



STATE OF WASHINGTON
— OFFICE OF GOVERNOR JAY INSLEE —

June 29, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure:

In 2014, hundreds of people from the public and private sectors were asked to share their ideas on how the health care system could produce better health and better care at a lower cost. The feedback I received helped form my plan for a healthier Washington, where residents can receive whole-person care – care for the mind and body.

One way we are working toward a healthier Washington is through our state's Section 1115 Medicaid demonstration waiver, called the Medicaid Transformation Project (MTP). Through MTP, our state is focusing on whole-person care through integrated care and coordination with community services, such as housing, employment, and more. Washington has also leveraged a broad, collaborative regional approach to building healthier communities through Accountable Communities of Health.

MTP was approved by your offices in January 2017. In 2018 and 2020, the Centers for Medicare & Medicaid Services also approved Washington state's amendments for substance use disorder and mental health treatment in certain types of inpatient facility settings.

Now, Washington seeks an MTP demonstration renewal. This five-year renewal will be known as "MTP 2.0," as Washington state continues to move forward as a national leader in health system transformation and innovation. We will build on the meaningful improvement of health and health care that Washington has achieved prior to and during MTP.

The Washington State Health Care Authority's work over the last decade – catalyzed by Medicaid expansion, Cascade Care (which includes public option plans), and other coverage gains – focuses on achieving whole-person care. Our state is moving from volume-based to value-based payment while forging and strengthening connections between the health care delivery system and community.

The Honorable Chiquita Brooks-LaSure

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Washington is proud of these accomplishments, and our work must continue to advance an equitable system that provides whole-person care and services, improves outcomes, and reduces inequities. The COVID-19 pandemic further highlighted long-standing systemic inequities in health outcomes, access to care, and access to health-related social needs.

I look forward to your favorable considerations of Washington state's request to renew our partnership through MTP 2.0. This demonstration renewal will include new strategies that address health equity and health-related social needs, as well as continuing the projects, activities, and services that are transforming Washington's health care system.

Please feel free to reach out to Molly Voris, Senior Policy Advisor in my office, at Molly.Voris@gov.wa.gov or (360) 764.0214, with any questions.

Very truly yours,

A handwritten signature in black ink, appearing to read "Jay Inslee". The signature is fluid and cursive, with a large initial "J" and "I".

Jay Inslee
Governor

cc: Daniel Tsai, Deputy Administrator and Director, CMS
Judith Cash, Director of the State Demonstrations Group, CMS
Diona Kristian, Project Officer, State Demonstrations Group, CMS
Edwin Walaszek, Washington State Lead, Medicaid and CHIP Operations Group, CMS
Jilma Meneses, Secretary, DSHS
Susan E. Birch, Director, HCA
Dr. Charissa Fotinos, Medicaid and Behavioral Health Medical Director, HCA



STATE OF WASHINGTON
HEALTH CARE AUTHORITY

626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

July 1, 2022

Daniel Tsai, Deputy Administrator and Director
Judith Cash, Director of the State Demonstrations Group
Center for Medicaid & CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Tsai and Ms. Cash:

The Washington State Health Care Authority (HCA) hereby submits this request for a renewal of the Section 1115 Medicaid demonstration waiver, called the Medicaid Transformation Project (MTP). We propose a five-year renewal of the agreement, which is set to expire on December 31, 2022. This renewal will be referred to as “MTP 2.0.”

With support from a State Innovation Model (SIM) test grant, Washington invested in infrastructure to establish regional accountable communities of health (ACH), advance multi-payer models, and improve population health. This foundational work preceded and supported the approval and implementation of MTP in 2017.

Over the past five years, MTP has focused on transforming the health care delivery system to improve outcomes and increase equitable access for Medicaid enrollees across the state. As highlighted in our renewal application, we have worked to address systematic delivery system challenges; strengthen clinical and community linkages to address social determinants of health; improve outcomes; and decrease projected per capita cost growth. We are encouraged by our preliminary evaluation results related to quality measures, value-based payment adoption, and the many projects and services being provided through MTP.

While all aspects of our work were disrupted by the COVID-19 pandemic, we have had incredible opportunities to respond to a variety of needs among communities and providers. We have been able to support community and provider capacity through:

- Relying on ACH and Indian health care providers to coordinate and respond to needs at the local level.
- Helping older adults stay at home and delay institutional services.
- Assisting vulnerable Medicaid clients obtain and maintain housing and employment.
- Increasing access to mental health and substance use treatment.

Daniel Tsai
Judith Cash
July 1, 2022
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All these services and supports have been critical during the pandemic - responding to community needs and reinforcing the social infrastructure during the public health emergency.

Through public release of the draft renewal application, we observed statewide support for continuing the Medicaid demonstration waiver. During the public comment period, we received over 200 supportive comments reinforcing the positive impacts of the initiatives to-date, along with the need for a renewed focus on health equity and health-related social needs. Additionally, tribal roundtables and tribal consultation, public hearings, and partner/stakeholder meetings generated thoughtful input and support. More detail on these activities and feedback are available in the application.

This historical federal-state partnership has achieved much for Medicaid beneficiaries by improving and expanding services across Washington State, and we have much more work to do together. This five-year demonstration renewal will allow us to continue critical services, implement new programs, and build on the experience gained in the first demonstration period with opportunities to expand and sustain proven programs.

We thank you for the opportunity to build on our accomplishments and look forward to continuing to work with the Centers for Medicare & Medicaid Services and the federal review team. We are eager and excited to continue to innovate and evaluate new and continuing strategies that will further our health transformation goals across Washington State.

Sincerely,



Charissa Fotinos, MD, MSc
Medicaid and Behavioral Health Medical Director

cc: Susan E. Birch, Director, HCA
Jilma Meneses, Secretary, DSHS
Mich'l Needham, Chief Policy Officer, PD, HCA
Eli Greenfield, Project Officer, State Demonstrations Group, CMS
Nikki Lemmon, State Monitoring Lead, Medicaid and CHIP Operations Group, CMS

Washington State Medicaid Transformation Project

Section 1115 Medicaid Demonstration Waiver Renewal Request

Washington State Health Care Authority
Washington State Department of Social and Health Services

Washington State
Health Care Authority



Washington State
Department of Social
& Health Services

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Introduction

Washington State's Medicaid program

In Washington State, Medicaid is called Apple Health. Washington's Medicaid program, which includes managed care and fee-for-service, is managed by the Washington State Health Care Authority (HCA). As of March 2022, there were a total of 2,180,737 people who were eligible for Apple Health.

Of these, about 85 percent of clients are enrolled in a managed care plan, with the remaining 15 percent in the fee-for-service program. Below are several demographic data points from the state's [Apple Health Client Eligibility Dashboard](#).

