meeting regarding MTP renewal application timeline and public engagement

- January 19: participated in Community Health Aide Program (CHAP) Board workgroup

- January 20: participated in meeting between HCA and DOH on community-based care coordination

- January 25: participated in internal meeting regarding HRSN

- January 31: participated in an internal meeting regarding Tribes and IHCPs' participation in the evolution of Initiative 1 of MTP

- February 10: participated in internal workgroup on MTP renewal application

- February 14: participated in the Tribal Alignment Committee for North Sound Accountable Community of Health

- February 15: participated in internal meeting regarding MTP renewal application

- February 17: participated in conversation between Washington and Oregon regarding MTP waiver development

- February 24: participated in internal meeting regarding MTP renewal application

- February 28: participated in internal meeting regarding MTP renewal application

- March 1: participated in internal meeting regarding Tribes and IHCPs' engagement in MTP renewal application

- March 16: participated in internal meeting regarding MTP renewal application

- March 17: participated in internal meeting regarding the concept of flexible health equity funding

- March 23-25: participated in multiple meetings about MTP renewal application development, including conversations regarding ACHs and community-based care coordination, health equity and early conversations regarding Native Hub

- March 28-31: participated in internal meetings regarding MTP renewal application, including flexible health equity funding and renewal application development with Manatt

LTSS implementation accomplishments

This section summarizes LTSS program development and implementation activities from January 1 through March 31, 2022. Key accomplishments for this quarter include:

- As of March 31, 2022, almost 13,000 clients, in addition to their family caregivers, have received services and supports through the MAC and TSOA programs.

- Aging and Long-term Support Administration (ALTSA) in collaboration with HCA, began drafting the MTP renewal application.

Network adequacy for MAC and TSOA

The state noted continued high utilization of home-delivered meals and personal emergency response systems (PERS) this quarter. The primary need for PERS appear to be supports for medication management and fall prevention.

Some Area Agencies on Aging (AAAs) have been involved in a pilot project for a new service under health maintenance and therapies, called Furry Pets. These are robot companion pets for people who need the companionship of a pet but do not have the physical or mental means to care for a real pet. Other AAAs will continue their efforts next quarter for implementing this new service across the state.

AAAs continue to face the challenge of obtaining home care agency workers to assist and support care receivers and their family caregivers. Home and Community Services (HCS) remains committed to collaborating with AAAs to strategize potential solutions for the home care agency worker shortage.

Assessment and systems update

During Q1 of 2022, an electronic "calculator" was developed and integrated into the GetCare assessment tool. This will aid caregivers and case managers who assist care receivers in managing a six-month budget. Final testing is being completed and the state plans to release this new tool and conduct training next quarter on how to use it.

The TCARE evidence-based caregiver assessment is being revised by the owner/developer, TCARE, Inc. HCS has been working with the TCARE staff this quarter to identify the changes and hope to integrate the 5.0 version into GetCare next quarter.

Additionally, the HCS MTP team began to gather business requirements this quarter to develop the electronic interface with the Consumer Directed Employer (CDE) system, used in Washington State for employment of individual providers. When the systems and policy are ready, use of the CDE will provide the state with the ability to implement self-directed care for MAC and TSOA recipients. HCS hopes to complete this development by the end of 2022.

Staff training

MAC and TSOA program managers for HCS 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:

- January: Overview of the Quality Assurance Process and the Performance Measures for 2022

- March: Use of Electronic Forms and Client Notices in GetCare System

Upcoming webinars:

- April: MTD GetCare Desk Manual Orientation

- May: Those Rascally Recipient Aid Categories (RACs) and Other Errors (GetCare, CARE, and ProviderOne)

Data and reporting

Table 1: beneficiary enrollment by program

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of March 31, 2022	230	1425	3445
Number of new enrollees in quarter by program	36	255	490
Number of new person-centered service plans in quarter by program	15*	84**	188**
Number of beneficiaries self-directing services under employer authority**	0	0	0

*18 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.
**164 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.
***301 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 CDE is fully implemented for the 1915c and 1915k programs.

Figure 1: care plan proficiency

Care Plan Proficiency
Jan-Mar 2022
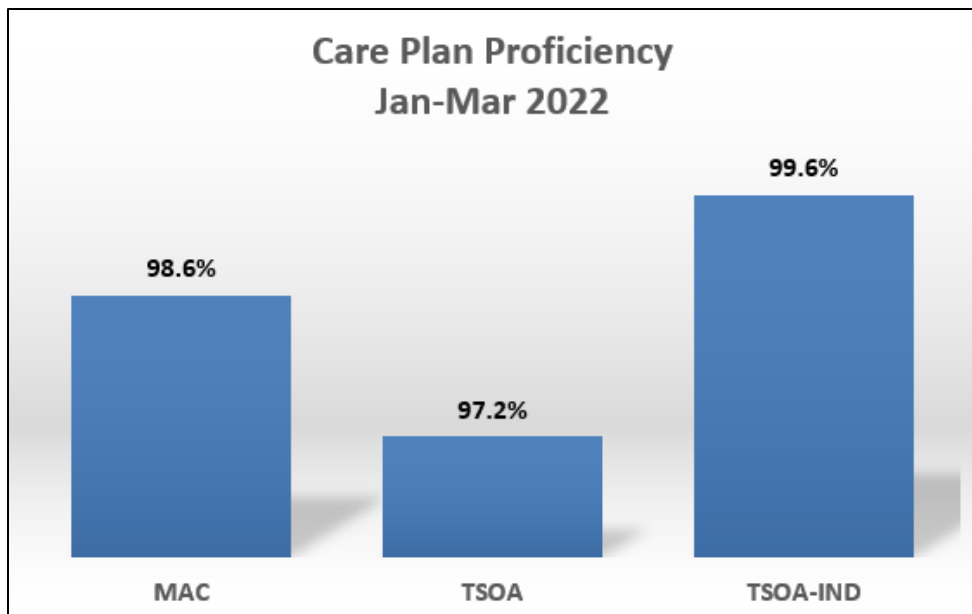
The state is proud to report the AAAs' continued proficiency in timely completion of care plans for enrollees.

