Washington State Medicaid Transformation Project (MTP) demonstration
Section 1115 Waiver Annual Report (DY6)/Quarterly Report (DY6 Q4)
Demonstration Year: 6 (January 1 to December 31, 2022)
Reporting Quarter: 4 (October 1 to December 31, 2022)

Table of contents

Introduction

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

Over the five-year MTP period, Washington will:

- Integrate physical and behavioral health purchasing and services to provide whole-person care.
- Convert 90 percent of Medicaid provider payments to reward outcomes instead of volume of service.
- Support providers as they adopt new payment and care models.
- Improve health equity by implementing population health strategies.
- Provide targeted services to support the state's aging populations and address social determinants of health (SDoH).
- Improve substance use disorder (SUD) treatment access and outcomes.

The state will accomplish these goals through these programs:

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

Vision: a healthier Washington

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

Annual report: demonstration year 6

In accordance with special terms and conditions (STC) 76 and 42 C.F.R. § 431.428, this report summarizes the activities and accomplishments for the sixth demonstration year of MTP (DY6). It documents accomplishments, project status, and operational updates and challenges.

Visit the Medicaid Transformation webpage to learn more about HCA's Medicaid transformation work.

Policy and administrative updates

MTP in 2022

In 2022, the state continued MTP under a one-year extension that was approved by CMS due to the impacts of COVID-19. The one-year extension allowed the state to continue its COVID-19 relief efforts, along with further planning and development of the full renewal package.

The state finalized and submitted to CMS a five-year MTP renewal package during 2022. This MTP renewal package reflects significant engagement with partners to explore enhancements to existing programs and consider lessons learned over the current MTP waiver. Engagement with CMS to discuss the renewal package began in October, 2022 and will continue into 2023.

MTP amendments

The state continues to coordinate with CMS regarding pending MTP amendment requests. The pending amendments cover presumptive eligibility and transportation services within Initiative 2 and the adjustment of the value-based purchasing (VBP) target from 90 percent to 85 for DY5. The proposed VBP target adjustment aligns with managed care contracts and, if approved, will impact the DY5 statewide accountability results.

MTP temporary extension request and approval

On November 28, 2022, the state received approval of its request for a temporary extension. MTP was scheduled to end December 31, 2022, but the extension continues MTP from January 1–June 30, 2023.

This extension will allow:

- Current MTP programs to continue, and Apple Health enrollees can continue to have access to services without disruption of care.
- Time for CMS to continue to review the state's MTP 2.0 application.
- The state to continue to negotiate and work with CMS.

Annual expenditures

Delivery System Reform Incentive Payment (DSRIP) program expenditures

During the period of January 1 through December 31, 2022, **all nine** Accountable Communities of Health (ACHs) earned nearly **$105,505,211** in project incentives for demonstrating completion of required project and integration milestones during DY6, including the submission of implementation plans. During DY6, Indian Health Care Providers (IHCPs) earned nearly **$1,879,000** for IHCP-specific projects.

Table 1: 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	$0.00	$9,103,699	$0.00	$1,671,549.00	$10,775,248.00	$5,387,624.00
Cascade Pacific Action Alliance	$0.00	$9,462,549	$0.00	$1,565,278.00	$11,027,827.00	$5,513,913.50
Elevate Health	$0.00	$12,361,357	$0.00	$1,913,790.00	$14,275,147.00	$7,137,573.50
Greater Health Now (formally Greater Columbia)	$0.00	$11,373,483	$0.00	$2,160,418.00	$13,533,901.00	$6,766,950.50
HealthierHere	$0.00	$19,146,935	$0.00	$3,400,668.00	$22,547,603.00	$11,273,801.50
North Central	$0.00	$5,344,126	$0.00	$806,274.00	$6,150,400.00	$3,075,200.00
North Sound	$0.00	$12,980,082	$0.00	$2,327,378.00	$15,307,460.00	$7,653,730.00
Olympic Community of Health	$0.00	$4,219,193	$0.00	$770,019.00	$4,989,212.00	$2,494,606.00
SWACH	$0.00	$5,803,354	$0.00	$1,095,059.00	$6,898,413.00	$3,449,206.50
Indian Health Care Providers	$0.00	$939,500	$0.00	$939,500.00	$1,879,000.00	$939,500.00

Table 2: 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	$0.00	$573,406.00	$0.00	$0.00	$573,406.00
CHPW	$0.00	$1,623,416.00	$0.00	$0.00	$1,623,416.00
CCW	$0.00	$1,393,036.00	$0.00	$0.00	$1,393,036.00
Molina	$0.00	$2,714,859.00	$0.00	$0.00	$2,714,859.00
United Healthcare	$0.00	$1,695,283.00	$0.00	$0.00	$1,695,283.00

Table 3: LTSS and FCS service expenditures

	Q1	Q2	Q3	Q4	DY6 Total
	January 1–March 31	April 1–June 30	July 1–September 30	October 1–December 31	January 1–December 31
Tailored Supports for Older Adults (TSOA)	$1,759,393	$7,049,254	$5,724,025.83	$5,556,649.95	$20,089,322.45
Medicaid Alternative Care (MAC)	$50,791	$201,047	$169,460.21	$174,456.45	$595,754.17
MAC and TSOA not eligible	$0.00	$281	$263.50	$30.00	$574.50
FCS	$ 3,047,246	$6,125,131	$6,015,533.00	$6,107,287.00	$21,295,197.00

LTSS data annual summary

Table 4: beneficiary enrollment by program

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of December 31, 2022	310	1938	4374
Number of new enrollees in 2022 by program	111	796	1423
Number of new person-centered service plans in 2022 by program	244	1509	3714
Number of beneficiaries self-directing services under employer authority	0	0	0

FCS data annual summary

Reports are available on the MTP resources webpage. These reports provide a month-by-month look at Medicaid clients enrolled in IPS and CSS since the programs began in January 2018.

Table 5: FCS client enrollment 2022

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Supported Employment – Individual Placement and Support (IPS)	2,611	2,787	2,827	2,652	2,675	2,814	2,756	2,800	2,888	2,784	2,775	2,835
Community Support Services (CSS)	4,525	4,839	4,924	5,060	5,204	5,488	5,594	5,906	6,151	6,353	6,515	6,646
CSS and IPS	1,726	1,897	1,930	1,913	1,903	1,994	2,056	2,096	2,183	2,196	2,202	2,275
Total aggregate enrollment	8,862	9,523	9,681	9,625	9,782	10,296	10,406	10,802	11,222	11,333	11,492	11,756

Data represents cumulative enrollment (number of individuals who had been enrolled at least one month during the life of the program). Month-to-month changes are due to client enrollment mix, not program impact. Some individuals may be enrolled in both IPS and CSS.
Data source: RDA administrative reports

MTP evaluation

In 2018, HCA began working with an independent external evaluator, the Center for Health System Effectiveness (CHSE) at Oregon Health and Science University. CHSE is responsible for evaluating the overall success and effectiveness of MTP. In DY5, CSHE continued its active engagement.

Notable deliverables for the MTP evaluation in 2022 include:

Rapid-cycle monitoring reports

CHSE produces this report for each quarter during MTP as part of their evaluation, which highlights MTP quarterly activities, key findings (as available) from analyses, and a summary of MTP activities planned for the coming quarter. These reports also highlight the work and progress across all initiatives as implementation continues. Rapid-cycle monitoring reports are available on the Medicaid Transformation reports page.

The reports received in DY6 include the thirteenth, fourteenth, fifteenth, and sixteenth rapid-cycle monitoring reports.

Thirteenth rapid-cycle monitoring report: delivered on March 23, 2022, this report covered an additional quarter making it a six-month progress report from October 1, 2021, through March 21, 2022. It presents findings in the state's Medicaid system performance through December 2022.

- Most performance measures provided in the report include data from the first nine months of the COVID-19 Public Health Emergency (PHE) in the state, as well as three months of data from the preceding time period. Effects of the pandemic were 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 21 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. Observations showed declining rates of preventive screenings and access to primary care for adults. These declines coincide with the onset of the pandemic.
- 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 pandemic.
- There were notable inequities in health care access and quality among the subpopulations.
    - American Indian/Alaska Native 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 (OUD), and more likely to be prescribed opioids compared with other groups.
    - Members with an SMI (serious mental illness) were more likely to be arrested and to experience homelessness.

Fourteenth rapid-cycle monitoring report: delivered on June 6, 2022, this report covered April 1 through June 30, 2022. It presents findings regarding the state's Medicaid systems performance through March 2021.

- The performance measures in this report include data from the first full year of the COVID-19 PHE in the state. Rates of care received in emergency departments dropped by 15.5 percent, and care in acute hospital settings dropped by 10.7 percent. Additionally, there were declining rates of preventive screenings, oral health care, and access to primary care for adults. These decreases likely represent combined challenges to access as well as behavioral changes in seeking care during this period.
- Some measures of health care access and quality improved during this measurement period. Access to substance use disorder (SUD) treatment improved, along with types of care that can be delivered virtually, such as medication management for mental health and chronic conditions.
- Visits to the emergency department and acute hospital care continued a sharp downward trajectory first observed at the onset of the COVID-19 pandemic. The timing suggests these decreases in utilization reflect pandemic-related behavioral changes in the population or barriers to care. Rates of care obtained in these settings varied widely among members of different racial and ethnic groups. However, individuals with an SMI received care in the emergency department at a rate three times higher than the statewide average.

Fifteenth rapid-cycle monitoring report: delivered on September 14, 2022, this report covers July 1 through September 30, 2022. It presents findings regarding the state's Medicaid system performance through June 2021.

- The performance measures in this report provide an ongoing look at how COVID-19 in the state may have affected health care access and quality of care for Medicaid members. After notable initial impacts, there was evidence of the beginning of recovery within several domains. Specifically, access to periodontal exams and wellness visits for children over the age of three improved during this period. Positive trends continued for other types of care that can be delivered virtually, including medication management for mental health and chronic conditions such as diabetes and heart disease.
- The state previously reported a dramatic downward trend in rates of care received in emergency departments and acute hospital settings, attributed to barriers to access resulting from the pandemic. This trend reversed. While still markedly lower than the previous year, there was a subtle uptick in care in these settings.
- There continues to be disparities in health care access and quality among subpopulations examined in this report.
    - Black members were less likely to receive follow-up care after an emergency department visit for alcohol or other drug use and were less likely to receive appropriate treatment for an OUD than other groups.
    - American Indian/Alaska Native members experienced markedly worse access to well-child visits, cancer screenings, and care related to chronic conditions, alongside higher emergency department visit rates.
    - Members with an SMI were more likely to experience homelessness.

Sixteenth rapid-cycle monitoring report: delivered on December 9, 2022, this report covers October 1 through December 31, 2022, and present findings on the state's Medicaid system performance through September 2021.

- This measurement period falls entirely after the statewide stay-at-home order was issued. Some measures of quality and access to care began to rebound after the impacts of COVID-19. Rates of well-child visits for children over the age of three and well-care visits for members under 21 improved substantially compared with the previous year, regaining much of the ground lost following the beginning of the PHE. Rates of periodontal exams for adults show a similar pattern, with substantial increases during this reporting period, following sharp declines during the first year of the pandemic.
- There were persistently lower rates for several outcome metrics that declined during the early months of the pandemic. Most notably, adults' access to primary care and rates of cancer screenings remained low, showing further declines during this reporting period compared with the previous year. Previously reported was a dramatic downward trend in rates of care received in emergency departments and acute hospital settings. While reducing care in these settings could be viewed as a positive trend, in this context, it is likely attributable to barriers to access resulting from the pandemic. Decreases in care received in these settings have leveled off in more recent reporting periods but have not yet rebounded to pre-pandemic levels.
- Disparities in health care access and quality among subpopulations continued.

- Asian and Black members continue to receive lower rates of follow-up care after an emergency department visit for alcohol or other drug use and have less access to SUD treatment than other groups.
- American Indian/Alaska Native members experienced markedly worse access to well-child visits, cancer screenings, mental health care, and care related to chronic conditions, alongside higher rates of emergency department utilization and acute hospitalization.
- Members living with a chronic health condition or an SMI were more likely to experience homelessness and unemployment, and experienced higher rates of arrest.