Figure 1: age group

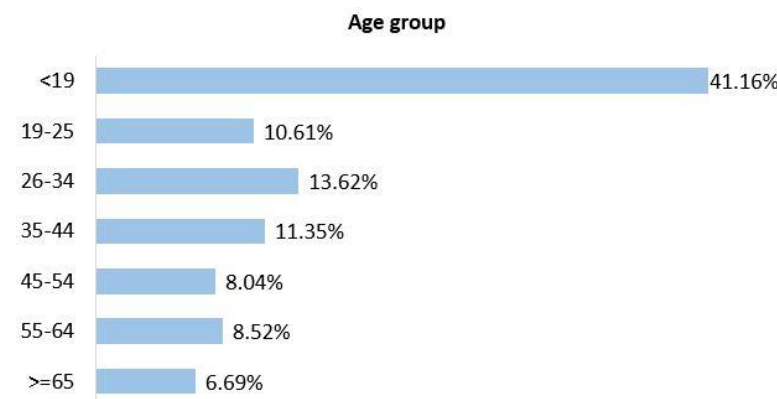
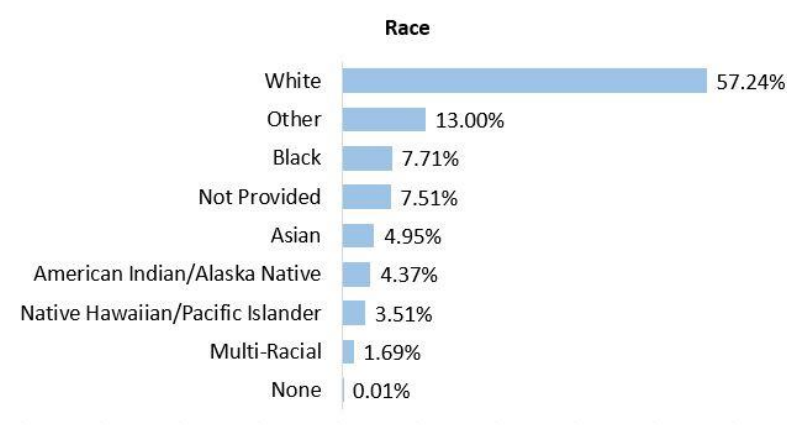


Figure 2: race



Renewal request

HCA is requesting a five-year renewal of Washington State's Section 1115 Medicaid demonstration waiver, which ends on December 31, 2022. (In December 2021, the Centers for Medicare & Medicaid Services (CMS) approved a one-year extension to Washington's current demonstration period, which ends December 31, 2022.)

HCA is requesting a continuation of several components of the original demonstration, along with new authorities. The purpose of the renewal is to continue advancing the state’s goal of improving health outcomes and reducing health disparities for people and families covered by Medicaid.

This five-year demonstration renewal will retain the same name—the Medicaid Transformation Project (MTP)—with the caveat of calling the renewal “MTP 2.0.” MTP. 2.0 will begin as demonstration year 7 (DY7).

Through MTP 2.0, Washington will continue to innovate as a national leader in health system transformation. The state will build on the meaningful improvement of health and health care achieved prior to and during MTP. HCA’s work over the last decade—catalyzed by Medicaid expansion and other coverage gains—has focused on achieving whole-person care; moving from volume-based payment to value-based payment; and forging and strengthening connections between the clinical delivery system and the community. Notable achievements include:

- **Community empowerment and collaboration:** the state formalized regional multi-sector collaboration and community empowerment by developing a robust system of Accountable Communities of Health (ACHs) that align with the state’s managed care purchasing regions. ACHs are unique public/private partnerships consisting of counties, providers, health plans, and community-based organizations (CBOs) to catalyze, facilitate, and support transformation activities. ACHs have helped facilitate Washington’s enormous strides toward linking community-based and clinical services for the 2 million people covered by Apple Health (Medicaid) and Apple Health for Kids—almost one in four people in the state.
- **Integrated managed care (IMC):** Washington successfully transitioned every purchasing region in the state to IMC by January 2020, bringing funding for behavioral health services within managed care and measurably improving outcomes related to substance use disorder (SUD) and medications for depression.¹ ACHs were instrumental in facilitating the coordination and convening necessary to reach this goal.
- **Paying for health and value:** Washington has advanced adoption of value-based purchasing (VBP) in Apple Health, while building provider capacity to enter VBP arrangements. Statewide VBP adoption targets set in the MTP demonstration were met during 2017-2019. As of 2020, the state achieved 82 percent VBP adoption within Medicaid, just below the 2020 target of 85 percent.
- **Addressing employment and housing:** over 23,000 individuals have received housing and/or employment support through the Foundational Community Supports (FCS) program, with promising reductions in outpatient emergency department (ED) and inpatient utilization for FCS enrollees.
- **Long-term services and supports (LTSS):** as of March 2022, Washington has served over 12,500 enrollees through the MTP Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) programs. These programs:
 - Expand care options for people, ages 55 and older, so they can stay at home and delay or avoid more intensive services, such as moving to a nursing facility.
 - Provide assistance to unpaid family caregivers, ages 18 or older, who provide care for their loved ones.

Washington is proud of these accomplishments, and more work is needed to truly achieve an equitable Medicaid program and health care system that provide holistic and person-centered care and services,

¹ Center for Health Systems Effectiveness. Rapid Cycle Report. June 2022.
<https://www.hca.wa.gov/assets/program/medicaid-transformation-evaluation-rapid-cycle-june-2022.pdf>

improves outcomes, and reduces inequities. COVID-19 highlighted long-standing systemic inequities in health outcomes, access to care, and access to health-related social supports. The continuing global pandemic has further exacerbated these inequities while straining the ability of individuals and families to have their needs met and achieve optimal health.

Washington experienced early and sustained pandemic effects, including the first documented case of COVID-19 in the United States, followed by a congregate setting outbreak and the first known COVID-19 death in the nation. The stay-at-home order and related economic impacts resulted in unemployment levels not seen since the Great Depression.² In addition to disease burden and economic hardship, Washington, like many states, has also experienced trends and realities of hardship, disparity, and worsening outcomes. These include:

- **Increased Medicaid enrollment:** Washington experienced a 17.1 percent increase in Medicaid enrollment between February 2020 and September 2021. This increase mirrors a national trend related to the Medicaid continuous coverage requirements under the Families First Coronavirus Relief Act (FFCRA)³ but also reflects the financial burden of pandemic-related economic contraction.⁴
- **Worsening outcomes in behavioral health:** according to census data, symptoms of anxiety and depression have increased by 20 percent for Washington adults, compared to pre-pandemic levels. Additionally, Washington has paralleled national trends in behavioral health-related ED visits for youth, which are up over 30 percent compared to pre-pandemic levels. Tragically, Washington drug overdoses in 2020 were measured at the highest single-year increase in 20 years, also mirroring national trends.⁵
- **Social needs went up:** in Washington, economic instability and uncertainty, as well as the impact of disease burden, exacerbated unmet social needs. For example, Washington residents experience a higher degree of food insecurity, increasing from about 10 percent pre-pandemic to 27 percent as of mid-2021.⁶
- **COVID-19 inequities were prevalent:** the pandemic has highlighted longstanding racial health inequities. In Washington, white people make up the largest share of the overall population but have one of the lowest COVID-19 case rates. Black people are twice as likely to contract COVID-19 as their white or Asian counterparts, and Native Hawaiian and Other Pacific Islander and Latino people are 3.5 times as likely. Further, these populations have worse COVID-19 outcomes, exacerbating already present inequities.⁷

² US Department of Labor Bureau of Labor Statistics. The Employment Situation. News Release, May 8, 2020.

https://www.bls.gov/news.release/archives/empsit_05082020.pdf

³ Families First Coronavirus Response Act. H.R.6201, 116th Congress (2020).