Tribal engagement

ALTSA met with several Tribes to discuss Medicaid services and MTP Initiatives 2 and 3 during the quarter. The meetings included:

- March 8, 2021: ALTSA Region 1 HCS Tribal Liaisons shared LTSS brochures and long-term care/MAC/TSOA application packets with the Yakama Nation Confederated Tribes.
- ALTSA Region 1 HCS Tribal Liaisons discussed bringing a second MAC/TSOA training to Tribal workers.
- 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.

Washington State continues to be under a declared state of emergency (public health emergency). It has impacted all aspects of state, local, and Tribal government operations.

Outreach and engagement

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

Table 2: outreach and engagement activities by AAA

	January	February	March
	Number of events held		
Community presentations and information sharing	36	27	23

Quality assurance

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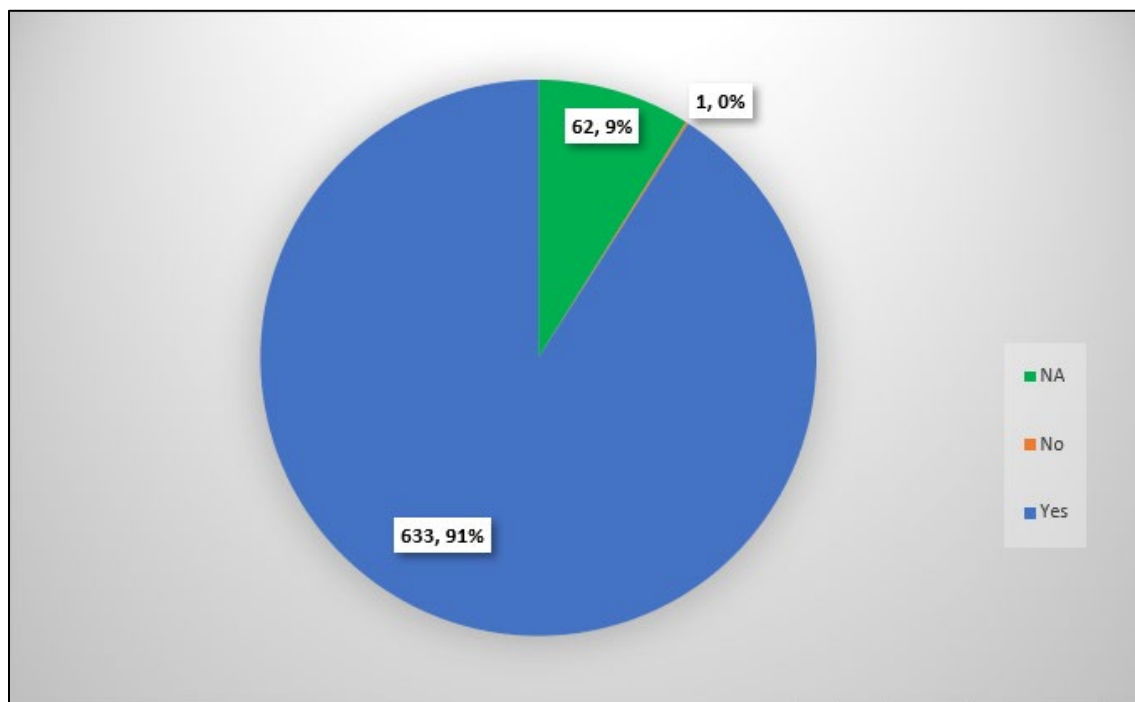
Figure 3: Question 2a: did the client remain eligible after the PE period?
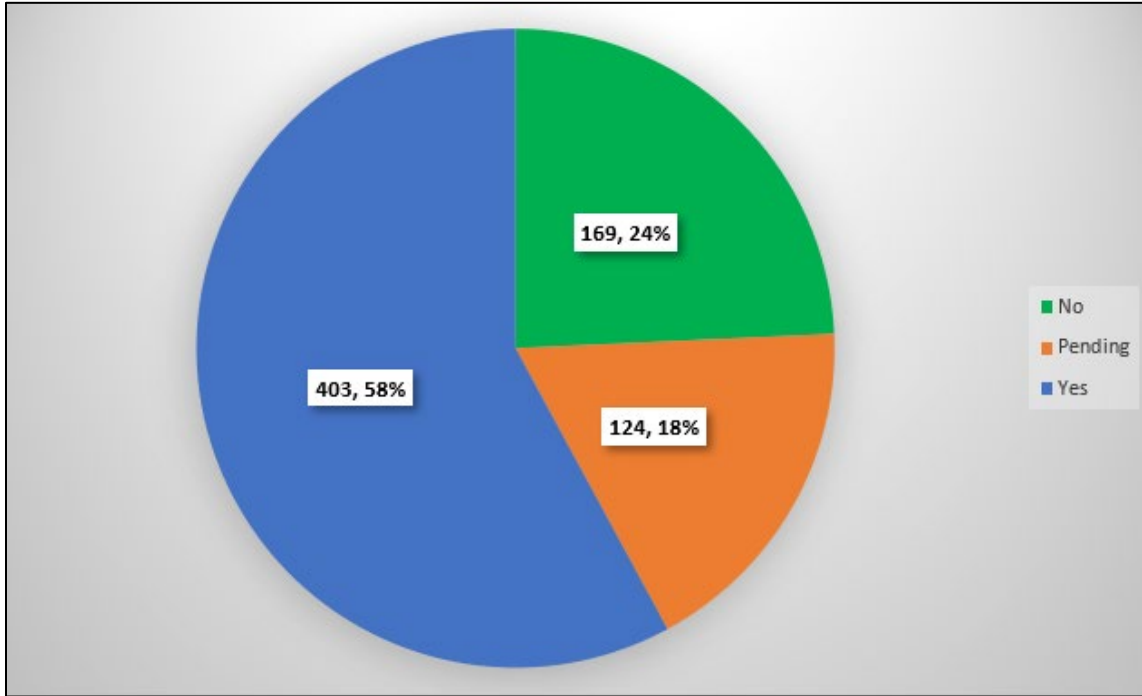