State legislative developments

The Washington State Legislature's 2022 session ran from January 10 to March 10, 2022. The operating budget provided continued spending authority for MTP. At the request of the Legislature, the state presented MTP updates to multiple legislative committees during 2022.

The state continued to discuss the planned submission of the five-year renewal request, including legislative direction related to MTP waiver strategies and related priorities that resulted from the 2021 and 2022 legislative sessions.

MTP Public Forum

On December 7, 2022, HCA held the annual MTP Public Forum. During the forum, HCA:

- Provided an overview of MTP and its initiatives.
- Shared this year's successes and challenges.
- Talked about MTP 2.0 and gave an update on and next steps.
- Gave attendees a chance to ask questions and share comments.

More than 140 people attended the forum. Attendees asked questions about behavioral health services, our partnership with Tribes, and much more. View the slide deck or watch the recording.

Summary of public comments received during DY6

The following public comments were received during DY6, organized by program:

DSRIP program public comments

Quarter 1

- No MTP stakeholder concerns were reported.

Quarter 2

- See public comments received during the MTP renewal public comment and public notice process (Appendix H in the MTP renewal application). Overall, the information received was positive and supportive of the new and existing programs in the renewal package.

Quarter 3

- No MTP stakeholder concerns were reported.

Quarter 4

- Stakeholders and partners continued to ask questions leading up to the CMS approval of the temporary extension at the end of 2022. Questions focused on the state of the MTP renewal application and the desire to avoid an expiration that would discontinue essential programs and services.

LTSS program public comments

Quarter 1

- 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. Department of Social and Health Services (DSHS) Home and Community Services (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. In addition, MAC and TSOA programs will collaborate on the implementation of the consumer directed employer vendor to utilize individual providers who will provide personal care and respite care services.

Quarter 2

- No new stakeholder concerns were noted this quarter. DSHS Aging and Long-Term Support Administration (ALTSA) and HCA did receive feedback this quarter related to the 1115 waiver renewal public comment process. Overall, the information received was positive and supportive of the programs continuing to be available for Washington's aging population and their families.

Quarter 3

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

Quarter 4

- Concerns were raised by Area Agencies on Aging (AAA) about a decrease in MAC and TSOA enrollments since July 2022 when the Personal Needs Allowance (PNA) was increased for traditional in-home LTSS clients.
- The in-home caregiver shortage continues to be a concern for families and clients who are needing assistance.

FCS program public comments

Quarter 1

- None received.

Quarter 2

- None received.

Quarter 3

- HCA received public comments related to the renewal of the waiver expressing a desire to increase reimbursement rates for CSS, in addition to providing more funding for capacity building and TA (technical assistance). Overall, the information received was supportive of the continuation of FCS, including the proposed enhancements.

Quarter 4

- None received.

MTP 2.0 partner activities

Earlier this year, HCA, three ACH representatives, and three MCO representatives formed a task force to explore how the Medicaid program could deliver health-related social need (HRSN) services. The task force

is also working on design and implementation of Community Hubs and re-entry coordination for the justice involved population under the Taking Action for Healthier Communities (TAHC) program within MTP 2.0.

To develop consistent policies, HCA's Office of Tribal Affairs (OTA) participates on the task force, as does DSHS and the Washington State Department of Health (DOH). The task force's meeting schedule helps the group stay aligned with CMS negotiations on the policies and programs proposed within MTP 2.0.

Quarterly report: October 1–December 31, 2022

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

Summary of quarter accomplishments

- On November 28, 2022, the state received approval for its request for a temporary extension. The extension allows the continuation of MTP from January 1–June 30, 2023.
- ACHs continue to distribute incentive funds to partnering providers through the FE portal. During the reporting quarter, ACHs distributed approximately $28 million to partnering providers and organizations. There were no earned incentives to distribute to IHCPs for this reporting quarter.
- As of January 2023, more than 14,200 clients, in addition to their family caregivers, have received services and supports through the MAC and TSOA programs. New enrollees in LTSS for this quarter reporting period includes 24 MAC dyads, 161 TSOA dyads, 268 TSOA individuals.
- Within FCS, the total aggregate number of people enrolled in services at the end of DY 6 Q4 includes 5,110 in IPS and 8,921 in CSS. The total unduplicated number of enrollments at the end of this quarter reporting period is 11,756.

MTP-wide stakeholder engagement

In early December, HCA held the annual MTP Public Forum, intended for the public and those interested in MTP. Learn more.

Also during the reporting period, HCA shared news about CMS' short extension to the current MTP wavier period. Read more from an earlier section of this report. HCA updated the MTP webpage section with this new information and is currently reviewing all MTP pages and content for DY7. This will continue into the new year.

Statewide activities and accountability

Value-based purchasing (VBP)

VBP Roadmap and Apple Health Appendix

The VBP Roadmap describes HCA's VBP goals, purchasing and delivery system transformation strategies, innovation successes to date, and plans to accelerate the transition into value-based payment models. The appendix, in accordance with the 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 Inventive Payment (DSRIP) incentives for MCOs and ACHs. In Q4, HCA updated the annual roadmap and the VBP website. They will be released publicly in Q1 of 2023.

Validation of financial performance measures

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

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

Upon successfully completing the validation of MCO VBP performance on VBP adoption and provider incentives metrics, the IA delivered a final report to HCA and began disseminating formal communications to MCOs.

The tables below provide details on the MCO and ACH incentives for VBP adoption provider incentives targets. They also include the partial earn-back where MCOs did not achieve the target.

Table 6: MCO achievement of VBP targets

MCO	% VBP	DY5 target	Target achieved	Partial earn-back
IMC				
Amerigroup	98%	85%	Yes	N/A
Community Health Plan	89%	85%	Yes	N/A
Coordinated Care	85%	85%	Yes	N/A
Molina	80%	85%	No	95%
United Healthcare	91%	85%	Yes	N/A
IFC				
Coordinated Care	85%	85%	Yes	N/A

Table 7: MCO achievement of quality targets

MCO	% incentives	DY5 target	Target achieved	Partial earn-back
IMC				
Amerigroup	3.32%	1.25%	Yes	n/a
Community Health Plan	3.39%	1.25%	Yes	n/a
Coordinated Care	5.64%	1.25%	Yes	n/a
Molina	3.59%	1.25%	Yes	n/a
United Healthcare	3.72%	1.25%	Yes	n/a
IFC				
Coordinated Care	1.66%	1.25%	Yes	n/a

Table 8: achievement of DSRIP-funded P4P incentives earned by MCOs and ACHs

MCO	% VBP	DY5 target*	Target achieved	MACRA A-APM arrangement **	% incentives earned***
MCO					
Amerigroup	98%	85%	Yes	No	TBD
Community Health Plan	89%	85%	Yes	Yes	TBD
Coordinated Care	85%	85%	Yes	Yes	TBD
Molina	80%	85%	No	Yes	TBD
United Healthcare	91%	85%	Yes	No	TBD
ACH					
Better Health Together	86%	85%	Yes	Yes	TBD
Cascade	84%	85%	No	Yes	TBD
Elevate Health	88%	85%	Yes	Yes	TBD
Greater Columbia	75%	85%	No	Yes	TBD
Healthier Here	88%	85%	Yes	Yes	TBD
North Central	90%	85%	Yes	Yes	TBD
North Sound	86%	85%	Yes	Yes	TBD
Olympic	81%	85%	No	Yes	TBD
SWACH	81%	85%	No	Yes	TBD

* The 85 percent DSRIP target was originally 90 percent and is still under discussion with CMS as part of a proposed amendment.
**Medicare Access and CHIP Reauthorization ACT of 2015 (MACRA) Advanced Alternative Payment Model (A-APM)
***Pending CMS determination on performance-weighting options.

Statewide progress toward VBP targets

HCA sets annual VBP adoption targets for MCOs and ACH regions in alignment with HCA's state-financed purchasing goals. To track progress, HCA collects financial performance measure data from MCOs by ACH region through the VBP validation process and from commercial and Medicare payers and providers through an annual survey. In Q4, HCA analyzed the results of the annual Paying for Value survey for plans/payers, which had been conducted in Q3. The results, which are available on the state's Value-Based Purchasing website, show that MCOs successfully met the target of shifting 85 percent of health care payments into value-based arrangements by the end of 2021.

Technical support and training

- No activities to report in Q4.

Upcoming activities

- HCA will publicly share the updated VBP roadmap and VBP website in Q1 of 2023.

Integrated managed care (IMC) progress

In 2014, the Legislature directed a transition to integrate the purchasing of medical and behavioral health services for the state's Medicaid clients through an IMC system no later than January 1, 2020.

The COVID-19 pandemic introduced new challenges for stabilizing the behavioral health provider network. In addition, significant behavioral health workforce gaps are a significant concern, and ACHs and MCOs have been exploring and implementing strategies to address the shortage.

Since April 2021, HCA has partnered with MCOs and ACHs to advance bidirectional integrated care by advancing recommendations, improvements, and monitoring of performance measures across the state.

In addition, in 2021, the state completed its research to identify a new clinical integration assessment tool to better support the advancement of bidirectional physical and behavioral health clinical integration in Washington State. The tool, called the Washington Integrated Care Assessment (WA-ICA), is completed by outpatient behavioral and physical health practices. WA-ICA tracks progress toward clinical integration and serves as a roadmap for practice teams to advance 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 website.

During Q4 of 2022, the WA-ICA workgroup continued to refine its Consensus Recommendations for the Provision of Support and Technical Assistance to Practices Completing the WA-ICA, as well as to confirm the workgroup's objectives, action plan, and timelines for the next phase of work in 2023. Following notification from CMS that a decision on the state's MTP 2.0 application would be delayed, the workgroup developed a modified set of action items and timeline, including:

- Analysis of the budget and the limited carry over funds.
- In conjunction with ACHs and MCOs, a revision of goals for the first half of 2023.
- Decision to prioritize provider and stakeholder engagement and focused TA and coaching for cohort 1 providers during the first half of 2023.
- Delay of cohort 2 providers until fall 2023, and cohort 3 providers until 2024.

The workgroup continued to clarify data standards and developed a data use agreement that would be signed by the ACHs, MCOs, and the HCA with HealthierHere (King County ACH) as the centralized data management entity.

HCA developed a set of MCO contract requirements clarifying the expectations for the MCOs' continued collaboration with peer MCOs, HCA, and the ACHs in advancing bidirectional clinical integration, including driving participation in completing the assessment, conducting regional collaborative/action planning meetings, and continuing to provide support to practices. MCOs are expected to submit semiannual reports to HCA beginning July 2023.

Finally, a subgroup began the process of developing a comprehensive Quality Improvement Resource Guide to provide standardized and detailed support to practices in their efforts to advance along the integration continuum, as well as a standardized tool to aid in coaching/TA efforts.

Health information technology (Health IT)

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)
- Crisis Call Center and Related Activities
- Mental Health / Institutions for Mental Disease (MH IMD) waiver

- Master Person Index (MPI)
- Provider directory
- Payment models and sources
- SDoH and Long-term Care (LTC)/Social Service Data Exchange
- CMS Interoperability Rules
- MTP, Extension, and Waiver Renewal
- Clinical Data Repository (CDR)
- Tribal engagement

Q4 of 2022 focused heavily on planning for the following health IT-related initiatives:

- 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 Consent Management Solution

Activities and successes

The Health IT team spent much of the fourth quarter of 2022 continuing its focus on advancing multi-year initiatives involving Health IT.