<https://www.congress.gov/116/plaws/publ127/PLAW-116publ127.pdf>

⁴ Kaiser Family Foundation. Analysis of recent trends in Medicaid and CHIP enrollment. March 3, 2022.

<https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment>

⁵ Mental Health Technology Transfer Center Network. Behavioral Health Impacts During & After COVID-19. April 2021.

<https://mhttcnetwork.org/sites/default/files/2021-04/Behavioral%20Health%20Impacts%20During%20and%20After%20COVID-19%20Return%20to%20School%20Document%20%2817%29%20%281%29.pdf>

⁶ UW News. Food insecurity remains high and need for assistance dramatically up in Washington. July 30, 2021.

<https://www.washington.edu/news/2021/07/30/food-insecurity-remains-high-and-need-for-assistance-dramatically-up-in-washington>

⁷ COVID-19 Morbidity and Mortality by Race, Ethnicity and Spoken Language in Washington State. Washington State Department of Health; 2021:28.

While the pandemic has brought issues to the forefront that cannot be ignored, Washington’s work to transform the health system transcends COVID-19. Building on the foundation and infrastructure of MTP, the work authorized through this renewal—which includes broadening the availability of health-related services (HRS)—will enable Washington to better meet the physical health, behavioral health, oral health, LTSS, and health-related social needs (HRSN) of all Apple Health enrollees.

Through this renewal demonstration, HCA will continue to advance whole-person care at every life stage, with a clear focus on improving health and reducing health disparities and inequities. The vision for MTP 2.0 includes refreshed aims and goals to guide the evolution of current MTP initiatives. MTP 2.0 aims are to:

- **Ensure equitable access to whole-person care, empowering people to achieve their optimal health and wellbeing in the setting of their choice.**
- **Build healthier, equitable communities, with communities.**
- **Pay for integrated health and equitable, value-based care.**

MTP 2.0 goals are:

- **Expanding coverage and access to care, ensuring that people can get the care they need.**
- **Advancing whole-person primary, preventive, and home- and community-based care.**
- **Accelerating care delivery and payment innovation focused on HRSN.**

Following is the package of programs, authorities, and activities necessary to achieve each of these goals.

Table 1: overview of MTP 2.0 proposals

Primary goal	Policy/program name	Status within this renewal request
Goal 1: expanding coverage and access to care, ensuring that people can get the care they need	1.1 Continuous Apple Health enrollment for children	New
	1.2 Re-entry coverage for continuity of care	New
	1.3 Apple Health postpartum coverage expansion	New
	1.4 SUD and mental health IMD: supports for people receiving SUD and mental health treatment (formerly MTP Initiatives 4 and 5)	Continuing
Goal 2: advancing whole-person primary, preventive, and home- and community-based care	2.1 MAC and TSOA programs (formerly MTP Initiative 2)	Continuing
	2.2 Program innovations for LTSS <ul style="list-style-type: none"> • Rental subsidies • Coordinated personal care • Guardianship and decision-making supports • Presumptive eligibility 	New

	2.3 Washington Integrated Care Assessment (WA-ICA)	New
Goal 3: accelerating care delivery and payment innovation focused on HRSN	3.1 Taking Action for Healthier Communities (TAHC) program (formerly MTP Initiative 1): <ul style="list-style-type: none"> • Community-based care coordination hub (“Community Hubs”) • HRS • Health equity programs • Community-based workforce 	Evolving
	3.2 FCS (formerly MTP Initiative 3)	Continuing

Definitions

Health equity

Washington is using the Robert Wood Johnson Foundation definition of health equity: “Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”⁸

Health inequities

Conversely, health inequities refer to systemwide differences in how people can achieve health and wellbeing, based on shared identity or circumstance. For example, inequities are noted in racial groups, the LGBTQ+ community, immigrant families, people with a physical or behavioral disability, people who experience lower socioeconomic status, and others.⁹ This leads to avoidable gaps in health outcomes and health and wellbeing advantages compared to other groups.

Social determinants of health (SDOH)

These are the conditions under which people are born, grow, live, work, and age.¹⁰ SDOH are a general concept used to talk about the factors that influence health and health outcomes, but are not located in or directly influenced by the health care delivery system.¹¹ Common SDOH categories are health care access and quality; education access and quality; social and community context; economic stability; and neighborhood and built environment.¹²

⁸ Braveman, Orleans, and Plough. What is Health Equity? Robert Wood Johnson Foundation. May 1, 2017. <https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html>

⁹ Communities in Action: pathways to health equity. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. Washington (DC): National Academies Press (US); 2017 Jan 11.

¹⁰ Commission on Social Determinants of Health, 2008. <https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1>

¹¹ Bharmal et. Al. Understanding the upstream social determinants of health. https://www.rand.org/content/dam/rand/pubs/working_papers/WR1000/WR1096/RAND_WR1096.pdf

¹² Centers for Disease Control and Prevention. About Social Determinants of Health (SDOH). <https://www.cdc.gov/socialdeterminants/about.html>

Health-related social needs (HRSN)

In line with the Centers for Medicare & Medicaid Services' (CMS') ACH model, CMS chose HRSN to describe the conditions people experience outside of the health care system that are harmful to their health. These include food insecurity and housing instability. HRSN are the cause of higher utilization and spending in health care, while also being a large contributor to adverse health outcomes.¹³

Health-related services (HRS)

Washington is defining HRS as a broad range of nonclinical services that address HRSN. These services can be authorized, delivered, and paid for through multiple authorities, depending on the service and allowability.

In-lieu of services (ILOS)

These are services authorized under managed care authority as substitutes to services or settings covered under the Medicaid state plan (Apple Health). ILOS may be immediate substitutes to a covered service, or in some cases, to prevent the need for a covered service. ILOS must be:

- Optional for Medicaid health plans to offer and for enrollees to receive.
- Cost-effective and medically necessary.
- Incorporated into managed care rates and contracts.¹⁴

Many ILOS also meet the state's definition of HRS (see above).

Section 1: vision and goals for renewal

Washington has long been recognized as a national leader in innovative health policy. HCA applied for the current MTP demonstration and obtained approval in 2017, with the goal of fundamentally transforming the health care delivery system. Washington set a course to monumentally shift from a system that was fragmented and inefficient to one that is fully integrated, community driven, and focused on providing high-quality, cost-effective, well-coordinated and whole-person care for people.

Washington initiated significant transformation activities since 2017. The MTP demonstration—which set ambitious goals, particularly around integrating physical and behavioral health, improving whole-person care, significantly advancing VBP programs, and creating linkages between clinical and community-based services—has catalyzed health care delivery improvements across Washington's Medicaid program, called Apple Health.

Through diligent work across the state during the MTP demonstration, HCA has moved Washington's health care delivery system closer to this vision, but more work remains to be done. In MTP 2.0, Washington aims to continue and deepen the impact of the current demonstration and center its focus on advancing health equity.