Figure 4: Question 2b: if "No" to question #2a, why?
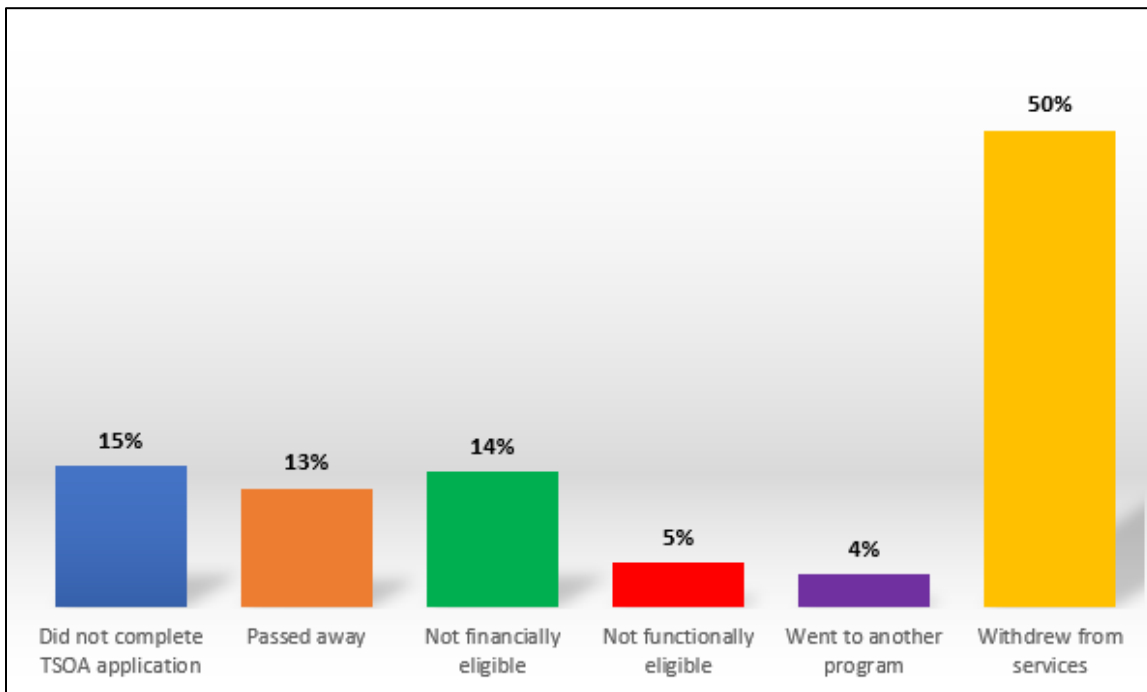
Note: these percentages represent the "No" population in the previous table (24 percent). For example, the 14 percent of PE clients found to be not financially eligible are 14 of the 24 percent illustrated in Question 2a.

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 was conducted with all 13 AAAs. An identical review process was used in each AAA Planning and Service Area (PSA), using the same quality assurance tool and the same 19 performance measures.

The Quality Assurance team reviewed a statistically valid sample of case records. The sample size in 2022 was 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
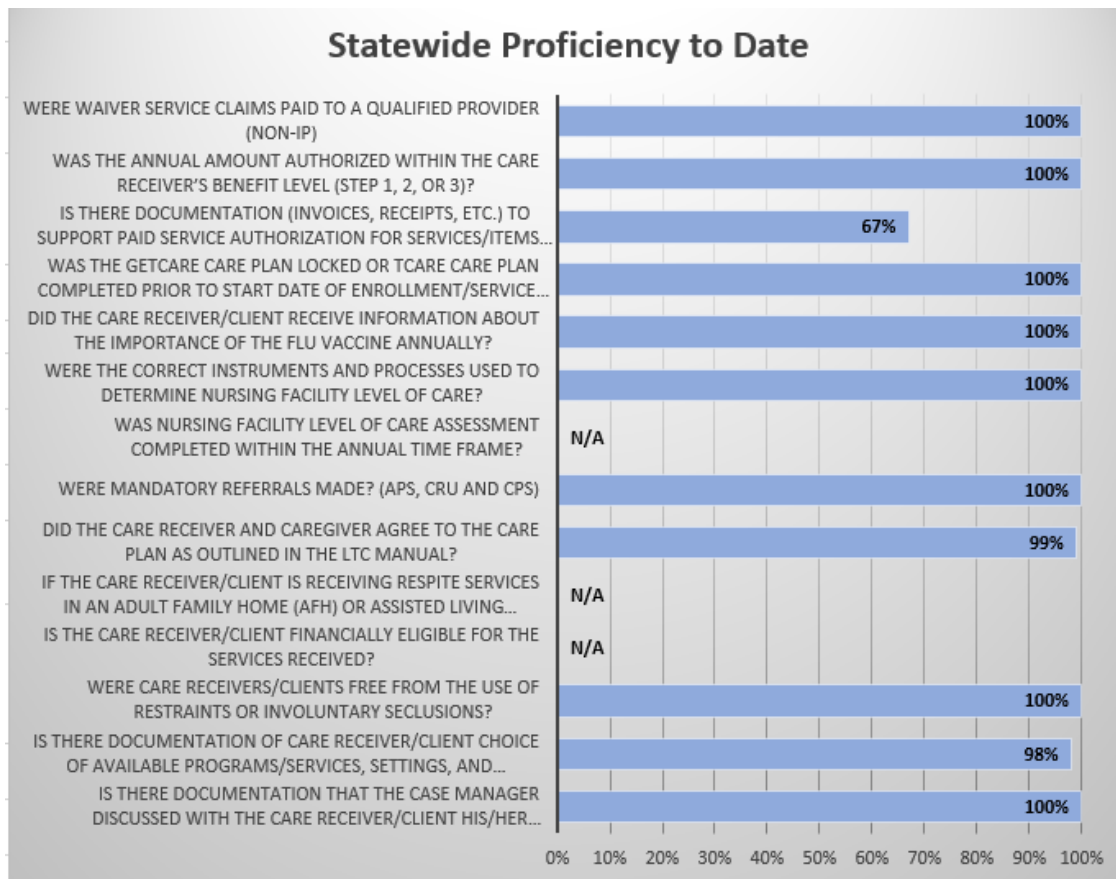
State rulemaking

HCS began 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.