- **Crisis Call and Response Services:** The HCA Health IT team, in coordination with DOH, continued implementation planning for the nationally required 988 crisis call system and the more expansive state requirements in E2SHB 1477 for a Crisis Call Center Hub System and the Behavioral Health Integrated Client Referral System.
  HCA engaged in the following activities to develop and finalize the Technical and Operational Plan for the enhanced Crisis Call Center platform and Integrated Client Referral System required under E2SHB 1477:
    - Coordinated and collaborated with DOH, the Governor's Office, and multiple divisions within HCA including the Office of Health IT, Division of Behavioral Health and Recovery (DBHR), Medicaid Programs Division (MPD), Enterprise Technology Services (ETS), and the OTA.
    - Engaged an Independent Verification and Validation (IV&V) contractor and modified the Technical and Operational Plan based on their input.
    - Led a review and comment process on the draft final plan involving the following entities:
        - HCA and DOH leadership
        - Tribal Governments
        - The Office of Financial Management (OFM)
        - Office of the Chief Information Officer (OCIO)
        - Governor's Office
        - State Legislative Committees
        - Crisis Response Improvement Strategy (CRIS) Technology Subcommittee
        - CRIS Steering Committee
    - In partnership with DOH, produced the statutorily required Final Technical and Operational Plan for the National 988 System: Crisis Call Center and Behavioral Health Integrated Referral System. See the final plan.
    - Began planning for the publication of a Request for Information (RFI) from technology vendors concerning the systems, tools, and associated costs for the tools needed to support

the requirements to improve the state's enhanced crisis call and response system. Publication is anticipated in Spring 2023.

- **Electronic Consent Management (ECM):** The ECM solution will initially focus on facilitating the exchange of SUD information, subject to 42 CFR Part 2, and will ultimately be a generalized consent solution to address many future use cases. The Health IT project team released a request for proposals (RFP) for the procurement and implementation of an ECM solution. Vendor responses were received by November 23, 2022, when the submission window closed. A review team encompassing subject matters experts across various domains (management, technical, functional/operations) scored the Stage 1 written vendor responses and a debrief was held to determine which vendors would be advancing.
  Stage 2 will include formal presentations and product demonstrations scheduled for mid-January 2023. Content outlines, agendas and other materials for those sessions were completed by the end of Q4.
  HCA is also closely monitoring the 42 CFR Part 2 NPRM that was published in November 2022 and prepared an agency-wide coordinated response to CMS.
- **Community Information Exchange (CIE):** Initial investments in CIE technology and planning in the ACH regions support the progress toward community-based care coordination. This will help with the referral of Medicaid clients to local organizations that assist people with healthy behaviors or other services that help to sustain a family's health.
- **MPI project:** The Health and Human Service Coalition (Coalition) MPI project launched during the Q3 of 2022 when the state's ProviderOne system established a production connection to the MPI Integration Layer, creating 5.2 million identities. The Coalition also launched an operational governance model to support administration of the Coalition MPI. In the next several months, we anticipate that DOH will establish a connection to the Coalition MPI. Dozens of other Coalition systems are targeting connecting in 2023–2025, pending funding from the legislature.
- **Provider Directory Application Programming Interface (API):** MyHealthButton App was published in the Google and Apple application stores. HCA is currently testing and working through usability issues. HCA has also been working on bringing in other TPAs to connect to the Fast Healthcare Interoperability Resources (FHIR) server. Currently, the state is working with OneRecord and they have submitted their patient access checklist, completed a walk through MTP with the workgroup. The state is waiting on a few outstanding questions from them before they will be ready to connect. The state is also working with Flexpa, another TPA, that is interested in connecting with the state's FHIR server. The state currently has 145,776 providers listed in their provider directory.
- **EHR:** HCA, in collaboration with the OCIO/WaTech (the lead state agency for this work) and other state agency partners like the Department of Corrections (DOC) and DSHS, are working to develop, by June 30, 2023, a plan for procuring and implementing a state EHR, including identifying additional funding sources.
  HCA will continue to work with the WA State Department of Enterprise Services (DES) to develop, by June 30, 2023, the procurement strategy for the state EHR.
- **WA-ICA:** The WA-ICA Initiative involves behavioral health and primary care practices completion of a practice level self-assessment of their level of bidirectional clinical integration and supports to increase their level of clinical integration. As practices advance along the continuum of integration, technology tools are used to support clinical integration. As part of the WA-ICA Initiative, the workgroup (comprised of HCA, MCOs, and ACHs) continued to support activities related to this Initiative, including the following:
  - The Centralized Data Entity, HeathierHere, continued its analysis of the assessment results for the first cohort of outpatient behavioral health (MH and SUD) and primary care

practices that completed self-assessments of their level of bidirectional clinical integration between primary and behavioral health. HealthierHere produced reports regarding these results.
- The workgroup planned for activities to be undertaken in 2023, including engagement timeline for future cohorts of practices, TA scope and delivery, and practice coaching as proposed under MTP 2.0.
- HCA continued to explore the feasibility of using Medicaid claims and encounter data to identify Medicaid primary care practices to participate in the WA-ICA.

DSRIP program implementation accomplishments

ACH project milestone achievement

Pay for reporting (P4R)

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

Next steps

HCA and ACHs continue to partner on the transition from DSRIP to the TAHC program. This program introduces strategies to address health equity through community-based care coordination (Community Hub model) and implementation of HRSN. HCA continues to convene a task force that includes representatives from MCOs, ACHs, DOH, DSHS, and HCA to discuss roles and partnership opportunities to support the Community Hub model and HRSN implementation. Conversations in Q1 of 2023 will focus on reentry and transitions from carceral settings in the context of the Community Hub model and access to HRSN services.

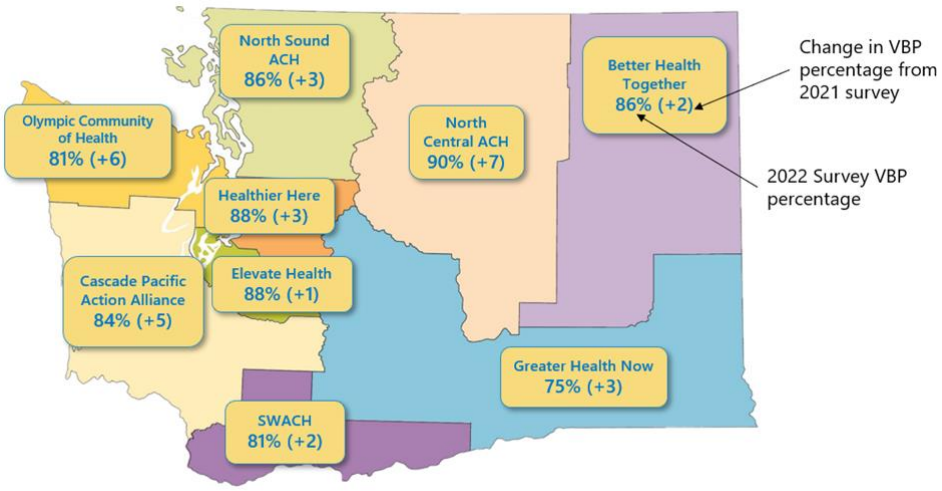
Annual VBP milestone achievement by ACHs

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

ACHs typically play an instrumental role in promoting and encouraging provider participation in the annual Paying for Value survey, but HCA did not conduct a survey for providers in 2022.

The figure below shows MCO VBP adoption for calendar year 2021 by ACH region, with the change from 2020 in parenthesis. Five of the nine ACH regions achieved the VBP adoption target for 2021 of 85 percent (pending CMS approval of the target adjustment).

Figure 1: MCO VBP adoption for 2021 by ACH region



Financial executor (FE) portal activity

ACHs continue to distribute incentive funds to partnering providers through the FE portal. During the reporting quarter, ACHs distributed more than **$28 million to 276** partnering providers and organizations in support of project planning and implementation activities. There were no earned incentives to distribute to IHCPs for this quarter.

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.

DSRIP measurement activities

DY5 regional and statewide VBP results assessed and pending approval from CMS. DY5 P4P and HPP baseline and performance rates were presented to ACHs.

- P4P changes:
    - Given that the health care system has not yet stabilized to pre-COVID-19 levels, using a pre-COVID baseline year would introduce unnecessary bias into the performance measurement. Instead of maintaining a two-year gap between the baseline year and performance year, a year-over-year, improvement-over-self approach will be used. This change is documented in the Funding and Mechanics Protocol as approved by CMS on December 22, 2021. As a result, 2021 (DY5) utilized a baseline year of 2020 (DY4) to account for the disruption that occurred between 2019 and 2020 due to COVID-19.
    - HCA sent each ACH and the IA a copy of the P4P baseline and performance rates for DY5 excluding the maternal and child health metrics. Those will be available in January 2023 and will be sent to the ACHs and the IA.

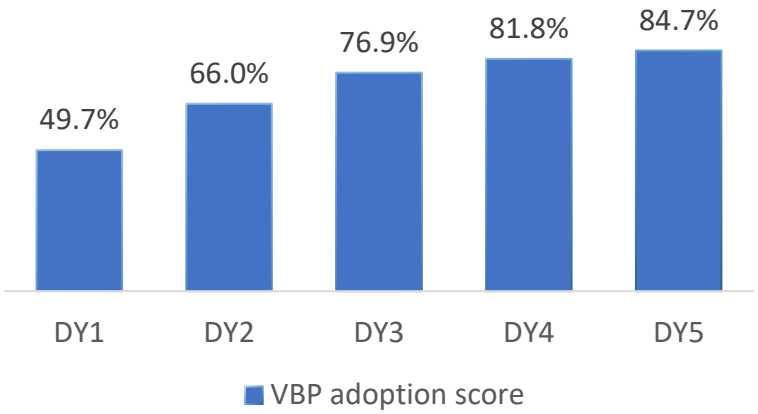
Statewide results

HCA submitted the DY5 statewide accountability report to CMS on December 28, 2022. The report includes both quality improvement and VBP adoption outcomes.

HCA submitted a change request in April 2020 for the VBP target to be shifted to 85 percent for DY5 to align with the change made in the IMC contract. The current adoption target is set at 90 percent. HCA submitted the inclusion of both potential VBP targets for DY5 (85 percent and 90 percent) pending the CMS approval of the amendment to the current MTP 1115 waiver.

While the state missed the VBP target in DY5, it should be noted that the state has improved year-over-year staring from DY1–DY5 in VBP.

Figure 2: Statewide VBP adoption scoring



VBP

When using 90 percent as the VBP target, the VBP adoption for DY5 was 84.69 percent. MCOs did not collectively meet the target of 90 percent. The total at-risk amount for DY5 is $2,850,000 for DY5. The state's overall VBP adoption earnings would be 26 percent or $749,954, and total funds lost would be 74 percent or $2,100,046.

When using 85 percent as the VBP target, the VBP adoption for DY5 was 84.69 percent. At the revised target, MCOs narrowly missed the target of 85 percent. The total at-risk amount for DY5 is $2,850,000. The state's overall VBP adoption earnings would be 68 percent or $1,929,127 and total funds lost would be 32 percent or $920,873.

Quality Improvement Strategy (QIS)

The state's performance toward the QIS measures was 1.10 and validates that the state met and exceeded the QIS threshold expectation of 20 percent. The state improved over baselines in all but two measures with five exceeding the quality or improvement score. However, two measures did not improve from their previous baseline. Those measures received a zero (0) in the measure composite score, contributing only as a weight percentage against the total QIS.

DSRIP program stakeholder engagement activities

- During the reporting period, HCA announced that ACHs earned incentives for the second P4R cycle. Earnings are for July–December 2022 and total about $12.1 million.
- HCA also renamed the Greater Columbia ACH page to "Greater Health Now."

DSRIP stakeholder concerns

- No stakeholder concerns were reported apart from the questions pertaining to the pending MTP renewal application and the temporary extension.

Upcoming DSRIP activities

- Following CMS approval of the statewide accountability report, HCA will account for any withheld funds unearned and adjust ACH P4P and HPP incentives accordingly. ACH incentives are anticipated to be distributed in June of 2023. This impacts the following:

- DY5 regional and statewide VBP results have been assessed by the IA. Results will be presented in Q2, 2023 to ACHs. HCA is waiting on a decision from CMS regarding the VBP target adjustment from 90 percent to 85 percent.
- DY5 P4P and HPP achievement values calculations are calculated and will be completed by the IA by the end of Q1, 2023. Results will be provided to the ACHs in Q2, 2023.

Tribal project implementation activities

Primary milestone: Earned $939,500 by submitting the report for the second half of 2021.