Governor Jay Inslee has directed a statewide commitment to a pro-equity, anti-racist agenda and for all state agencies to be accountable for the effectiveness of services and programs—and with input from impacted communities—achieve equitable access to opportunities and resources that reduce disparities

¹³ JSI Viewpoint. Managing Health Related Social Needs: The prevention imperative in an Accountable health system. January 10, 2017. <https://www.jsi.com/managing-health-related-social-needs-the-prevention-imperative-in-an-accountable-health-system/>

¹⁴ 42 C.F.R. § 438.3(e)(2)

and improve equitable outcomes statewide.¹⁵ MTP 2.0 is a core vehicle for HCA to realize this commitment.

By continuing successful strategies, learning from our experiences, listening to communities and partners on the ground, adapting to new realities, and moving into the future, HCA will continue to move the state toward a transformed Medicaid system with MTP 2.0.

Table 2: vision for system change

Previous system	Current system	MTP 2.0
Fragmented clinical and financial approaches to care delivery	Financially and administratively integrated systems.	Integrated systems that deliver whole-person care.
Disjointed care and transitions	Care is coordinated for some populations. Capacity has been built for improving care transitions in some areas.	Coordinated care and transitions for all across health care, home, and social service settings.
Disengaged enrollees	Many enrollees, particularly during COVID-19, have not been connected to needed care.	Activated enrollees who are connected to the care they need and empowered to take a greater role in their health.
Capacity limits for critical services (e.g., behavioral health) and in geographic areas (e.g., rural communities)	Improved network capacity in most service areas. Limited capacity is still a challenge primarily in rural communities tied to general workforce challenges.	Optimal access to appropriate services throughout the state.
Individuals impoverish themselves to access LTSS, and caregiver burnout leads to out-of-home placement	Some enrollees and settings have access to needed pre-Medicaid supports implemented for LTSS enrollees and their caregivers through MTP 2.0.	Timely supports accessible statewide that delay or divert need for LTSS.
Inconsistent measurement of delivery system performance	Improved measurement and accountability systems for clinical outcomes.	Standardized performance measurement with accountability for improved outcomes, including HRSN, and for decreases in disparities.
Fee-for-service payment	Significant progress in VBP adoption, though opportunities remain for more adoption of VBP and higher-level (e.g., total cost of care) arrangements.	VBP that rewards quality of care and improved outcomes.
Health disparities based on inequities and unmet needs	COVID-19 has built momentum to address disparities, and HCA built initial capacity to track and address disparities.	All people have a fair and just opportunity to be as healthy as possible.

¹⁵ [Executive Order 22-04](#)

Previous system	Current system	MTP 2.0
Exclusive focus on clinical care	Continued momentum toward upstream interventions and strategies that address HRSN.	HRSN and community-based care coordination are valued, promoted, integrated with the clinical care delivery system, and appropriately resourced.

Aims and goals

MTP 2.0 has three primary aims:

- Ensure equitable access to whole-person care, empowering people to achieve their optimal health and wellbeing in the setting of their choice.**

Building upon the foundation of the current MTP demonstration, Washington will continue working toward fully integrated health systems. Through MTP, Washington will also advance opportunities for people to receive care in their preferred setting, including in their homes and communities, with priority focus on transitions from institutional and carceral (justice-involved) settings.
- Build healthier, equitable communities, with communities.**

All health is local, and innovations within communities and in partnerships with communities are vital. This aim reflects HCA’s commitment to taking a community-driven approach to health. Working with consumers, providers, health plans, ACHs, CBOs, Tribes, Indian health care providers (IHCPs) and other partners, and state and local health agencies will advance equity and healthy opportunities for all.
- Pay for integrated health and equitable, value-based care.**

HCA’s mission statement is to “provide high-quality health care through innovative health policies and purchasing strategies.” Beyond paying for care, HCA will continue to leverage our purchasing power to shape the health system for the benefit of the nearly 2 million enrollees in Apple Health across all life stages, building new foundations to improve the health of future generations.

Washington will accomplish the above aims, advancing health equity throughout the stages of life, by:

- Goal 1: expanding coverage and access to care, ensuring that people can get the care they need.**

As noted by CMS, Medicaid coverage in and of itself is critical to health equity, a central focus of MTP 2.0.¹⁶ MTP 2.0 will increase access to care through strategic expansion of Medicaid coverage across life stages (infants and children, postpartum parents) and for high-risk and historically marginalized populations, such as people with behavioral health issues, disabilities, and those involved in the criminal justice system.
- Goal 2: advancing whole-person primary, preventive, and home- and community-based care.**

Decades of evidence show that access to primary and preventive care are the cornerstones of population health. MTP 2.0 will support physical and behavioral health providers and expand crucial services beyond the clinical setting into communities. These services will be implemented through innovative policy and improved payment arrangements.
- Goal 3: accelerating care delivery and payment innovation focused on HRSN.**

¹⁶ A Strategic Vision for Medicaid and The Children’s Health Insurance Program (CHIP).
<https://www.healthaffairs.org/doi/10.1377/forefront.20211115.537685/full/>

HRSN like nutrition, housing, transportation, education, and social supports deeply affect the health of Medicaid enrollees. Building on our commitment to create a health system that treats individuals as whole people, MTP 2.0 will leverage community-driven delivery and payment models to advance programs and policies that meet and measure these HRSN.

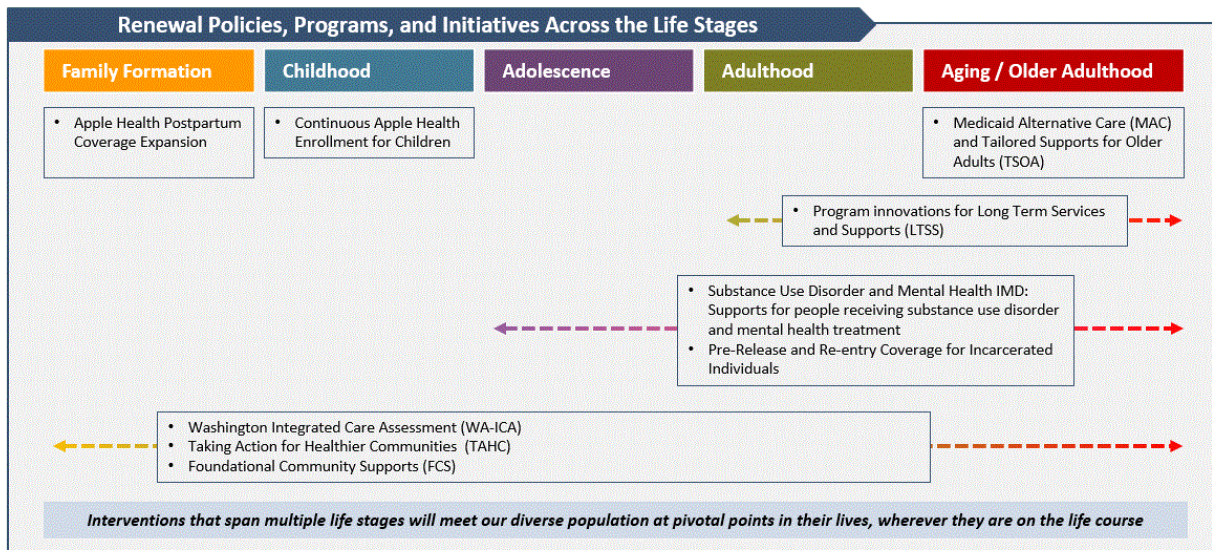
Life-stage approach

Washington seeks to embed a life-stage philosophy into its MTP 2.0 vision, which recognizes: (1) different ages and stages of life, (2) health promotion and prevention, disease condition management, and palliative care, (3) intergenerational influences on health, and (4) HRSN. These different ages and stages of life for Washington are:

- Family formation
- Childhood
- Adolescence
- Adulthood
- Aging/older adulthood

This life-stage approach allows MTP 2.0 to meet Washington’s diverse population at pivotal points in their lives. In particular, HCA seeks to bring special focus to reducing disparities and addressing inequities across the life stages of groups who have been economically or socially marginalized.