Upcoming activities

The HCS MTP team will continue efforts, in collaboration with HCA, to conduct public hearings, Tribal Consultations, and drafting of the MTP renewal application. Program managers will present an overview of 1915c, 1915k and 1115 LTSS programs to Health Home Coordinators across the state in April 2022.

LTSS stakeholder concerns

There were no new stakeholder concerns noted in Q1 of 2022. As reported in Q4 of 2021, stakeholders remain concerned about the lack of available respite and personal care providers across the state. HCS anticipates improvements in this area over the next year as new staff (who are dedicated to recruitment and retention of the direct care workforce) are hired and begin their work. Improvements are also anticipated based on MAC and TSOA collaboration with the CDE vendor to utilize individual providers who will provide personal care and respite care services.

FCS implementation accomplishments

MTP 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 January 1 through March 31, 2022. Key accomplishments for the quarter include:

- Total aggregate number of people enrolled in FCS services at the end of DY6 Q1:
    - CSS: 6,854
    - IPS: 4,757
- There were 170 providers under contract with Amerigroup at the end of DY6 Q1, representing 462 sites throughout the state.

Note: CSS and IPS enrollment totals include 1,930 participants enrolled in both programs. The total unduplicated number of enrollments at the end of this reporting period was 9,681.

Network adequacy for FCS
Table 3: FCS provider network development

FCS service type	January		February		March	
	Contracts	Service locations	Contracts	Service locations	Contracts	Service locations
IPS	35	73	35	73	37	76
CSS	19	45	19	45	19	45
CSS and IPS	113	337	114	338	114	338
Total	167	455	168	456	170	459

The FCS provider network saw new growth in DY6 Q1 with the addition of one provider network delivering both IPS and CSS services, and two new providers offering IPS services only. The growth of the provider network has largely been able to satisfy the needs of the growing enrollee count.

Client enrollment
Table 4: FCS client enrollment

	January	February	March
IPS	2,611	2,787	2,827
CSS	4,525	4,839	4,924
CSS and IPS	1,726	1,897	1,930
Total aggregate enrollment	8,862	9,523	9,681

Data source: Research and Data Analysis (RDA) administrative reports

Table 5: FCS client risk profile

		Met HUD homeless criteria	Avg. PRISM risk score	SMI
January	IPS	553 (13%)	.91	3,001 (69%)
	CSS	1,371 (22%)	1.18	3,992 (64%)
February	IPS	585 (12%)	.93	3,282 (70%)
	CSS	1,466 (22%)	1.24	4,385 (65%)
March	IPS	587 (12%)	.97	3,186 (67%)
	CSS	1,470 (21%)	1.3	4,239 (62%)

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
January	IPS	3,633	3,389 (93%)	2,218 (61%)	2,107 (58%)
	CSS	5,172	4,759 (92%)	3,812 (74%)	3,566 (69%)
February	IPS	3,932	3,647 (93%)	2,385 (61%)	2,261 (58%)
	CSS	5,564	5,088 (91%)	4,108 (74%)	3,829 (69%)
March	IPS	3,990	3,689 (92%)	2,386 (60%)	2,260 (57%)
	CSS	5,664	5,153 (91%)	4,142 (73%)	3,852 (68%)

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

Table 7: FCS client service utilization

		Medicaid-only enrollees*	LTSS	MH services	SUD services (received in last 12 months)	Care + MH or SUD services
January	IPS	3,633	378 (10%)	2,685 (74%)	1,391 (38%)	317 (9%)
	CSS	5,172	596 (12%)	3,488 (67%)	2,338 (45%)	481 (9%)
February	IPS	3,932	412 (10%)	2,873 (73%)	1,496 (38%)	345 (9%)
	CSS	5,564	630 (11%)	3,678 (66%)	2,503 (45%)	510 (9%)
March	IPS	3,990	427 (11%)	2,858 (72%)	1,474 (37%)	349 (9%)
	CSS	5,664	644 (11%)	3,639 (64%)	2,476 (44%)	522 (9%)

(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
January	IPS	1,294 (30%)	79 (2%)	459 (11%)	1,942 (45%)	444 (10%)	119 (3%)

	CSS	2,060 (33%)	298 (5%)	769 (12%)	2,125 (34%)	927 (15%)	72 (1%)
February	IPS	1,400 (30%)	87 (2%)	495 (11%)	2,097 (45%)	478 (10%)	127 (3%)
	CSS	2,219 (33%)	324 (5%)	810 (12%)	2,318 (34%)	988 (15%)	77 (1%)
March	IPS	1,428 (30%)	91 (2%)	508 (11%)	2,111 (44%)	491 (10%)	128 (3%)
	CSS	2,275 (33%)	330 (5%)	826 (12%)	2,333 (34%)	1,010 (15%)	80 (1%)

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

Quality assurance and monitoring activity

FCS staff worked with the third-party administrator (TPA), Amerigroup, to monitor the implementation of FCS during Q1. 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.

Significant work focused on identifying processes to reconnect enrollees to FCS because of changes in their health care 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 completed 11 fidelity reviews of contracted FCS providers, six for IPS service providers and five for CSS service providers. These reviews were completed virtually 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 (DVR) from the Department of Social and Health Services (DSHS) to facilitate more cross-system collaboration.

FCS staff also held two fidelity reviewers training events that teach FCS providers and prospective reviewers the 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 Substance Abuse and Mental Health Services Administration (SAMHSA) block grants to become reviewers or host a review.