Tribal partner engagement timeline

October 11–12: Attended the 2022 Learning Symposium, which included a discussion on ACH-Tribal relationships and next steps for MTP 2.0

October 18: Participated in HealthierHere Care Coordination Partner Convening

October 19–21: Visited the three ACHs on the east side of the state: Better Health Together (ACH for Ferry, Stevens, Pend Oreille, Spokane, Lincoln. Adams and Whitman Counties), North Central ACH, and Greater Health Now (Greater Columbia ACH) to discuss the state of tribal relationships, discuss care coordination and plans for MTP 2.0

October 27: Participated in the TAHC Task Force with ACHs and MCOs to discuss care coordination and MTP 2.0

October 28: Met with consultants from the American Indian Health Commission for Washington State (AIHC) as the Tribal Coordinating Entity

November 2: Met internally to plan for ACH Tribal Liaison workgroup.

November 7: Met internally to build out the health equity investment concept.

November 9: Participated in the TAHC Task Force

November 10: Began internal discussions regarding HRSN and the fee-for-service population.

November 14: Met internally to build out the health equity investment concept.

December 5: Met internally to build out the health equity investment concept.

December 7: Attended the AIHC Quarterly Delegates' meeting.

December 12: Met with staff from HealthierHere to discuss tribal relationships and MTP 2.0

December 13: Met internally on the health equity investment concept in preparation to present to CMS.

December 15: Participated in the TAHC Task Force

December 19: Met internally to build out the health equity investment concept.

LTSS implementation accomplishments

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

- As of January 6, 2023, more than 14,200 clients, in addition to their family caregivers, have received services and supports through the MAC and TSOA programs. The average caseload for the quarter was 4,195 clients.
- Washington's 1115 waiver was extended through June 30, 2023, while negotiations continue with CMS for the renewal of the waiver.

Network adequacy for MAC and TSOA

In-home care worker shortages continue to be an issue across the state and the nation. The AAAs continue to engage a variety of new providers to serve as a bridge when personal care or respite workers are in short supply. Additionally, the AAAs maintain and monitor existing service contracts.

Assessment and systems update

- Work continues with Consumer Direct of Washington (CDWA) to build an interface between their system and the MAC/TSOA case management system, GetCare. This interface will allow case managers to send and receive required documents necessary to utilize individual providers who will deliver personal care and respite services.
- Refinement to the upcoming Tailored Caregiver Assessment and Referral (TCARE 5.0) caregiver assessment tool continued this quarter. The planned release is February 1, 2023.

Staff training

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

- October 27, 2022: Presented overview of MAC and TSOA programs to new case managers statewide
- November 16, 2022: Back to Basics – Washington Caregiver Programs

Upcoming webinars include:

- January 19, 2023: Overview of 2023 Quality Assurance Performance Measures and QA process
- February 8, 2023: Caregiver Programs Learning Collaborative – Family Caregiving for Someone with Alzheimer's or Other Dementias

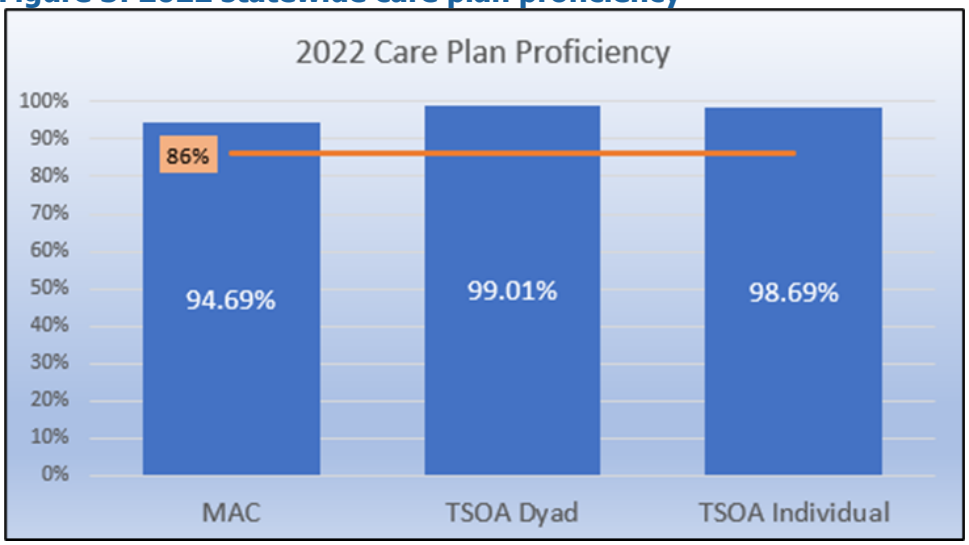
Data and reporting

Table 9: beneficiary enrollment by program

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of December 31, 2022	222	1219	3134
Number of new enrollees in quarter by program	24	161	268
Number of new person-centered service plans in quarter by program	10*	58**	120***
Number of beneficiaries self-directing services under employer authority**	0	0	0

*14 of the new enrollees do not require a care plan because they are still in the care planning phase and services have yet to be authorized.
**104 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.
*** 143 of the new enrollees do not require a care plan because they are still in the care planning phase and services have yet to be authorized.
****The State will begin using individual providers after the Consumer Directed Employer is fully implemented for the 1915c and 1915k programs.

Figure 3: 2022 statewide care plan proficiency



The state continues to monitor and assist AAAs with compliance in timely completion of care plans for enrollees.

Tribal engagement

DSHS ALTSA met with a number of Tribes to discuss Medicaid services and Initiative 2 and 3 of the demonstration during this quarter. The events include:

- October 2022: Shared MAC/TSOA information and contact information at the Indian Policy Advisory Committee (IPAC) subcommittee meeting. Promoted and reminded tribal members of MAC/TSOA video casting.
- Extended invitation to connect with MAC/TSOA subject matter experts.
- October 2022: Attended Skokomish resource fair, handed out program brochures in packet. Spoke about MAC/TSOA and the benefits of the program.
- November 2022: Attended in person meeting with Yakama Nation. Spoke with tribal members of programs, including MAC and TSOA, during break and lunch.
- November 2022: Met with Nisqually Tribe to discuss Tribal Initiative 2 and 3 programs.

The Fall/Winter Tribal Summit initially planned for December 2022 was postponed. It was rescheduled for Spring 2023. The MAC and TSOA Program Manager in ALTSA worked with the planning committee for the Spring Tribal Summit which will include sessions on Family Caregiver programs.

Washington State Tribes are still working under limited guidelines due to COVID-19, RSV, and influenza outbreaks, which has impacted all aspects of state, local, and tribal government operations by means of face-to-face interaction. Most outreach is being done on a limited basis or virtually.

The OTA was in process of recruitment and hiring during the last quarter of 2022. Discussion with Tribes was limited in December due to assisting and training a new staff whose responsibility will be program outreach with Tribal Initiative and MAC/TSOA programs.

Outreach and engagement

ALTSA's MAC/TSOA program manager is still seeking indigenous volunteers to participate in interviews for the Caregivers Program video.

Table 10: outreach and engagement activities by AAA

	October	November	December
	Number of events held		
Community presentations and information sharing	**94**	**35**	**7**

The volume and type of outreach activities were impacted this quarter by COVID-19, RSV, influenza, and holidays statewide.

Quality assurance

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

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

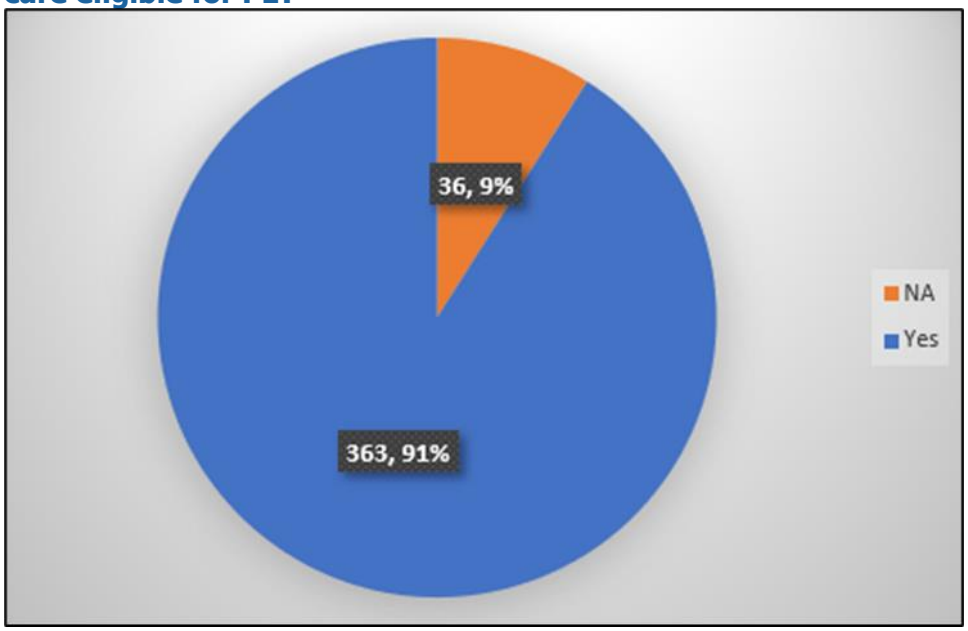


Figure 5: Question 2a: did the client remain eligible after the PE period?

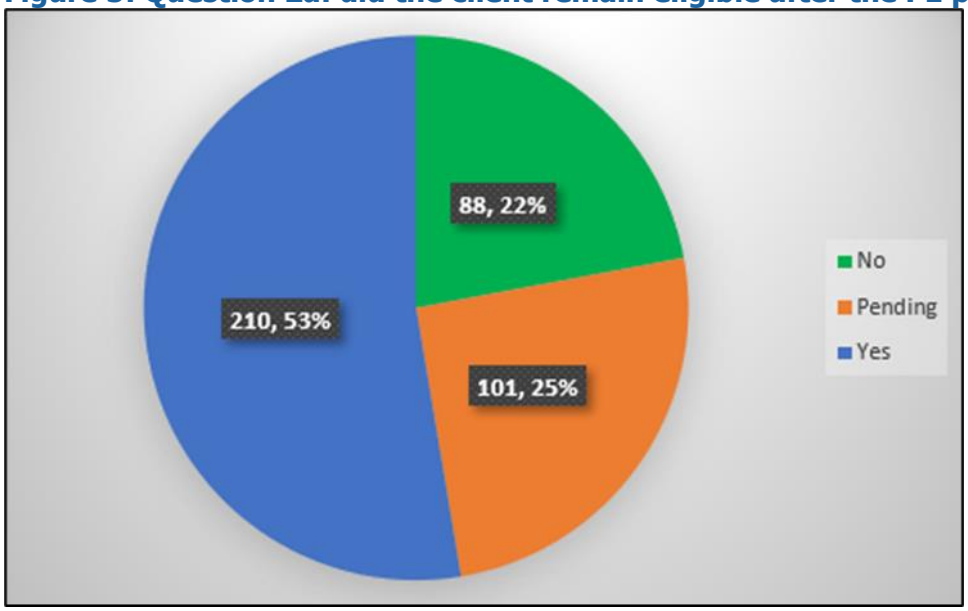
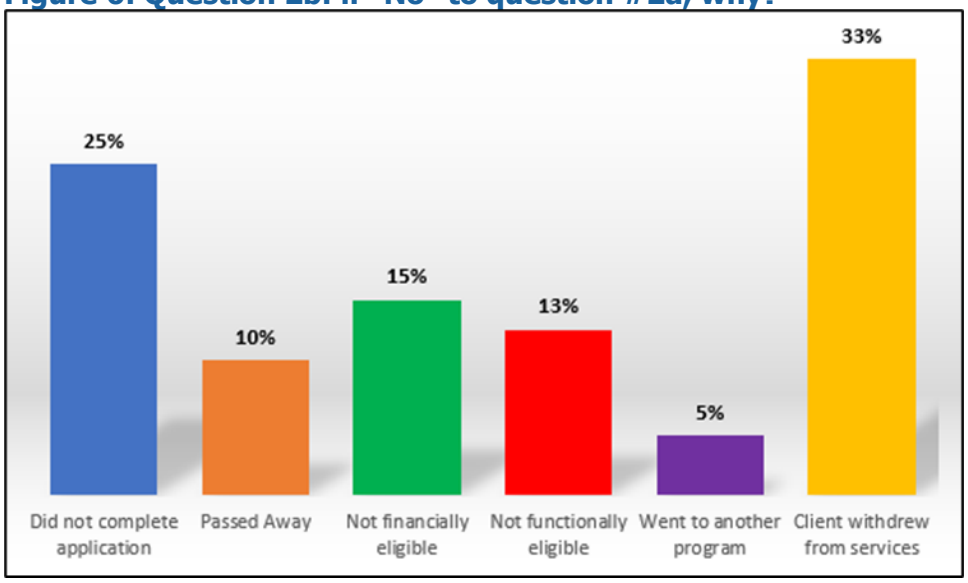


Figure 6: Question 2b: if "No" to question #2a, why?