Figure 3: MTP 2.0 renewal policies, programs, and initiatives across the life stages



Section 2: historical summary of MTP

State transformation history

Washington has been a progressive leader in health system transformation for decades. This includes the early expansion of Medicaid access for pregnant individuals and young children in the 1990s and implementation of a managed care system to purchase care for most Medicaid enrollees.

When the Affordable Care Act (ACA) passed, HCA took advantage of the opportunity. HCA worked to provide better access to care and services for those in need by expanding Medicaid and converting the state Basic Health Program into Medicaid coverage. HCA also developed the robust, state-based Washington Health Benefit Exchange.

ACA coverage expansions helped close Washington's uninsured gap by over 10 percent, resulting in an uninsured rate of 6.4 percent in 2015¹⁷ and half that rate for children, at 2.9 percent.¹⁸ The state built on these coverage gains, turning the focus to key efforts to improve quality, cost, and outcomes through several large-scale initiatives and strategies, which are summarized below.

State Innovation Model (SIM) planning and test grants

In 2012, HCA received a SIM planning grant from the Center for Medicare & Medicaid Innovation (CMMI), referred to as SIM round 1. With these resources, HCA undertook a statewide process to gather input from a broad array of partners, including Tribes, other Washington State agencies, providers, health plans, and consumers to develop a statewide plan for health system transformation.

This effort produced the State Health Care Innovation Plan¹⁹ (SHCIP) which provided a foundation for upcoming transformation strategies, including MTP. Based on the groundwork laid by SHCIP and SIM round 1, in 2014 HCA was awarded a \$65 million SIM testing grant from CMMI, called SIM round 2.

SIM 1 and SIM 2 launched "Healthier Washington," a broad and transformative initiative designed with three goals: (1) improving population health outcomes, (2) improving quality of care, especially for persons with physical and behavioral health comorbidities, and (3) reducing the rate of per capita health care costs. SIM round 2 initiatives included several interrelated strategies:

- Creating regional ACHs to promote community empowerment and collaboration.
- Developing and implementing VBP models.
- Integrating physical and behavioral health into managed care.
- Creating population health strategies.
- Supporting workforce development.
- Building statewide analytic and research capacity, including measuring health outcomes.
- Supporting providers through practice transformation to better prepare for VBP and integrated care arrangements.

IMC and VBP

As a result of state legislation, Washington moved to integrate three separate systems of health care purchasing beginning in 2016 and ending in 2020. Physical health, mental health, and SUD treatment were integrated into the Medicaid managed care system. In this integrated system, Medicaid managed care organizations (MCOs) are accountable for physical and behavioral health care services, while behavioral health administrative service organizations manage the statewide crisis system and other essential services that are also available to all state residents.

The purpose of IMC was to advance more integrated, coordinated care for individuals experiencing co-occurring physical and behavioral health conditions. MCOs, ACHs, and counties worked hand-in-hand to support regional transitions to IMC, including extensive provider engagement and technical assistance

¹⁷ Witters, Dan. "In U.S., Uninsured Rates Continue to Drop in Most States." Gallup. 10 August 2015.

<http://www.gallup.com/poll/184514/uninsured-rates-continue-drop-states.aspx>

¹⁸ CCF Georgetown. "Children's health coverage in Washington." Children's health care report card. 2022.

<https://kidshealthcarereport.ccf.georgetown.edu/states/washington>

¹⁹ https://www.hca.wa.gov/assets/program/SHCIP_InnovationPlan.pdf

surrounding contracting and billing. These were essential supports for behavioral health providers who had no history of billing as they transitioned from a county-based grant financing system.

With IMC being integrated as of January 2020, MCOs are continuing to solidify networks, enhance provider contracts to expand value-based arrangements to reinforce whole-person care, and assist provider practices to support whole-person care.

Along with IMC, Washington State made significant progress implementing VBP contracts between 2017 and 2019. Annual surveys conducted by HCA show significant strides in widespread participation in new VBP arrangements: 82 percent of MCO payments to Medicaid providers in 2020 were made through arrangements that included shared savings and shared risk, compared with 59 percent of commercial payments and 80 percent of Medicare Advantage payments.²⁰

Creation of ACHs

Through SIM round 1, the need for neutral, multi-sector, and local collaboration emerged as a critical component of ongoing health system transformation. One of HCA's main goals was to support community transformation through a collaborative, regional approach. The initial ACH concept design centered on the recognition that health is more than health care—and health is local—requiring local insight and collaboration. With the support of foundational legislation, ACHs began convening in 2015 as regional coalitions, supported by funding from SIM round 2.

Washington applied learnings from the SIM grants and other health system experiences. The state reviewed Section 1115 demonstration strategies from other leading states like New York and designed the Delivery System Reform Incentive Payment (DSRIP) program. The initial MTP demonstration proposal included a commitment to designate ACHs as the lead organizations to carry out key demonstration goals. To support readiness, HCA established a set of standards each ACH had to meet, including legal status, governance structures, and administrative capacity.

LTSS

Washington State has worked hard over the years to create a rebalanced system where individuals have a community care entitlement for LTSS. This state LTSS system, managed by the Aging and Long-Term Support Administration (AL TSA), within the Washington State Department of Social and Health Services (DSHS), has earned the ranking of first in the nation by the American Association of Retired Persons (AARP).²¹

AARP noted Washington's high performance in supporting seniors, adults with disabilities, and their family caregivers. To build on the current system and create a transformed system for long-term care focused on better outcomes and more freedom of choice for individuals, the state worked to create new long-term care benefits that were included in the first iteration of MTP.

MTP 2017-2022

Leveraging much of the momentum from the SIM work, as well as state initiatives related to LTSS for vulnerable adults, HCA, in partnership with DSHS, proposed a five-year demonstration request to CMS. On January 9, 2017, CMS approved this request, resulting in Section 1115 Medicaid demonstration

²⁰ Paying for Value Survey Results, February 15, 2022.

<https://www.hca.wa.gov/assets/program/2021-p4v-survey-results-webinar.pdf>

²¹Sackett, Victoria. States Moving in the Right Direction on Long Term Care Services. June 14, 2017.