Other FCS program activity

HCA continues to convene a monthly workgroup with ALTSA and RDA staff to develop, discuss, and decide on 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. The meeting series was organized by King County, the most populous county in Washington State. The meetings offer housing providers the opportunity to discuss implementation and learn from fellow providers on best practices when offering CSS or IPS services.

In partnership with DVR, HCA participates in a quarterly workgroup to improve consistency, collaboration, and employment outcomes for DVR customers with a behavioral health condition and who are receiving services from the DVR Supported Employment program and FCS.

Upcoming activities
- FCS staff will attend and present at the annual Housing First Partners Conference in Seattle in early Q2.

- FCS Transition Assistance Program (TAP) launches May 2, 2022, to provide Washington State-funded support to CSS enrollees with behavioral health treatment needs who are making housing transitions. The TAP fund, which is being administered by the TPA, will be drawn upon by CSS providers.

- FCS staff will continue to hold monthly workgroup meetings focused on the implementation of CSS services to support individuals transitioning out of inpatient behavioral health treatment settings. This work is largely aligned with MTP Initiatives 4 and 5 and coordinates similar efforts across other supportive housing programs.

- The first of two six-week Medicaid Academies will be offered to potential and current FCS providers in Q2, and then 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 interested in becoming Medicaid billers.

FCS program stakeholder engagement activities

HCA continues to receive inquiries from other states and entities about 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

	January	February	March
	Number of events held		
Training and assistance provided to individual organizations	40	54	81
Community and regional presentations and training events	2	5	2
Informational webinars	8	7	9
Stakeholder engagement meetings	19	18	19
Total activities	69	84	111

Training and assistance activities to individual organizations continued to increase this quarter. Webinars are intended to inform, educate, and coordinate resources for FCS providers serving people who need housing and employment services, resources, and supports.

Q1 topics included:

- Benefit planning overview

- Working with justice-involved individuals

- FCS implementation

- IPS review and sustainability

- Solution-focused discussion of continued job development challenges

- FCS Transition Assistance Program

- Workforce crisis: managing your vocational staff during times of staff shortages

- Case consultation

- SUD incentive funding

- Love yourself: overcoming burnout through resilience

- Fidelity training

- IPS elements and FCS

- Participant engagement and use of FCS

- Professionalism and boundaries for staff

- Fair housing updates

- Homeless services and coordinated entry

- FCS and housing policy

- Shared decision making in health outcomes in supportive housing

- Determining accommodations for job seekers

- Billing efficiency

- Q&A for forms and documentation

- Info exchange for FCS and peer navigators

- Barriers for FCS providers

- Housing resources for young adults

FCS stakeholder concerns

FCS program staff fielded various questions from providers around FCS billing in Q1. Changes in the ProviderOne database, which went into effect January 1, 2022, now require all providers to use their National Provider Identifier (NPI) for claims to be processed with MCOs.

Because the TPA is part of one of Washington's five Medicaid MCOs, this change also impacted FCS providers and their billing. In DY3 and DY4, HCA worked internally to create a streamlined enrollment process for providers (who were new to Medicaid billing) to enroll in ProviderOne. The majority of providers in the FCS network have previously enrolled in ProviderOne, which will likely mitigate additional challenges related to enrollment and billing.

SUD IMD waiver implementation accomplishments

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

This section summarizes SUD IMD waiver development and implementation activities from January 1 through March 31, 2022.

- The Washington State Legislature made additional investments in SUD funding during the 2021 legislative session. Highlights include:
    - Significant rate adjustments were funded for behavioral health care providers
    - $1 million in funding was added for opioid awareness marketing campaigns
    - $8.8 million in funding was added for opioid treatment provider rates
    - $3.6 million in funding was added for mobile opioid treatment services
    - $.5 million in funding was added for contingency management
    - $1.7 million in funding for pregnant and parenting individuals
    - $6 million in funding for overdose prevention/harm reduction efforts

Implementation plan
- No updates

SUD HIT plan requirements
During Q1 2022:

- The Washington State Legislature approved the Governor's budget proposal requesting funds to support the implementation of the Health IT requirements for the MH IMD waiver. HCA will begin planning to implement some of the HIT tasks included in its 2022 Annual HIT Operational Plan.

- HCA coordinated internally and with DOH to support implementation planning for the nationally required 988 crisis call system and the Crisis Call Center Hub System and Behavioral Health Integrated Client Referral System required under state law. 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 the being considered include tools for support crisis call response and dispatch, and behavioral health referral and follow-up.

- The HIT Team contracted with a project manager, who will help create an RFP for the design and implementation of an ECM solution. The first use case that this solution will focus on is the exchange of SUD information subject to 42 CFR Part 2.

Evaluation design
- No updates

Monitoring protocol
- No updates

Upcoming activities
- No updates

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. This program, known as MTP Initiative 4, began January 1, 2021. It 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 January 1 through March 31, 2022.

- The Washington State Legislature made additional investments in MH funding during the 2021 legislative session.. Highlights include:
    - $100 million in behavioral health provider relief to support capacity in the wake of COVID-19 disruptions
    - $10.2 million in support of behavioral health jail diversion programs
    - $6.4 million in support of crisis stabilization services for jail diversion
    - $8 million in funding for housing-first opportunities
    - $5.2 million in funding for assisted outpatient treatment programs
    - $4.2 million in funding for alternative response teams
    - $8 million in funding for behavioral health response teams and mobile crisis in King County
    - $2.8 million in funding for intensive outpatient and partial hospitalization services
    - $2.4 million in funding for transition-aged youth services
    - $2.3 million in funding for behavioral health personal care
    - $1.5 million in funding for homeless behavioral health respite care
    - $1.2 million in funding related to wraparound intensive services
    - $.8 million in funding for housing stabilization teams

Implementation plan

The state is required to submit an implementation plan for the MH IMD waiver, incorporating milestones outlined by CMS. At the time of the waiver application, Washington met a number of these milestones, based on its existing provision of MH services. Where the state did not yet meet the milestones, CMS was engaged to confirm appropriate adjustments. These changes, included in the state's MH implementation plan, are described below:

- **Milestone:** "2.a Actions ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning and include community-based providers in care transitions."
    - **Timeline:** MCO contracts updated to require pre-discharge planning and participation of community providers, effective January 2022.