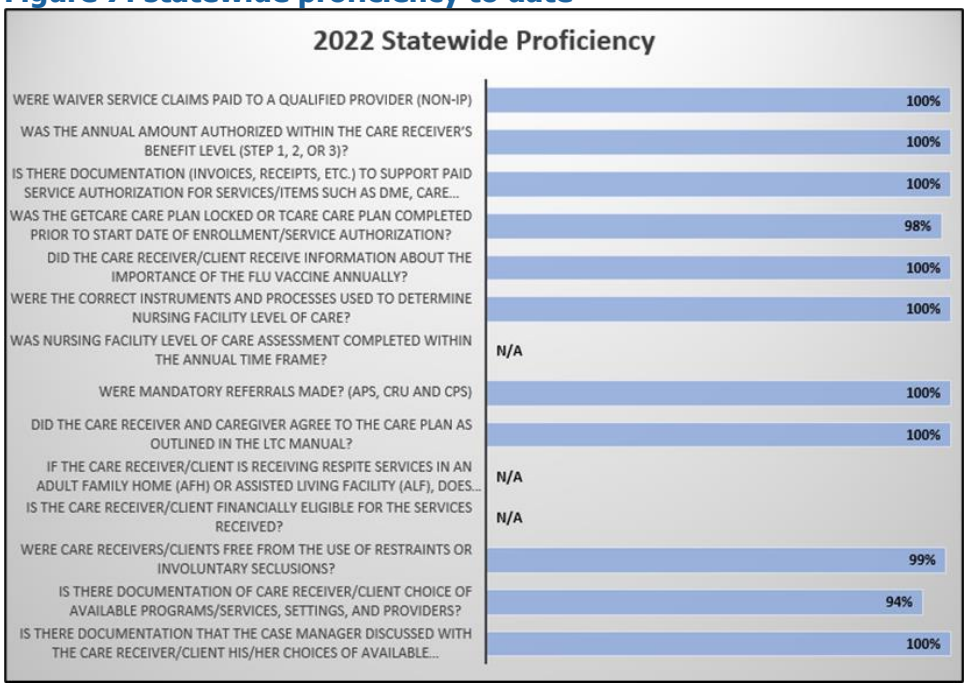


2022 quality assurance results to date

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

The Quality Assurance team reviews a statistically valid sample of case records. The sample size in 2022 was 355 cases. The methodology used is the same 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 7: statewide proficiency to date



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

State rulemaking

ALTSA continued the rule making process this quarter to modify Washington Administrative Code (WAC) related to proposed new MAC and TSOA services requested in the 1115 wavier renewal currently under review by CMS.

Upcoming activities

- The revised version of the evidence-based caregiver assessment, TCARE 5.0, will be released February 1, 2023.
- Program managers and field staff continue work on policy and procedures revisions related to the potential new services requested in the MTP renewal under review with CMS.
- The state expects to complete the work with CDWA and implement use of individual providers (for personal care and respite services) by mid-2023.

LTSS stakeholder concerns

- Concern has been raised by AAAs about a decrease in MAC/TSOA enrollments since July 2022 when the Personal Needs Allowance (PNA) was increased for traditional in-home LTSS clients.
- The in-home caregiver shortage continues to be a concern for families and clients who need assistance.

FCS implementation accomplishments

Initiative 3 provides evidence-based supportive housing and supported employment services to eligible Medicaid clients. This section summarizes the FCS program development and implementation activities from October 1 through December 31, 2022. Key accomplishments for the quarter include:

- Total aggregate number of people enrolled in FCS services at the end of DY6 Q4:
    - CSS: 8,921
    - IPS: 5,110

- There were 184 providers under contract with Amerigroup at the end of DY6 Q4, representing 501 sites throughout the state.

Note: CSS and IPS enrollment totals include 2,275 participants enrolled in both programs. The total unduplicated number of enrollments at the end of this reporting period was 11,756.

Network adequacy for FCS

Table 11: FCS provider network development

	October		November		December	
FCS service type	Contracts	Service locations	Contracts	Service locations	Contracts	Service locations
Supported Employment – Individual Placement Support (IPS)	36	77	36	77	36	77
Community Support Services (CSS)	20	46	20	46	22	57
CSS and IPS	124	364	126	367	126	367
Total	**180**	**487**	**182**	**490**	**184**	**501**

Client enrollment

Table 12: FCS client enrollment

	October	November	December
Supported Employment – Individual Placement and Support (IPS)	2,784	2,775	2,835
Community Support Services (CSS)	6,353	6,515	6,646
CSS and IPS	2,196	2,202	2,275
Total aggregate enrollment	**11,333**	**11,492**	**11,756**

Data source: RDA administrative reports

Table 13: FCS client risk profile

		Met HUD homeless criteria	Avg. PRISM risk score	Serious mental illness
October	IPS	611 (12%)	1.09	3,550 (71%)
	CSS	1,819 (21%)	1.34	5,647 (66%)
November	IPS	596 (12%)	1.02	3,505 (70%)
	CSS	1,878 (22%)	1.25	5,658 (65%)
December	IPS	600 (12%)	1.01	3,594 (70%)
	CSS	1,930 (22%)	1.25	5,791 (65%)

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 14: FCS client risk profile continued

		Medicaid only enrollees*	MH treatment need	SUD treatment need	Co-occurring MH + SUD treatment needs flags
October	IPS	4,170	3,846 (92%)	2,543 (61%)	2,395 (57%)
	CSS	7,113	6,418 (90%)	5,180 (73%)	4,765 (67%)
November	IPS	4,160	3,817 (92%)	2,503 (60%)	2,351 (57%)
	CSS	7,260	6,505 (90%)	5,260 (72%)	4,816 (66%)
December	IPS	4,279	3,902 (91%)	2,545 (59%)	2,377 (56%)
	CSS	7,441	6,640 (89%)	5,358 (72%)	4,894 (66%)

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

Table 15: FCS client service utilization

(Aging CARE assessment in last 15 months)

		Medicaid only enrollees*	Long-term Services and Supports	Mental health services	SUD services (received in last 12 months)	Care + MH or SUD services
October	IPS	4,170	488 (12%)	3,055 (73%)	1,579 (38%)	421 (10%)
	CSS	7,113	710 (10%)	4,668 (66%)	3,138 (44%)	588 (8%)
November	IPS	4,160	497 (12%)	2,997 (72%)	1,529 (37%)	425 (10%)
	CSS	7,260	705 (10%)	4,649 (64%)	3,133 (43%)	579 (8%)
December	IPS	4,279	522 (12%)	3,036 (71%)	1,539 (36%)	444 (10%)
	CSS	7,441	732 (10%)	4,640 (62%)	3,132 (42%)	591 (8%)

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

Table 16: 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
October	IPS	1,489 (30%)	113 (2%)	527 (11%)	2,112 (42%)	590 (12%)	149 (3%)
	CSS	2,657 (31%)	436 (5%)	1,074 (13%)	2,880 (34%)	1,415 (17%)	87 (1%)
November	IPS	1,509 (30%)	115 (2%)	506 (10%)	2,117 (43%)	574 (12%)	156 (3%)
	CSS	2,722 (31%)	419 (5%)	1,063 (12%)	2,972 (34%)	1,453 (17%)	88 (1%)
December	IPS	1,552 (30%)	116 (2%)	523 (10%)	2,186 (43%)	575 (11%)	158 (3%)
	CSS	2,782 (31%)	434 (5%)	1,093 (12%)	3,063 (34%)	1,461 (16%)	88 (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 continued to work with the TPA to monitor the implementation of FCS during Q4. 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 due to changes in coverage. Because FCS is not an entitlement benefit, enrollment in the program is a manual process requiring weekly workflows to enroll and reenroll (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 fidelity review of contracted FCS providers. These reviews were completed virtually (or a hybrid of virtual and on-site review) over two or more days with a review team of HCA staff and FCS providers. The FCS training staff are also bringing on fidelity reviewers from other state agencies such as the Division of Vocational Rehabilitation to facilitate more cross-system collaboration. FCS training staff began a new cycle of fidelity reviews that will carry into next quarter.

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

Lastly, FCS requested applications for a Permanent Supportive Housing (PSH) Fidelity Certification. FCS will host two trainings in 2023 that certify supportive housing staff in PSH fidelity which will directly impact service delivery of programs throughout the state. The FCS team estimates 45 direct service staff will be certified and have essential knowledge of PSH fidelity and how to implement the principles within their own programs. Certified reviewers will also participate and lead reviews of other agencies across the state, increasing the capacity of FCS trainers significantly.

Other FCS program activity

- HCA continues to convene a monthly workgroup with DSHS 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 bimonthly meeting series with CSS providers organized by King County, the most populous county in the state. This meeting offers housing providers in that county the opportunity to discuss implementation and learn from fellow providers about best practices when running an FCS benefit.
- In partnership with DSHS Division of Vocational Rehabilitation (DVR), HCA participates in a quarterly workgroup to improve consistency, collaboration, and employment outcomes for DVR customers with a behavioral health condition receiving supported employment services from DVR Supported Employment program and FCS.
- FCS staff attended and presented at two conferences during Q4: Co-Occurring Disorders and the Colorado IPS Conference. Presentation topics included:
    - Discharge Planners Toolkit for reducing homelessness
    - Community inclusion and the importance of collaboration
    - Career profile development
    - Provider engagement

Upcoming activities

- Medicaid Academy: The first of two six week Medicaid Academies will be offered to potential and current FCS providers in Q1 2023. The Medicaid Academy will be offered again in Q3. 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 billing providers, who have been having issues with billing to Medicaid, and those who are interested in billing Medicaid for CSS and IPS services.
- Supportive Housing Academy: A series of nine trainings, based on direct provider feedback, was developed to increase tenant feedback, clarify roles and responsibilities, and increase housing inventory. This academy will be offered during Q1 2023.
- FCS staff continue to meet regularly with the Department of Commerce on the planning and development of two programs:
    - Apple Health and Homes, a partnership among the Department of Commerce, DSHS, and the HCA focused on creating permanent supportive housing units for CSS-eligible individuals.
    - The expansion of the Housing and Essential Needs (HEN) program to create a bridge period of up to 9 months of additional rental support for IPS-enrolled individuals. Roughly 30 percent of IPS enrollees have a referral for and receive assistance from the HEN program.

FCS program stakeholder engagement activities

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

Table 17: FCS program stakeholder engagement activities

	October	November	December
	Number of events held		
Training and assistance provided to individual organizations	71	69	72
Community and regional presentations and training events	10	10	6
Informational webinars	11	14	14
Stakeholder engagement meetings	16	17	15
Total activities	**108**	**110**	**107**

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.
Q4 topics included:

- How to build partnerships with worksource, temp agencies, and marketing services
- Best practices in job coaching
- Trauma Informed Supervision
- Strengthening relationships with employers: beyond the initial meeting
- Case management approaches and best practices to address hoarding behaviors
- Overview of SAMHSAs core elements of Permanent Supportive Housing
- Motivational Interviewing
- Permanent Supportive Housing fidelity: Access to housing

- How to engage hard to engage participants

FCS stakeholder concerns

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

SUD IMD waiver implementation accomplishments

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

This section summarizes SUD IMD waiver development and implementation activities from October 1 through December 31, 2022. Accomplishments for the quarter include:

- Co-Occurring Conference
- Provider Relief funds

Implementation plan

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

- Milestones satisfied.