<https://www.aarp.org/caregiving/health/info-2017/states-long-term-care-scorecard-fd.html>

waiver No. 11-W-00304/0, “Medicaid Transformation Project (MTP).” The goals of the first five years of MTP included:

- Improving the health care delivery system’s capacity to address local health priorities.
- Delivering high-quality, cost-effective, and whole-person care.
- Creating a sustainable link between clinical and community-based services.

Over the five-year MTP period ending in December 2021 (which was extended an additional year to December 2022), Washington State committed to:

- Integrating physical and behavioral health purchasing and services to provide whole-person care.
- Converting 90 percent of Medicaid provider payments to reward outcomes instead of volume of service.
- Supporting providers as they adopt new payment and care models.
- Improving health equity by implementing population health strategies.
- Providing targeted services to support the state’s aging populations and their family caregivers and address SDOH.
- Helping Washington’s most vulnerable population get and keep stable housing and employment.
- Improving SUD treatment access and outcomes.
- Improving the quality of care in institutions for mental diseases (IMDs) and ensuring one’s timely and successful return to the community.

The state planned to accomplish these goals through the following programs:

Initiative 1: transformation through ACHs and IHCPs

This initiative is also referred to as the DSRIP program. Through the first iteration of MTP, DSRIP enabled communities to improve the health system at the local level, implemented through ACHs and IHCPs.

ACHs

In the first year of MTP, ACHs became independent, legal entities and continued developing core capacity to manage the breadth of the DSRIP program. This included community engagement and establishing provider supports for behavioral health integration.

ACHs are now independent, regional organizations whose boundaries match the Medicaid managed care purchasing regions in Washington. Their goal is to provide several community-oriented functions to the state’s health and wellness system. These functions include:



Figure 4: map of ACH regions

- Neutral convening
- Providing traditional and nontraditional provider supports
- Sharing health equity resources
- Providing technical assistance
- Advocacy
- Local collaboration

ACHs implemented a portfolio of transformation projects in several categories, both within and outside of the health care delivery system, specific to the needs and partnership opportunities within its region. These projects focused on:

- **Health systems and community capacity-building** by supporting a VBP system, developing the health care workforce, and making improvements in population health management. This included developing enhanced data collection, analytic capacity, and community information exchange (CIE) infrastructure.
- **Care delivery redesign** by integrating physical and behavioral health care, improving care coordination, making better transitions between services and settings, and helping people access the most appropriate service or facility for their needs.
- **Prevention and health promotion** by focusing on opioid use, maternal and child health, access to oral health services, and chronic disease prevention and management.

Through this implementation, it became clear that ACHs' community focus and local insights ideally positioned them to focus on health equity and SDOH, while also supporting health care delivery system improvements.

IHCPs

The other portion of Initiative 1 are IHCP-specific projects. To maintain a government-to-government relationship with Tribal Nations, MTP funds were administered directly by HCA to IHCPs, with assistance from the American Indian Health Commission of Washington State, designated as the Tribal Coordinating Entity.

As part of MTP, IHCP-specific projects align with the broader goals of the MTP. Additionally, IHCP projects:

- Integrate traditional and culturally appropriate practices to better meet American Indian /Alaska Native (AI/AN) whole-person needs.
- Prioritize IHCP administrative capacity and technological interoperability to enable IHCPs to become purchasers of outpatient services.
- Support systems transformation designed and led by those experiencing the worst inequities.

Initiative 2: MAC and TSOA

Initiative 2 expands options for people receiving LTSS so they can stay at home and delay or avoid the need for more intensive services. These programs also support family members in caring for their loved ones while increasing the wellbeing of caregivers. This initiative has two components:

- **MAC:** benefit package for individuals who are eligible for Medicaid but not currently accessing Medicaid-funded LTSS. This benefit package provides services to unpaid caregivers, designed to assist caregivers in getting the supports necessary to continue to provide high-quality care and focus on their own health and wellbeing.

- **TSOA:** new eligibility category and benefit package for individuals “at risk” of future Medicaid LTSS use who currently do not meet Medicaid financial eligibility criteria. TSOA is designed to help individuals avoid or delay impoverishment and the need for Medicaid-funded services. The TSOA benefit package provides services and supports to unpaid family caregivers as well as services and supports to individuals without unpaid caregivers.

MAC and TSOA includes the following benefits:

- **Caregiver assistance services:** services that take the place of those typically performed by an unpaid caregiver.
- **Training and education:** assist caregivers with gaining skills and knowledge to care for the recipient.
- **Specialized medical equipment and supplies:** goods and supplies needed by the care receiver.
- **Health maintenance and therapies:** clinical or therapeutic services for caregivers to remain in their role or care receiver to remain at home.
- **Personal assistance services:** supports involves the labor of another person to help the recipient (TSOA individuals only).

Initiative 3: FCS

Community providers play a key role in addressing HRSN of housing and employment. However, assistance to vulnerable groups for housing and employment are historically under-resourced and Washington is now finding ways to provide access to those most in need. By leveraging Medicaid to organize, provide resources, and support providers in delivering these important services, Medicaid enrollees who face the most barriers to safe and stable employment and housing can have a better chance of being connected to the services they need and improving their quality of life and health outcomes in the process.

FCS provides a new set of services: Community Support Services (CSS, also called **supportive housing**) and Supported Employment Services (also called Individual Placement and Support Services or **supported employment**). These benefits serve people throughout the state—people who are often highly vulnerable and have complex care needs. (For example, individuals with a behavioral health diagnosis who are experiencing homelessness.)

FCS is a partnership between HCA and AL TSA. Amerigroup is the contracted third-party administrator. Amerigroup works with a variety of agencies that provide supportive housing and supported employment services, based on evidence-based practices to help people find and keep housing and jobs.

Supportive housing and supported employment service providers and agencies work with employers and property owners to match individuals with the right environment, while providing ongoing support. These services do not pay for housing, wages, or wage enhancements.

Initiative 4: SUD IMD

In July 2018, CMS approved the first amendment to MTP. The amendment allowed the state to improve SUD services and receive federal financial participation (FFP) for Medicaid SUD treatment services in facilities that are designated as IMDs. It relaxed restrictions on the use of federal funds to pay for people receiving SUD treatment in a mental health or SUD facility, for an average of 30 days. The SUD amendment has the following goals:

- Increase rates of identification, initiation, and engagement in treatment for opioid use disorder (OUD) and other SUDs.

- Increase adherence to and retention in treatment for OUD and other SUD.
- Reduction in overdose deaths, particularly those due to opioids.
- Reduce utilization of ED and inpatient hospital settings for OUD and other SUD treatment through improved access to other continuum of care services.
- Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.
- Improve access to care for physical health conditions among enrollees with OUD or other SUDs.

Implementation of this program is ongoing, with development of the required quality metrics and milestones. As identified by CMS, the six milestones used to guide Washington’s SUD IMD initiative are:

- Access to critical levels of care for OUD and other SUD.
- Widespread use of evidence-based, SUD-specific patient placement criteria.
- Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications.
- Sufficient provider capacity at each level of care, including medications for opioid use disorder (MOUD).
- Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD.
- Improved care coordination and transitions between levels of care.