- **Milestone:** "2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community- based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge"
    - **Timeline:** HCA amended its MCO contracts to shorten the contact period to 72 hours, effective January 1, 2022.

MH HIT plan requirements

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

- See activities under SUD HIT plan requirements.

Evaluation design

- Approval pending

Monitoring protocol

- Approved anticipated in Q2 2022

Upcoming activities

- Virtual public hearings for the MTP renewal

- Behavioral Health Conference in June

Quarterly expenditures

The following table reflects quarterly expenditures for DSRIP, LTSS, and FCS during DY6 (2022). In the first quarter, there were no incentives paid out to ACHs or MCOs.

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					
Cascade Pacific Action Alliance	$0					
Elevate Health	$0					
Greater Columbia	$0					
HealthierHere	$0					
North Central	$0					
North Sound	$0					
Olympic Community of Health	$0					
SWACH	$0					
Indian Health Care Providers	$0					

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				

CHPW	$0				
CCW	$0				
Molina	$0				
United Healthcare	$0				

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
TSOA	$1,759,393				
MAC	$50,791				
MAC and TSOA not eligible	$0				
FCS	$3,047,246				

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 October 2021.

November 2021 through March 2022 member months for non-expansion adults are forecasted caseload figures from CFC. Actual data for those months will be provided once available. Actual member months data for the SUD population is currently available through January 2022. HCA finalized the data criteria for identifying expenditures for the MH IMD waiver and is reporting member months for the first time for this population.

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	376,307	0	0	0	0				
Feb-17	375,204	0	0	0	0				
Mar-17	374,734	0	0	0	0				
Apr-17	373,588	0	0	0	0				
May-17	373,132	0	0	0	0				
Jun-17	373,037	0	0	0	0				
Jul-17	372,126	0	0	0	0				
Aug-17	371,860	0	0	0	0				
Sep-17	370,594	0	0	0	0				
Oct-17	370,399	0	0	0	0				
Nov-17	370,228	0	0	0	0				
Dec-17	370,256	0	0	0	0				

Jan-18	370,295	0	0	0	0				
Feb-18	368,922	0	0	0	0				
Mar-18	368,731	0	0	0	0				
Apr-18	367,472	0	0	0	0				
May-18	367,838	0	0	0	0				
Jun-18	367,118	0	0	0	0				
Jul-18	366,861	5	19	91	113				
Aug-18	366,263	9	17	95	458				
Sept-18	365,267	4	19	80	356				
Oct-18	365,265	4	22	93	401				
Nov-18	364,799	3	27	93	315				
Dec-18	364,252	4	17	96	201				
Jan-19	364,172	36	135	438	417				
Feb-19	362,491	32	120	413	395				
Mar-19	362,125	43	150	426	426				
Apr-19	361,626	57	136	473	526				
May-19	361,078	44	125	483	534				
June-19	360,263	65	150	577	573				
Jul-19	360,674	65	197	680	628				
Aug-19	360,213	66	243	746	482				
Sep-19	359,739	75	214	780	408				
Oct-19	359,188	74	237	886	469				
Nov-19	358,287	82	190	813	574				
Dec-19	358,575	59	213	940	559				
Jan-20	358,991	32	129	533	505				
Feb-20	358,889	24	125	480	441				
Mac-20	360,596	33	133	485	428				
Apr-20	364,087	42	109	383	304				
May-20	366,527	25	97	377	318				
Jun-20	369,311	46	157	553	199				
Jul-20	371,996	25	84	337	32				
Aug-20	374,843	29	107	353	38				
Sep-20	377,066	34	100	333	46				
Oct-20	379,086	26	93	370	43				
Nov-20	380,008	28	87	377	25				
Dec-20	381,502	39	100	444	24	6	5	30	0
Jan-21	382,657	16	57	224	30	5	7	32	1
Feb-21	382,706	25	89	294	18	10	7	42	2
Mar-21	384,048	21	86	315	28	9	14	48	2
Apr-21	385,365	25	98	367	14	7	14	48	1
May-21	386,553	31	85	310	25	15	13	49	1
Jun-21	387,611	17	37	163	20	14	11	37	0
Jul-21	389,200	25	102	366	19	8	10	37	2
Aug-21	391,258	19	90	319	19	7	10	34	4
Sep-21	392,684	17	85	329	15	3	8	27	5
Oct-21	394,012	24	120	406	10	3	6	28	2
Nov-21	395,171	14	76	279	8	4	3	27	1
Dec-21	396,462	5	37	197	3	0	1	19	0

Jan-22	398,300	0	7	33	0	0	0	3	0
Feb-22	399,156	0	0	0	0	0	0	0	0
Mar-22	400,291	0	0	0	0	0	0	0	0
Total	23,511,356	1349	4521	16830	10447	91	109	461	21

Budget neutrality

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

Designated state health programs (DSHP)

- HCA continues to contract with MSLC 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) 2020. Expected completion of the review is June 30, 2022.

Overall MTP development and issues

Operational/policy issues

Within the state, there are several staff transitions occurring at the state and regional levels. There are no identified risks—but there is ongoing commitment from leadership—and program leads continue to coordinate closely as new program staff are onboarded.

Consumer issues

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

MTP evaluation

- The independent external evaluator (IEE), Oregon Health and Science University's Center for Health Systems Effectiveness (CHSE), continued their active engagement on evaluation activities. The IEE's thirteenth rapid-cycle monitoring report was delivered on March 23, 2022, in compliance with the contracted deliverable timeline. This report covers October 1, 2021, through March 31, 2022. It presents findings in these areas:

  o **Washington State's Medicaid system performance through December 2020**, which includes key performance indicators in 10 measurement domains as well as an examination of equity and disparities among specific populations within measurement domains.

  o An analysis of the impact of two programs designed to offer older adults and their caregivers supportive alternatives to traditional Medicaid LTSS: **TSOA and MAC**. This analysis includes current rates of LTSS utilization and forecasts of expected future utilization.