SUD Health IT plan requirements

During Q3 of 2022:

- HCA continued to coordinate with DOH to support development of the Technical and Operational Plan for the nationally required 988 crisis call system and enhanced Crisis Call Center Hub System and Behavioral Health Integrated Client Referral System required under state law (E2SBH 1477).
  The Crisis Call Center Hub System and Behavioral Health Integrated Client Referral System includes a focus on persons with SUD and MH needs.
  The technology systems and tools that are the being considered include tools to support crisis call, response, and dispatch; and behavioral health referral and follow-up.
  HCA, in partnership with DOH, produced the statutorily required Final Technical and Operational Plan for the National 988 System: Crisis Call Center and Behavioral Health Integrated Referral System. See the final plan.
- **Tele-Behavioral Health:** HCA continued to support the use of tele-behavioral health through its contract with the Behavioral Health Institute.
- **Medicaid Managed Care Contract Language:** HCA finalized Medicaid Managed Care contract language that will require, effective January 1, 2023, MCOs to:

- Require that inpatient psychiatric hospitals and units that have access to and use interoperable Health IT create and send admission/discharge/transfer notifications (ADTs) to providers, facilities, or practitioners on behalf of enrollees admitted to these facilities; and
- Annually submit to the HCA an ADT Notification report that includes:
  - Information about the in-patient psychiatric hospitals/units creating and sending ADTs; and
  - Information about community based psychiatric hospitals/units that do not have access to interoperable Health IT/EHR and the hospitals'/units' current or future plans to acquire interoperable Health IT/EHR and date of proposed implementation.

Evaluation design

- No updates

Monitoring protocol

- No updates

Upcoming activities

- Pending additional information

MHIMD waiver implementation accomplishments

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

This section summarizes MH IMD waiver development and implementation activities from October 1 through December 31, 2022.

- The state applied for a grant that would create a Certified Community Behavioral Health Clinic (CCBHC) demonstration plan in 2023.
- The state's first intensive behavioral health treatment facility opened in December.
- Provider Relief dollars continued to be distributed.

Implementation plan

- Items are under review and will be included in the next iteration.

MH Health IT plan requirements

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

- Activities can be found under the SUD Health IT plan requirement section.

Evaluation design

- No changes

Monitoring protocol

- No changes

Upcoming activities

- Further refinements of Crisis system

Quarterly expenditures

The following table reflects quarterly expenditures for DSRIP, LTSS, and FCS during Q4.

Table 18: DSRIP expenditures

	Q1	Q2	Q3	Q4	DY6 Total	Funding source
	January 1–March 31	April 1–June 30	July 1–September 30	October 1–December 31	January 1–December 31	Federal financial participation
Better Health Together	$0	$9,103,699	$0	$1,671,549.00	$10,775,248.00	$5,387,624.00
Cascade Pacific Action Alliance	$0	$9,462,549	$0	$1,565,278.00	$11,027,827.00	$5,513,913.50
Elevate Health	$0	$12,361,357	$0	$1,913,790.00	$14,275,147.00	$7,137,573.50
Greater Health Now (formally Greater Columbia)	$0	$11,373,483	$0	$2,160,418.00	$13,533,901.00	$6,766,950.50
HealthierHere	$0	$19,146,935	$0	$3,400,668.00	$22,547,603.00	$11,273,801.50
North Central	$0	$5,344,126	$0	$806,274.00	$6,150,400.00	$3,075,200.00
North Sound	$0	$12,980,082	$0	$2,327,378.00	$15,307,460.00	$7,653,730.00
Olympic Community of Health	$0	$4,219,193	$0	$770,019.00	$4,989,212.00	$2,494,606.00
SWACH	$0	$5,803,354	$0	$1,095,059.00	$6,898,413.00	$3,449,206.50
Indian Health Care Providers	$0	$939,500	$0	$939,500.00	$1,879,000.00	$939,500.00

Table 19: MCO-VBP expenditures

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

Table 20: LTSS and FCS service expenditures

	Q1	Q2	Q3	Q4	DY6 Total
	January 1–March 31	April 1–June 30	July 1–September 30	October 1–December 31	January 1–December 31
Tailored Supports for Older Adults (TSOA)	$1,759,393	$7,049,254	$5,724,025.83	$5,556,649.95	$20,089,322.45
Medicaid Alternative Care (MAC)	$50,791	$201,047	$169,460.21	$174,456.45	$595,754.17

MAC and TSOA not eligible	$0	$281	$263.50	$30.00	$574.50
FCS	$3,047,246	$6,125,131	$6,015,533.00	$6,107,287.00	$21,295,197.00

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 2022. November 2022 through December 2022 member months for non-expansion adults are forecasted caseload figures from CFC.

Table 21: 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	376,302	0	0	0	0				
Feb-17	375,198	0	0	0	0				
Mar-17	374,726	0	0	0	0				
Apr-17	373,578	0	0	0	0				
May-17	373,122	0	0	0	0				
Jun-17	373,025	0	0	0	0				
Jul-17	372,112	0	0	0	0				
Aug-17	371,847	0	0	0	0				
Sep-17	370,580	0	0	0	0				
Oct-17	370,385	0	0	0	0				
Nov-17	370,215	0	0	0	0				
Dec-17	370,242	0	0	0	0				
Jan-18	370,280	0	0	0	0				
Feb-18	368,905	0	0	0	0				
Mar-18	368,713	0	0	0	0				
Apr-18	367,451	0	0	0	0				
May-18	367,815	0	0	0	0				
Jun-18	367,094	0	0	0	0				
Jul-18	366,837	5	19	91	10				
Aug-18	366,238	8	17	95	44				
Sept-18	365,242	4	19	80	44				
Oct-18	365,241	4	22	93	47				
Nov-18	364,774	3	27	93	34				
Dec-18	364,225	4	17	96	23				
Jan-19	364,151	34	133	411	37				
Feb-19	362,468	31	115	391	40				
Mar-19	362,121	42	144	398	45				

Apr-19	361,650	56	136	473	38				
May-19	361,137	43	125	483	49				
June-19	360,376	65	150	573	54				
Jul-19	360,804	65	197	676	55				
Aug-19	360,379	66	243	744	49				
Sep-19	359,934	75	214	779	44				
Oct-19	359,421	73	237	884	36				
Nov-19	358,557	81	190	812	44				
Dec-19	358,883	58	213	940	51				
Jan-20	359,323	32	129	531	44				
Feb-20	359,317	24	125	478	44				
Mac-20	360,995	33	133	484	45				
Apr-20	364,448	42	109	383	21				
May-20	366,870	25	97	376	29				
Jun-20	369,623	46	157	553	46				
Jul-20	372,279	25	84	335	32				
Aug-20	375,085	51	218	711	38				
Sep-20	377,270	65	208	680	47				
Oct-20	379,257	52	191	756	44				
Nov-20	380,125	54	179	762	27				
Dec-20	381,571	65	172	784	24	43	33	146	4
Jan-21	382,704	16	59	223	31	1	3	189	14
Feb-21	382,719	25	89	299	18	0	0	207	11
Mar-21	384,038	21	85	318	26	1	1	230	14
Apr-21	385,357	25	97	368	14	0	3	190	18
May-21	386,558	31	85	313	27	1	3	203	16
Jun-21	387,614	17	33	157	21	0	3	205	16
Jul-21	389,214	25	103	369	19	271	178	602	16
Aug-21	391,243	19	90	323	20	250	176	563	13
Sep-21	392,675	16	85	324	15	241	177	602	12
Oct-21	394,016	16	81	278	11	256	198	619	16
Nov-21	395,947	14	78	300	14	248	224	608	20
Dec-21	396,568	6	46	214	13	237	221	624	12
Jan-22	398,164	1	14	79	6	237	234	625	14
Feb-22	399,444	15	98	366	7	220	249	598	14
Mar-22	401,011	20	116	413	20	234	239	669	11
April-22	403,194	23	111	392	12	195	165	448	7
May-22	404,620	26	105	386	8	199	217	574	5
Jun-22	406,872	22	84	335	22	180	168	504	2
Jul-22	408,932	5	30	181	10	60	44	198	1
Aug-22	411,731	21	95	344	12	255	215	682	1
Sep-22	413,134	4	22	137	2	234	188	565	1
Oct-22	414,966	0	0	0	0	69	31	139	0
Nov-22	417,154	0	0	0	0	0	0	0	0
Dec-22	418,967	0	0	0	0	0	0	0	0
Total	27,217,033	1,599	5,626	21,064	1,513	3,432	2,970	9,990	238

Budget neutrality

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

Designated state health programs (DSHP)

- HCA has continued to contract with Myers & Stauffer to perform an independent audit based on agreed-upon procedures to validate the accuracy of DSHP claims reported on the CMS-64 for CY2021. Expected completion of the review is June 30, 2023.

Overall MTP development and issues

Operational/policy issues

No operational or policy issues were identified in Q4 2022. The state appreciates the timely approval of the short-term extension while negotiations continue regarding the MTP renewal package. This allowed the state to communicate proactively with partners to mitigate demonstration expiration concerns.

Consumer issues

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

MTP evaluation

The MTP IEE submitted their quarterly rapid-cycle report on December 19, 2022. Their report covers October 1 through December 31, 2022, and presents findings on Washington State's Medicaid system performance through September 2021.

The IEE report also includes key performance indicators in 10 measurement domains as well as an examination of equity and disparities among specific populations within measurement domains. The full report is available on the HCA website.

Quantitative analysis and Medicaid data

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

Qualitative analysis of Medicaid data

- Continued to analyze previously collected qualitative data; these ongoing analyses will be documented in the final evaluation report.
- Actively coding and analyzing data from the final round of ACH interviews.
- The qualitative team's institutional review board (IRB) amendment submission to interview behavioral health provider organizations was approved.
- Actively sampling for and recruiting behavioral health provider organization interviewees, tailoring interview guides, developing a codebook, and conducting interviews along with data analysis. During this reporting period, the IEE team met weekly to listen to audio recordings, analyze transcripts, and refine the codebook.

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

This is the third measurement period, which falls entirely after the statewide stay-at-home order was issued in Washington. Some measures of quality and access to care began to rebound after the impacts of the COVID-19 Public Health Emergency (PHE). Rates of well-child visits for children over the age of three and well-care visits

for members under 21 improved substantially compared with the previous year, regaining much of the ground lost following the beginning of the PHE. Rates of periodontal exams for adults show a similar pattern, with substantial increases during this reporting period, following sharp declines during the first year of the PHE.

However, we also observed persistently lower rates for several outcome metrics that declined during the early months of the PHE. Most notably, adults' access to primary care and rates of cancer screenings remain low, showing further declines during this reporting period compared with the previous year. We previously reported a dramatic downward trend in rates of care received in emergency departments and acute hospital settings. While reducing care in these settings would usually be viewed as a positive trend, in this context, it is likely attributable to barriers to access resulting from the PHE. Decreases in care received in these settings have leveled off in more recent reporting periods but have not yet rebounded to pre-PHE levels.

Finally, we continue to note disparities in health care access and quality among subpopulations examined in this report. Asian and Black members continue to receive lower rates of follow-up care after an emergency department visit for alcohol or other drug use and have less access to substance use disorder treatment than other groups. American Indian and Alaska Native members experienced markedly worse access to well-child visits, cancer screenings, mental health care, and care related to chronic conditions, alongside higher rates of emergency department utilization and acute hospitalization. Members living with a chronic health condition or a serious mental illness were more likely to experience homelessness and unemployment, and higher rates of arrest.

Summary of changes in Medicaid system performance

Better

- Access to well-care visits for members ages three to 21 improved by 6.9 percentage points over the previous year, while rates of well-child visits for children over 3 climbed 7.2 percentage points. Decreases in this type of care represented some of the most notable impacts of the PHE but have nearly rebounded to pre-PHE levels in this reporting period. New data on rates of well-child visits in the first 30 months of life were not available for this reporting period.
- The IEE saw improvements to several metrics of access to mental health care, including a decline in 30-day hospital readmissions for a psychiatric condition.
- Statewide access to periodontal exams for adults improved almost ten percentage points from a low point at the onset of the PHE, with Hispanic members experiencing notably better access than the state average.