Initiative 5: mental health (MH) IMD

In November 2020, CMS approved a second amendment to MTP. Similar to the SUD IMD amendment, the MH IMD amendment allows the state to improve mental health services and receive federal financial participation (FFP) for Medicaid mental health treatment services in facilities that are designated as IMDs.

This program has overarching goals and required implementation milestones like the SUD IMD initiative. As identified by CMS, the five goals of Washington’s MH IMD initiative are:

- Reducing utilization and length of stay in EDs among enrollees with serious mental illness (SMI) or serious emotional disturbance (SED) while awaiting mental health treatment in specialized settings.
- Reducing preventable readmissions to acute care hospitals and residential settings.
- Improving availability of crisis stabilization services, including call centers and mobile crisis units, intensive outpatient services, as well as acute short-term stays in residential stabilization programs, psychiatric hospitals, and residential treatment settings.
- Addressing chronic mental health care needs for enrollees with SMI/SED by improving access to community-based service through increased integration of primary and behavioral health care.
- Improving care coordination and continuity of care following episodes of acute care in hospitals and residential treatment facilities.

Implementation of this program is ongoing, with development of the required quality metrics and milestones. As identified by CMS, the milestones used to guide Washington’s MH IMD initiative are:

- Ensuring quality of care in psychiatric hospitals and residential settings.
- Improving care coordination and transitions to community-based care.
- Increasing access to continuum of care including crisis stabilization services.
- Earlier identification and engagement in treatment including through increased integration.

MTP extension year (DY6)

In early 2020, Washington State experienced the first case of COVID-19 confirmed by the Centers for Disease Control and Prevention and the first known death from COVID-19 in the United States. Despite the unprecedented challenges facing the health care system, HCA and partner organizations successfully pivoted to respond to the pandemic in critical ways. These response efforts began in March 2020 and used new and existing infrastructure to support providers, health systems, and communities as they navigated unanticipated needs and issues.

Recognizing the pandemic’s significant disruptions to MTP implementation, administration, service provision, and sustainability planning—in early 2021—HCA sought a one-year extension of authorities from CMS to continue existing MTP waiver activities through 2022. Approved in December 2021, this extended all MTP initiatives and activities through a sixth demonstration year by applying the existing, unused program spending authority from the first five years of MTP.

The aims, goals, and programs stated above remained consistent during the extension year. The extension year also provided additional time to research and determine a path for MTP evolution, engagement with Tribes, other state agencies, providers, plans, community organizations, and other key partners, and seek authorization from the Washington State Legislature.

Successes and lessons learned through MTP

As demonstration year six of MTP concludes, it is clear that Washington has made transformational accomplishments and learned meaningful lessons about what worked well and what could be improved. While significant progress has been made across MTP goals, ongoing investment, transformation, and evolution of strategies is still needed to achieve a truly transformed system with improved health outcomes. The following sections and figure 5 highlight some of the identified successes and lessons learned.

Figure 5: MTP successes and lessons learned



Successes

An operational, statewide system of ACHs have a meaningful role in community health transformation and robust partner networks.

MTP provided a vehicle for ACHs to establish themselves, both regionally and statewide, as a critical component of the health and social services system. Through MTP project implementation, ACHs set up contractual relationships with and coordinated across a diverse set of partnering providers and communities, including social service agencies; primary care providers; behavioral health organizations; hospital systems; health plans; CBOs; justice-involved organizations; emergency medical services; philanthropic organizations; AI/AN health organizations; and other traditional and nontraditional providers.

Projects were implemented in a variety of areas and with a broad set of participants, and most ACHs chose to take a “portfolio approach” to project implementation to avoid creating silos between regional projects.

ACHs also played a vital role in IMC implementation regionally, with ACHs working directly with MCOs and providers to make meaningful progress toward integration and make sure no enrollees or providers were falling through the cracks. ACHs have continued supporting integration work with initial testing of the WA-ICA tool, which will assess practices along the integration continuum and provide resources to help them reach integration goals.

ACHs have had time to mature and are now working together as an organized, statewide system, while also functioning independently at the regional level. During the height of the COVID-19 pandemic, ACHs played a critical role in meeting community needs for individuals and organizations.

Their community-based care coordination infrastructure provided a foundation for the Department of Health’s (DOH’s) Care Connect Washington program. Through this program, several ACHs served as “community hubs” and supported individuals who tested positive for COVID-19 and were required to isolate and quarantine. These ACHs worked to contract with care coordination agencies to distribute food and care kits, grocery vouchers, and other resources on behalf of Care Connect Washington’s isolation and quarantine goals.

Additionally, ACHs have maintained sharp focus on health equity and SDOH and are uniquely positioned as regional facilitators and collaboration enablers for the health system as a whole. MTP has helped the state see the important role neutral regional entities can provide by coordinating across sectors and across communities.

Projects designed for and by AI/AN individuals

Many IHCP projects involved changes to the Indian health care system to support better health and wellness. These projects supported the priorities of Tribes by:

- Providing flexible funding to target unique challenges to health and wellness of AI/AN individuals, including integration strategies aimed at transforming health systems and systems that support health. These include justice, behavioral health support, food, housing, and education.
- Addressing the current struggle between utilizing the federally provided electronic health record (EHR)—called the Resource and Patient Management Survey (RPMS)—or purchasing a new EHR. RPMS is a legacy system with the underlying code base being unsupported in the coming decade. Purchasing a new EHR is costly and viewed by some as an abdication of the federal trust responsibility.

- Contributing to the infrastructure for the development and certification of culturally specific providers with the Community Health Aide Program (CHAP), which includes providers like Community Health Aides (CHAs), Behavioral Health Aides (BHAs), and Dental Health Aide Therapists (DHATs).

On April 30, 2021, the Northwest Portland Area Indian Health Board (NPAIHB) and the American Indian Health Commission of Washington State (AIHC) submitted a joint letter to CMS, indicating their support for the MTP demonstration extension and amendment requests Washington State submitted on January 15, 2021.

“The goals of the MTP projects included integrating traditional and culturally relevant practices to better meet AI/AN whole person needs and IHCPs designing and supporting healthcare system transformations to reduce health inequities experienced by AI/AN people. Through the MTP projects, IHCPs have enhanced the Indian Health Delivery System by improving patient experience, population health, and lower health care costs... Many IHCPs reported to the NPAIHB, the Commission, and the HCA that they were better prepared to respond to the pandemic because of this work... Continued direct funding through the extension will allow IHCPs to fully complete this invaluable and groundbreaking work and build the needed infrastructure within IHCP programs.”