Key findings (extracted from the IEE's thirteenth report)

- Most performance measures in this report include data from the first nine months of the COVID-19 pandemic in Washington State, as well as three months of data from the preceding time period. Effects of the pandemic are evident in results reported here but may continue to become more pronounced over time as the measurement period shifts to include less pre-pandemic data.

- COVID-19 created some unique barriers to accessing care in 2020. The rate of well-care visits for Medicaid members between the ages of three and twenty-one declined sharply, falling 12.5

percentage points compared with the previous year. Measures of access to oral health care followed a similar pattern, with a continued sharp decline in the fourth quarter of 2020. There have been declining rates of preventive screenings and access to primary care for adults. These declines coincide with the onset of the pandemic in Washington State.

- Rates of care received in emergency departments and acute hospital settings also declined sharply following the start of the pandemic. That downward trend persisted in the most recent quarter. These decreases likely represent barriers to access resulting from the COVID-19 pandemic.

- In contrast, some measures of health care access and quality improved during this period. Measures of access to SUD treatment reported improved. There have been positive trends for types of care that can be delivered virtually, including medication management for MH and chronic conditions.

- Finally, there continues to be notable inequities in health care access and quality among the subpopulations examined in this report. American Indian (AI)/Alaska Native (AN) members experienced markedly worse access to well-child visits, cancer screenings, and care related to chronic conditions. Black members were less likely to receive follow-up care after an emergency department visit for alcohol or other drug use, less likely to receive appropriate treatment for an opioid use disorder, and more likely to be prescribed opioids compared with other groups. Members with an SMI were more likely to be arrested and to experience homelessness.

Upcoming IEE activities

- Evaluation efforts are ongoing and future reports will continue to present updates and assessments of MTP in 2022. Washington State has extended MTP for a sixth year, with 2022 to serve as the final year.

- Once the hospital and practice survey has been administered and analyzed, the qualitative team will select organizations for interviews based on survey responses. Recruitment, data collection, and interview guide development are expected to begin shortly after survey data are cleaned and summarized. The qualitative team will also begin coding and analyzing data collected from the last round of ACH interviews. Preliminary FCS findings will be presented in an upcoming rapid-cycle monitoring 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 by subscribing to HCA's GovDelivery topics listed under "health transformation."

Summary of attachments

- Attachment A: state contacts

- Attachment B: Financial Executor Portal Dashboard, Q1 2022

- Attachment C: 1115 SUD Demonstration Monitoring Report – Part B

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

Attachment A: state contacts

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

Table 14: state contacts

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

For mail delivery, use the following address:

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

Attachment B: Financial Executor Portal Dashboard, Q1 2022

[View this table on the HCA website](), which shows all funds earned and distributed through the FE portal through March 31, 2022.

Attachment C: 1115 SUD Demonstration Monitoring Report – Part B

1. **1115-SUD-Monitoring-Report-Template-v2.0**
   Trend Narrative Reporting

   Updated 02/19/2020

Section	Topic	Prompt (check corresponding box)	State Response	Measurement Period First Reported	Related metric (if any)
1.2.1	Assessment of Need and Qualification for SUD Services	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 seems to be trending downward slightly in more recent months. It is unknown if this is a true downward trend or not. 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)
			Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state anticipated reporting this metric next quarter.	07/01/2018 – 06/30/2019	#4: Medicaid beneficiaries with SUD diagnosis (annual)

			Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state anticipated reporting this metric next quarter.	07/01/2018 – 06/30/2019	#5: Medicaid beneficiaries treated in an IMD for SUD
2.2.1	Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)	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 who received any SUD treatment has fluctuated slightly and seems to be trending downward slightly in more recent months. It is unknown if this is a true downward trend or not. 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 and seems to be trending downward slightly in more recent months. It is unknown if this is a true downward trend or not. 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 seems to be trending downward slightly in more recent months. It is unknown if this is a true downward trend or not. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#8: Outpatient Services
			The monthly number of Medicaid beneficiaries with an SUD diagnosis who received residential and inpatient SUD treatment has fluctuated slightly and seems to be trending downward slightly in more recent months. It is unknown if this is a true downward trend or not. 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 seems to be trending downward slightly in more recent months. It is unknown if this is a true downward trend or not. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is	04/01/2019 – 06/30/2019	#11: Withdrawal Management

		unknown. Any changes in trends should be interpreted with caution.		
		The monthly number of Medicaid beneficiaries with an SUD diagnosis who received MAT SUD treatment has fluctuated slightly and seems to be trending downward slightly in more recent months. It is unknown if this is a true downward trend or not. 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
		Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state anticipated reporting this metric next quarter.	07/01/2018 – 06/30/2019	#36: Average Length of Stay in IMDs
3.2.1	Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)	The state has no metrics trends to report for this reporting topic.		
4.2.1	Use of Nationally Recognized SUD Program Standards to Set Provider	The state has no metrics trends to report for this reporting topic.		

	Qualifications for Residential Treatment Facilities (Milestone 3)				
5.2.1	Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)	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.	Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state anticipated reporting this metric next quarter.	07/01/2018 – 06/30/2019	#13: SUD provider availability
			Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state anticipated reporting this metric next quarter.	07/01/2018 – 06/30/2019	#14: SUD provider availability – MAT
6.2.1	Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.	The state has no metrics trends to report for this reporting topic 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)
7.2.1	Improved Care Coordination and Transitions between Levels of Care (Milestone 6)	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need	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 Department Visit for Mental Illness

		and qualification for SUD services.			
8.2.1	SUD Health Information Technology	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.	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.	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)
			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.	07/01/2018 – 06/30/2019	Q2: Substance Use Disorder Treatment Penetration Rate
			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.	07/01/2018 – 06/30/2019	Q3: Foundational Community Supports Beneficiaries with Inpatient or Residential SUD Services
9.2.1	Other SUD-Related Metrics	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 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	04/01/2019 – 06/30/2019	#24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries

			unknown. Any changes in trends should be interpreted with caution.		
			Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	07/01/2018 – 06/30/2019	#25: Readmissions Among Beneficiaries with SUD
			Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state anticipated reporting this metric next quarter.	07/01/2017 – 06/30/2018	#26: Overdose Deaths (count)
			Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state anticipated reporting this metric next 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.