Mixed

- Although the IEE saw improvements to well-care and well-child visits, other metrics of access to primary and preventive care and prevention and wellness declined during this period, with rates of breast cancer screening falling by three percentage points compared with the previous year.
- Most care for people with chronic conditions remained relatively flat during this reporting period, but access to controller medication for asthma improved somewhat. However, disparities in this domain persist for AI/AN who had less access to diabetes care, controller medication for asthma, and statin medication for cardiovascular disease.
- Although emergency department visits and care received in acute hospital settings fell statewide, these trends may reflect continued barriers to access resulting from the COVID-19 pandemic.

Worse

- Disparities in quality and access to care persisted during this reporting period, with AI/AN and Black members experiencing worse access to mental health care and notably higher rates of

utilization in emergency departments and acute hospital settings compared with statewide averages.

- Asian, Black, Native Hawaiian and Pacific Islander, and Hispanic members also saw less access to care for substance use disorders than observed in the state overall.

Quantitative analysis and Medicaid data

The IEE qualitative team will continue recruiting, conducting interviews, and meeting weekly to analyze data for behavioral health provider organization interviews. The IEE will report the findings from these interviews in the final evaluation report.

Summary of additional resources, enclosures, and attachments

Additional resources

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

Summary of attachments

- Attachment A: state contacts
- Attachment B: Financial Executor Portal Dashboard, Q4 2022
- Attachment C: 1115 SUD Demonstration Monitoring Workbook – Part A
- Attachment D: 1115 SUD Demonstration Monitoring Report – Part B
- Attachment E: 1115 SMI/SED Demonstration Monitoring Workbook – Part A
- Attachment F: 1115 SMI/SED Demonstration Monitoring Report – Part B

Attachment A: state contacts

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

Area	Name	Title	Phone
MTP and quarterly reports	Chase Napier	MTP Director, HCA	360-725-0868
DSRIP program	Chase Napier	MTP Director, HCA	360-725-0868
LTSS program	Debbie Johnson	Initiative 2 Program Manager, DSHS	360-725-2531
FCS program	Matthew Christie	FCS 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, Q4 2022

View this table on the HCA website, which shows all funds earned and distributed through the FE portal through December 31, 2022.

Attachment C: 1115 SUD Demonstration Monitoring Workbook – Part A

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

Attachment D: 1115 SUD Demonstration Monitoring Report – Part B

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

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

	matchable if the beneficiary were not residing in an IMD.

2. Executive Summary

SUD Metric trends for treatment needs showed a downward trend in the number of Medicaid beneficiaries through the second quarter of 2022, but there was an increase from the previous annual measurement period to 07/01/2021-06/30/2022. During this period, the number of Medicaid beneficiaries treated in an IMD for SUD decreased slightly. Metric trends for Medicaid beneficiary access to critical levels of care for opioid use disorder and other SUDs showed downward trends throughout Q2 of 2022, with a slight upward trend for early intervention, downward for outpatient SUD treatment, slightly upward for residential and inpatient treatment as well as withdrawal management, and downward for medication assisted treatment. Length of stays increased slightly (.37 percentage points) from the previous measurement period to 07/01/2021-6/30/2022. Increases in provider capacity were noted for SUD and MAT.

Decreases were noted in the following diagnosis cohorts: (a) alcohol abuse or dependence by -1.77, (b) opioid abuse or dependence by -2.01, (d) other drug abuse or dependence by -1.39, and (e) total AOD abuse or dependence decreased by -2.37.

The annual number of Medicaid beneficiaries who received engagement of AOD treatment trended downward since the year prior to the 01/01/2021-12/31/2021 measurement period: (a) alcohol abuse or dependence - 0.96, (b) opioid abuse or dependence - 5.77, (d) other drug abuse or dependence -1.44, and (e) total AOD abuse or dependence - 2.98.

Slight increases were noted in the use of opioids at high dosage in persons without cancer and decreases in the concurrent use opioids and benzodiazepines on an annual basis.

Fatal overdoses for all individuals in Washington trended downward over most categories except for synthetic opioids (methadone excluded).

Inpatient stays and emergency department utilization remained stable in the Q2 2022 measurement period.

The above measurement periods 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 state continues to invest in SUD treatment resources and is maintaining compliance with all implementation milestones.

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

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
1.2 Assessment of Need and Qualification for SUD Services			
1.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.	The monthly number of Medicaid beneficiaries with a SUD diagnosis continued to trend downward during the 04/01/2022-06/30/2022 measurement period, with an overall decrease of 329 between April and June 2022. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#3: Medicaid beneficiaries with SUD diagnosis (monthly)
	The annual number of Medicaid beneficiaries with a SUD diagnosis increased by 7,678 since the year prior to the 07/01/2021-06/30/2022 measurement period. 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	#4: Medicaid beneficiaries with SUD diagnosis (annual)
	The annual number of Medicaid beneficiaries treated in an IMD for SUD decreased slightly by 68 since the year prior to the 07/01/2021-06/30/2022 measurement period. 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	#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 a SUD diagnosis who received any SUD treatment continued to trend downward during the 04/01/2022-06/30/2022 measurement period, with an overall decrease of 348 between April and June 2022. 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 a SUD diagnosis who received early intervention (i.e., SBIRT) trended slightly upward during the 04/01/2022-06/30/2022 measurement period, with an overall increase of 22 between April and June 2022. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the	04/01/2019 – 06/30/2019	#7: Early Intervention

	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 outpatient SUD treatment trended downward during the 04/01/2022-06/30/2022 measurement period, showing an overall decrease of 288 between April and June 2022. 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 a SUD diagnosis who received residential and inpatient SUD treatment fluctuated slightly upward during the 04/01/2022-06/30/2022 measurement period, increasing overall by 31 between April and June 2022. 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 a SUD diagnosis who received withdrawal management SUD treatment fluctuated slightly upward during the 04/01/2022-06/30/2022 measurement period, increasing overall by 58 between April and June 2022. 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 a SUD diagnosis who received MAT SUD treatment trended downward during the 04/01/2022-06/30/2022 measurement period, showing an overall decrease of 130 between April and June 2022. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the	04/01/2019 – 06/30/2019	#12: Medication Assisted Treatment

	receipt of these services is unknown. Any changes in trends should be interpreted with caution.		
	The annual average length of stay for Medicaid beneficiaries with a SUD diagnosis who were discharged from IMD inpatient or residential treatment for SUD increased slightly by 0.37 percentage points since the year prior to the 07/01/2021-06/30/2022 measurement period. 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	#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, or (c) use of independent process for reviewing**			

placement in residential treatment settings.			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 2.			
☒ The state has no implementation update to report for this reporting topic.			
☒ The state is not reporting metrics related to Milestone 2.			
4.2 Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)			
4.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 3.			
☒ The state has no trends to report for this reporting topic.			
☐ The state is not reporting metrics related to Milestone 3.			
4.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards.** **☐ ii) State review process for residential treatment providers' compliance with qualifications standards.**			

☐ **iii) Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site.**			
☒ **The state has no implementation update to report for this reporting topic.**			
☒ **The state expects to make other program changes that may affect metrics related to Milestone 3.**			
☒ **The state has no implementation update to report for this reporting topic.**			
☒ **The state is not reporting metrics related to Milestone 3.**			
5.2 Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)			
5.2.1 Metric Trends			
☒ **The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4.**	The annual number of Medicaid providers who were qualified to deliver SUD services increased by 609 since the year prior to the 07/01/2021-06/30/2022 measurement period. 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	#13: SUD provider availability
	The annual number of Medicaid providers who were qualified to deliver SUD services and who meet the standards to provide buprenorphine or methadone as part of MAT increased by 500 since the year prior to the 07/01/2021-06/30/2022 measurement period. 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	#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 annual number of Medicaid beneficiaries who received initiation of AOD treatment trended downward since the year prior to the 01/01/2021-12/31/2021 measurement period. The percentage point change in the rates for the following diagnosis cohorts are as follows: (a) alcohol abuse or dependence decreased by 1.77, (b) opioid abuse or dependence decreased by 2.01, (d) other drug abuse or dependence decreased by 1.39, and (e) total AOD abuse or dependence decreased by 2.37. The annual number of Medicaid beneficiaries who received engagement of AOD treatment trended downward since the year prior to the 01/01/2021-12/31/2021 measurement period. The percentage point change in the rates for the following diagnosis cohorts	01/01/2017 – 12/31/2017	#15: Initiation and Engagement of Alcohol and Other Drug Treatment

	are as follows: (a) alcohol abuse or dependence decreased by 0.96, (b) opioid abuse or dependence decreased by 5.77, (d) other drug abuse or dependence decreased by 1.44, and (e) total AOD abuse or dependence decreased by 2.98. 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.		
	The annual number of Medicaid beneficiaries with use of opioids at high dosages without cancer slightly increased by 0.04 percentage points between CY2021 and CY2022 measurement periods. Overall, this number has remained fairly stable since the 1.83 percentage point decrease between CY2020 and CY2021. 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.	01/01/2018 – 12/31/2018	#18: Use of Opioids at High Dosage in Persons without Cancer (modified by State)
	The annual number of Medicaid beneficiaries with concurrent use of opioids and benzodiazepines decreased by 1.76 percentage points between CY2021 and CY2022 measurement periods. Overall, this shows a continued downward trend since CY2020 when there was a 1.74 percentage point decrease between CY2020 and CY2021. 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.	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. Metric results for this topic are currently in progress by the producer and will be reported by the state at the next reporting period.	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. This topic is not due for reporting for this reporting period.	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. This topic is not due for reporting for this reporting period.	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.	The annual number of fatal drug overdoses in the state of Washington, not restricted to Medicaid beneficiaries, has generally trended downward since the year prior to the 07/01/2021-06/30/2022 measurement period. The submetrics for this reporting topic are as follows: (a) all statewide fatal drug overdoses decreased by 138, (b) all opioids decreased by 34, (c) heroin decrease by 200, and	07/01/2017 – 06/30/2018	Q1: PDMP Statewide Fatal Drug Overdoses – All, All Opioids, Heroin,

	(d) prescription opioids (excluding synthetic opioids) decreased by 50. The synthetic opioids (not methadone) is the only submetric to show an upward trend, with an increase of 230 since the year prior to the 07/01/2021-06/30/2022 measurement period. 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.		Prescription Opioids (excluding synthetic opioids), Synthetic Opioids (not Methadone)
	The annual substance use disorder treatment penetration rate for Medicaid beneficiaries decreased slightly by 0.95 percentage points since the year prior to the 07/01/2021-06/30/2022 measurement period. 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
	The annual number of FCS Medicaid beneficiaries with inpatient or residential SUD services increased by 1.49 percentage points since the year prior to the 07/01/2021-06/30/2022 measurement period. 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.	• HCA continued to coordinate with DOH to support development of the Technical and Operational Plan for the nationally required 988 crisis call system and enhanced Crisis Call Center Hub System and Behavioral Health Integrated Client Referral System required under state law		

	(E2SBH 1477). The Crisis Call Center Hub System and Behavioral Health Integrated Client Referral System includes a focus on persons with SUD and MH needs. The technology systems and tools that are the being considered include tools to support crisis call, response, and dispatch; and behavioral health referral and follow-up. HCA, in partnership with DOH, produced the statutorily required Final Technical and Operational Plan for the National 988 System: Crisis Call Center and Behavioral Health Integrated Referral System. See the Final Plan here. • Tele-Behavioral Health: HCA continued to support the use of tele-behavioral health through its contract with the Behavioral Health Institute. • Medicaid Managed Care Contract Language: HCA finalized Medicaid Managed Care contract language that will require, effective January 1, 2023, MCOs to: o Require that inpatient psychiatric hospitals and units that have access to and use interoperable HIT create and send admission/discharge/transfer notifications (ADTs) to providers, facilities, or practitioners on behalf of enrollees admitted to these facilities; and o Annually submit to the HCA an ADT Notification report that includes: o Information about the in-patient psychiatric hospitals/units creating and sending ADTs; and		

	○ Information about community based psychiatric hospitals/units that do not have access to interoperable HIT/EHR and the hospitals'/units' current or future plans to acquire interoperable HIT/EHR and date of proposed implementation.		
☐ 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 monthly rate of emergency department utilization for SUD has remained relatively stable during the 04/01/2022-06/30/2022 measurement period, with only a minor decrease of 0.03 percentage points between April and June 2022. 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 monthly rate of inpatient stays for SUD has remained relatively stable during the 04/01/2022-06/30/2022 measurement period, with only a minor increase of 0.05 percentage points between April and June 2022. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries
	The state has no metrics trends to report for this reporting topic this quarter. Metric results for this topic are currently in progress by the producer and will be reported by the state at the next reporting period.	07/01/2018 – 06/30/2019	#25: Readmissions Among

			Beneficiaries with SUD
	The state has no metrics trends to report for this reporting topic this quarter. Metric results for this topic are currently in progress by the producer and will be reported by the state at the future reporting period.	07/01/2017 – 06/30/2018	#26: Overdose Deaths (count)
	The state has no metrics trends to report for this reporting topic this quarter. Metric results for this topic are currently in progress by the producer and will be reported by the state at the future reporting period.	07/01/2017 – 06/30/2018	#27: Overdose Deaths (Rate)
	The state has no metrics trends to report for this reporting topic this quarter. This topic is not due for reporting for this reporting period.	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.			
10.2.2 Implementation Update			
☐ The state expects to make other program changes that may affect budget neutrality			
☐ The state has no implementation update to report for this reporting topic.			
11.1 SUD-Related Demonstration Operations and Policy			
11.1.1 Considerations			
☐ States should highlight significant SUD (or if broader demonstration, then SUD-related) demonstration operations or policy considerations that could positively or negatively affect beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.			