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, 2022
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

Washington State's 1115 SUD demonstration is proceeding smoothly, and we have aligned our systems with the required milestones. The trend data shows some fluctuations. With the exception of the rate of emergency department utilization and the rate of inpatient stays for SUD, several trends appear to be moving downward, however, these measurement periods coincide with the COVID-19 pandemic and the impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.

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 seems to be trending downward slightly in more recent months. It is unknown if this is a true downward trend or not. 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)
	Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state anticipated reporting this metric next quarter.	07/01/2018 – 06/30/2019	#4: Medicaid beneficiaries with SUD diagnosis (annual)
	Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state anticipated reporting this metric next quarter.	07/01/2018 – 06/30/2019	#5: Medicaid beneficiaries treated in an IMD for SUD
☐ The state has no metrics trends to report for this reporting topic.			
1.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) The target population(s) of the demonstration.			

☐ ii) The clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration.			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to assessment of need and qualification for SUD services.			
☒ The state has no implementation update to report for this reporting topic.			

2.2 Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)

2.2.1 Metric Trends

☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1.	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received any SUD treatment has fluctuated slightly and seems to be trending downward slightly in more recent months. It is unknown if this is a true downward trend or not. 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 and seems to be trending downward slightly in more recent months. It is unknown if this is a true downward trend or not. 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 seems to be trending downward slightly in more recent months. It is unknown if this is a true downward trend or not. 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 and seems to be trending downward slightly in more recent months. It is unknown if this is a true downward trend or not. 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 seems to be trending downward slightly in more recent months. It is unknown if this is a true downward trend or not. 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 seems to be trending downward slightly in more recent months. It is unknown if this is a true downward trend or not. 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
	Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state anticipated reporting this metric next quarter.	07/01/2018 – 06/30/2019	#36: Average Length of Stay in IMDs
☐ The state has no metrics trends to report for this reporting topic.			

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

☐ i) Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria ☐ ii) Implementation of a utilization management approach to ensure: (a) beneficiaries have access to SUD services at the appropriate level of care? (b) interventions are appropriate for the diagnosis and level of care? (c) use of independent process for reviewing placement in residential treatment settings?			
Are there any other anticipated program changes that may impact metrics related to the use of evidence-based, SUD-specific patient placement criteria (if the state is reporting such metrics)? If so, please describe these changes.			
☒ The state has no implementation update to report for this reporting topic.			
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 is reporting metrics related to Milestone 3, but has no metrics trends to report for this reporting topic.			
☒ 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) 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.	Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state anticipated reporting this metric next quarter.	07/01/2018 – 06/30/2019	#13: SUD provider availability
	Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state anticipated reporting this metric next quarter.	07/01/2018 – 06/30/2019	#14: SUD provider availability – MAT
☐ 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: ☐ 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 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)
☐ The state has no trends to report for this reporting topic.			

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 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 Department Visit for Mental Illness
☐ The state has no trends to report for this reporting topic.			
7.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ Implementation of policies supporting beneficiaries' transition from residential			

and inpatient facilities to community-based services and supports.			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 6.			
☒ 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.	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.	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)
	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.	07/01/2018 – 06/30/2019	Q2: Substance Use Disorder Treatment Penetration Rate
	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.	07/01/2018 – 06/30/2019	Q3: Foundational Community Supports Beneficiaries with Inpatient or Residential SUD Services

☐ The state has no trends to report for this reporting topic.			
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
	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.	07/01/2018 – 06/30/2019	#25: Readmissions Among Beneficiaries with SUD
	Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state anticipated reporting this metric next quarter.	07/01/2017 – 06/30/2018	#26: Overdose Deaths (count)
	Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state anticipated reporting this metric next 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.

☐ The state has no trends to report for this reporting topic.

9.2.2 Implementation Update			
☐ The state expects to make other program changes that may affect metrics related to other SUD-related metrics.			
☒ The state has no implementation update to report for this reporting topic.			
10.2 Budget Neutrality			
10.2.1 Current status and analysis			
☐ If the SUD component is part of a broader demonstration, the state should provide an analysis of the SUD-related budget neutrality and an analysis of budget neutrality. Describe the status of budget neutrality and an analysis of the budget neutrality to date.			
☒The state has no metrics trends to report for this reporting topic.			
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.			
12.1 SUD Demonstration Evaluation Update			
12.1.1 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 D: 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

The SMI-IMD Monitoring Protocol appendix contains the current quarter of reporting (tab SMI-SED metrics_DY6Q1) as well as all the required back reporting to the start of the baseline year (tabs SMI-SED metrics_JanMar2020 through SMI-SED metrics_AprJun2021). Per prior discussions with CMS, the state did not include the standardized definition of SMI and state-specific definition of SMI subpopulation reporting. The development of the state-specific definition of SMI is ongoing. The state also identified some reporting issues that are further described in the SMI-SED reporting issues tab. The state anticipates resolving these reporting issues over the next quarter. In addition, caution is advised when looking across quarters due to the impact of the COVID-19 pandemic on access to behavioral health services starting in March 2020.

With approval of the monitoring protocol, this is the first monitoring report submitted for Washington State's 1115 SMI/SED Demonstration.

Trend information will be available once we have all the metrics completed with at least two time periods for each metric. Ideally next quarter.

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 to: ☐ i) The licensure or accreditation processes for participating hospitals and residential settings ☐ii) The oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements ☐ iii) The utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay			

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

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

The MPT, FUH-CH, FUH-AD, FUA-AD, FUM-AD, AAP, APM, and APC measures (metrics #13, 14, 15, 16, 17, 18, 7, 8, 9, 10, 26, 29, 31) are Healthcare Effectiveness Data and Information Set