☐ The state has no related considerations to report for this reporting topic.			
11.1.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) How the delivery system operates under the demonstration (e.g., through the managed care system or fee for service).** **☐ ii) Delivery models affecting demonstration participants (e.g., Accountable Care Organizations, Patient Centered Medical Homes).** **☐ iii) Partners involved in service delivery.**			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities.			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state is working on other initiatives related to SUD or OUD.			
☒ The state has no implementation update to report for this reporting topic.			

☐The initiatives described above are related to the SUD or OUD demonstration (States should note similarities and differences from the SUD demonstration).			
☒ The state has no implementation update to report for this reporting topic.			
12. SUD Demonstration Evaluation Update			
12.1. Narrative Information			
☐ Provide updates on SUD evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. See report template instructions for more details.			
☒ The state has no SUD demonstration evaluation update to report for this reporting topic.			
☐ Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.			
☒ The state has no SUD demonstration evaluation update to report for this reporting topic.			
☐ List anticipated evaluation-related deliverables related to this demonstration and their due dates.			

☒ The state has no SUD demonstration evaluation update to report for this reporting topic.			
13.1 Other Demonstration Reporting			
13.1.1 General Reporting Requirements			
☐ The state reports changes in its implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol.			
☒ The state has no updates on general requirements to report for this reporting topic.			
☐ The state anticipates the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes.			
☒ The state has no updates on general requirements to report for this reporting topic.			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) The schedule for completing and submitting monitoring reports.** **☐ ii) The content or completeness of submitted reports and/or future reports.**			
☒ The state has no updates on general requirements to report for this reporting topic.			

☐ **The state identified real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation**			
☒ **The state has no updates on general requirements to report for this reporting topic.**			
13.1.2 Post-Award Public Forum			
☐ **If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual report.**			
☒ **No post-award public forum was held during this reporting period and this is not an annual report, so the state has no post-award public forum update to report for this topic.**			
14.1 Notable State Achievements and/or Innovations			
14.1 Narrative Information			
☐ **Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD (or if broader demonstration, then SUD related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita**			

cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.			
☒ The state has no notable achievements or innovations to report for this reporting topic.			

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

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

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

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

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

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

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

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

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

2. Executive Summary

Having accumulated sufficient reporting periods, metric trends are now provided. Note, these measurement periods occur during the COVID-19 pandemic. The impact of COVID-19 on the receipt of services is unknown. Thus, any changes in trends should be interpreted with caution.

Among reported trends: Average lengths of stay in IMDs decreased from calendar year (CY)2020 to CY2021, use of MH services remains stable with telehealth services increasing dramatically since the first report month and corresponds to the start of the COVID 19 pandemic. Mental Health ED visits decreased by half since baseline, and outpatient services has trended down since the baseline. Inpatient services remained stable, however, intensive outpatient and partial hospitalization services trended downward.

While there was a net increase in the number of readmissions from CY2020 to CY2021, the overall rate of unplanned readmissions has decreased. There has been a net increase in individuals with medication continuation following discharge from inpatient psychiatric settings, however, the overall rate of medication continuation has decreased. Follow up after hospitalization for youth and adults showed decreases.

The state continues to invest in the mental health system as a whole and is committed to making improvements in HIT that will improve quality of care and outcomes.

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

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
1.2 Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings (Milestone 1)			
1.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1.	There has been a net increase in the number of children and adolescents on antipsychotics who receive first-line psychosocial care from CY2020 to CY2021. However, the overall rate of first-line psychosocial care has decreased. 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.	01/01/2020-12/31/2020	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)
☐ 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.	Metric information is not available at this time.		All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit

			From Integrated Physical and Behavioral Health Care (PMH-20)
	There has been a net increase in the number of readmissions from CY2020 to CY2021. However, the overall rate of unplanned readmissions has decreased. 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.	01/01/2020-12/31/2020	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)
	There has been a net increase in the number of individuals with medication continuation following inpatient psychiatric discharge from CY2020 to CY2021. However, the overall rate of medication continuation has decreased. 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.	01/01/2020-12/31/2020	Medication Continuation Following Inpatient Psychiatric Discharge
	The rate of follow-up after hospitalization for mental illness among ages 6-17 within 7 days decreased. However, the rate within 30 days saw a slight increase. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the	01/01/2020-12/31/2020	Follow-up After Hospitalization for Mental Illness:

	receipt of these services is unknown. Any changes in trends should be interpreted with caution.		Ages 6-17 (FUH-CH)
	The rate of follow-up after hospitalization for mental illness among ages 18 and older within 7 days and 30 days decreased from CY2020 to CY2021. 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.	01/01/2020-12/31/2020	Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)
	The rate of follow-up after emergency department visits for alcohol and other drug abuse within 7 days and 30 days decreased from CY2020 to CY2021. 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.	01/01/2020-12/31/2020	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA-AD)
	The rate of follow-up after emergency department visits for mental illness within 7 days and 30 days decreased from CY2020 to CY2021. 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.	01/01/2020-12/31/2020	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)
☐ 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 use of mental health inpatient services fluctuates slightly over time, but remains fairly stable. 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.	04/01/2021-06/01/2021	Mental Health Services Utilization - Inpatient
	The use of mental health intensive outpatient and partial hospitalization fluctuates over time, but has trended downwards since the baseline. 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.	04/01/2021-06/01/2021	Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization
	The use of mental health outpatient services fluctuates over time, but has trended downwards since the baseline. 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.	04/01/2021-06/01/2021	Mental Health Services Utilization - Outpatient
	The use of mental health emergency department visits has decreased by half since the baseline. 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.	04/01/2021-06/01/2021	Mental Health Services Utilization - ED
	The use of telehealth for mental health services has increase dramatically since the first report month and corresponds with the start of the COVID-19 pandemic. Use of telehealth remains high. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is	01/01/2020-12/31/2020	Mental Health Services Utilization - Telehealth

	unknown. Any changes in trends should be interpreted with caution.		
	The overall use of mental health services has remained fairly stable since the baseline. 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.	01/01/2020-12/31/2020	Mental Health Services Utilization - Any Services
	The average length of stay has decreased from CY2020 to CY2021. 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.	01/01/2020-12/31/2020	Average Length of Stay in IMDs
	The average length of stay has decreased from CY2020 to CY2021. 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.	01/01/2020-12/31/2020	Average Length of Stay in IMDs (IMDs receiving FFP only)
	The number of beneficiaries treated in the an IMD for mental health has remained stable since the baseline. 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.	01/01/2020-12/31/2020	Beneficiaries With SMI/SED Treated in an IMD for Mental Health
☐ 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 number of beneficiaries with an SMI/SED diagnosis remained stable from the baseline through Fall of 2021. The number appears to have decreased since then, however the decrease may be a result of a data issue. The state will investigate further to determine if this is a true decrease. 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.	04/01/2022-6/30/22	Count of Beneficiaries With SMI/SED (monthly)
	The number of beneficiaries with an SMI/SED diagnosis in the year has remained stable from baseline. 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.	01/01/2020-12/31/2020	Count of Beneficiaries With SMI/SED (annually)
	No baseline data is available for this metric at this time. The state is working to calculate the baseline period. 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.		Diabetes Care for Patients with Serious Mental Illness: Hemoglobi

			n A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)
	The rate of access to preventive/ambulatory health services for Medicaid beneficiaries with SMI has increased slightly from CY2020 to CY2021. 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.	01/01/2020-12/31/2021	Access to Preventive /Ambulatory Health Services for Medicaid Beneficiaries With SMI
	The rate of metabolic monitoring for children and adolescents on antipsychotics has increased from CY2020 to CY2021. 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.	01/01/2020-12/31/2020	Metabolic Monitoring for Children and Adolescents on Antipsychotics
	There was a net increase in the number of adult Medicaid beneficiaries who are newly prescribed an antipsychotic medication who received follow-up care. However, the overall rate decreased slightly from CY2020 to CY2021. 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.	01/01/2020-12/31/2020	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsych

			otic Medicatio n
☐ 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.	No metric information is available at this time.		Community Based Psychiatric Hospitals Using HIT for Discharge Summaries
☒ 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.	• HCA continued to coordinate with DOH to support development of the Technical and Operational Plan for the nationally required 988 crisis call system and enhanced Crisis Call Center Hub System and Behavioral Health Integrated Client Referral System required under state law (E2SBH 1477). The Crisis Call Center Hub System and Behavioral Health Integrated Client Referral System includes a focus on persons with SUD and MH needs. The technology systems and tools that are the being considered include tools to support crisis call, response, and dispatch; and behavioral health referral and follow-up. HCA, in partnership with DOH, produced the statutorily required Final Technical and Operational Plan for the National 988 System: Crisis Call Center and Behavioral Health Integrated Referral System. See the Final Plan here. • Tele-Behavioral Health: HCA continued to support the use of tele-behavioral health through its contract with the Behavioral Health Institute.		

	• Medicaid Managed Care Contract Language: HCA finalized Medicaid Managed Care contract language that will require, effective January 1, 2023, MCOs to: o Require that inpatient psychiatric hospitals and units that have access to and use interoperable HIT create and send admission/discharge/transfer notifications (ADTs) to providers, facilities, or practitioners on behalf of enrollees admitted to these facilities; and o Annually submit to the HCA an ADT Notification report that includes: o Information about the in-patient psychiatric hospitals/units creating and sending ADTs; and o Information about community based psychiatric hospitals/units that do not have access to interoperable HIT/EHR and the hospitals'/units' current or future plans to acquire interoperable HIT/EHR and date of proposed implementation.		
☐ 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.	No metric information is available at this time.		Total Costs Associated With Mental Health Services Among Beneficiaries With

			SMI/SED - Not Inpatient or Residential
	No metric information is available at this time.		Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential
	No metric information is available at this time.		Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential
	No metric information is available at this time.		Per Capita Costs Associated

			With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential
	The number of grievances related to services for SMI/SED fluctuates over time, with a considerable spike in late 2021/early 2022. 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.	07/01/2022 - 09/30/2022	Grievances Related to Services for SMI/SED
	The number of appeals related to services for SMI/SED fluctuates from quarter to quarter. 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.	07/01/2022 - 09/30/2022	Appeals Related to Services for SMI/SED
	The number of critical incidents related to services for SMI/SED fluctuates from quarter to quarter. 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.	04/01/2022 - 06/30/2022	Critical Incidents Related to Services for SMI/SED
	No metric information is available at this time.		Total Costs Associated With Treatment for Mental Health in

			an IMD Among Beneficiaries With SMI/SED
	No metric information is available at this time.		Per Capita Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED
	There has been a slight increase in the mental health treatment rate from CY2020 to CY2021. 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.		Mental Health Treatment Rate
	There has been an increase in the use of Foundational Community Supports for beneficiaries with inpatient or residential mental health services from CY2020 to CY2021. 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.		Foundational Community Supports for Beneficiaries with Inpatient or Residential Mental Health Services

☒ 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
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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."

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