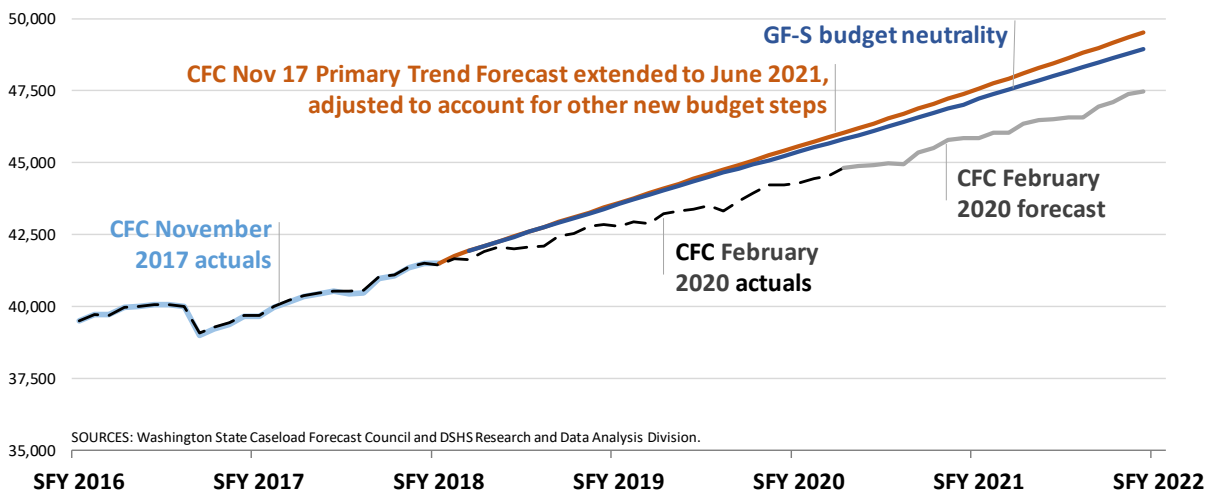
The IHCP-specific Projects were a success because of the ability of AI/AN individuals to design projects for AI/ANs. The knowledge that exists within the community on the challenges facing Indian Country and concurrent solutions, can never be replicated within a federal or state agency. Putting decision-making power purposefully in the hands of IHCPs has been foundational to the success of the IHCP-specific Projects.

[Steady rise in MAC and TSOA program enrollment and slower growth in intensive in-home personal care services](#)

As of June 2019, the MAC and TSOA programs served a total of 4,300 enrollees. A year later, the total number of enrollees served was 7,595. Even with COVID-19 impacting other parts of the LTSS system, the MAC and TSOA programs continued to see a steady rise in enrollees. Enrollees have taken advantage of these services that allow for the most appropriate care and family supports, while avoiding the need for more intensive services.

When the MAC and TSOA programs were implemented in 2017, the Washington State Legislature assumed the programs would produce offsetting savings in Home and Community Based Services (HCBS) services. Although MAC and TSOA program savings have since been rolled into the “primary trend” forecasts of the Washington State Caseload Forecast Council (CFC) for HCBS services, the budget forecast framework can be used to assess whether the MAC and TSOA programs are generating the expected level of savings.

Table 3: MAC/TSOA caseload impact model for in-home personal care



Source: caseload forecasts provided by the Washington State Caseload Forecast Council and DSHS’ Research and Data Analysis (RDA) Division.

The results so far are promising. Although in-home personal care service caseloads continue to grow at more than three percent per year, caseload growth has been slower than originally forecast when the MAC and TSOA programs were implemented. Although other factors may have affected caseload trends, in-home service caseload trends are consistent with the MAC and TSOA programs achieving the level of savings necessary to be budget neutral from a General Fund-State (GF-S) perspective.

Survey results indicate that most MAC and TSOA program participants are satisfied with the services they have received:

- Overall, 83 percent of survey respondents indicated they were satisfied with their respective program. Only five percent indicated they were not satisfied with their program.
- Overall, 78 percent of survey respondents indicated that their respective program services would delay a move to a nursing home or adult family home. Only nine percent indicated their program would not delay a move.

MAC participants also had fewer adverse health outcomes following enrollment.

Positive results from the FCS program

Since implementation of FCS in 2018, over 22,000 individuals have been enrolled in the program to date, and approximately 8,000 are currently enrolled.

DSHS’ Research and Data Analysis (RDA) Division performed an [update to their preliminary evaluation](#) in July 2021 on the first 18 months of FCS program implementation. Findings were largely positive and included the following: (**Note:** FCS enrollees are designated as affiliated with ALTSA if they had either a developmental disability Comprehensive Assessment Reporting Evaluation (CARE) assessment or an Aging CARE assessment within the 15 months prior to and during their initial six-month enrollment in FCS.)

Supported employment

- Uniformly positive impacts on employment rates for HCA and ALTSA populations.
- Modest increases in earnings and average hours worked among the HCA population.

- No statistically significant impacts on ED or inpatient utilization for ALTA or HCA enrollees.

Supportive housing

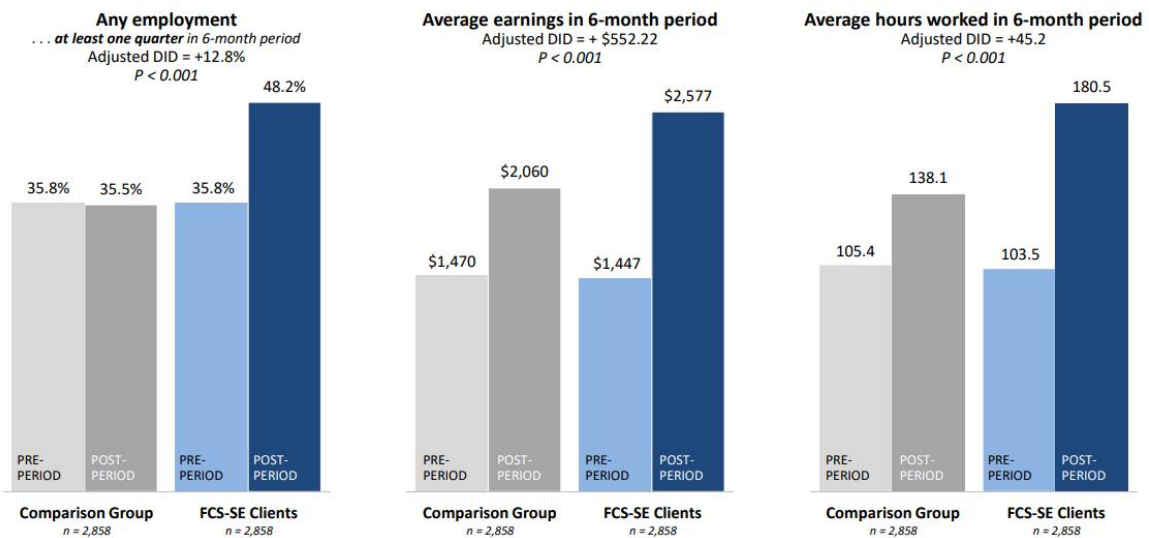
- Significant positive impacts on transitions out of homelessness for HCA enrollees.
- Statistically significant increases in the percentage of HCA enrollees housed in housing projects funded by the Department of Commerce.
- Statistically significant increases in receipt of in-home services for ALTA enrollees.
- Statistically significant increases in inpatient utilization and nursing facility placements for ALTA enrollees.
- No statistically significant impacts on ED utilization for ALTA or HCA enrollees or community residential placements for ALTA enrollees.

The tables below describe FCS outcomes.

Table 4: HCA supported employment outcomes: employment and earnings

HCA Supported Employment Outcomes: Employment and Earnings

Comparison of outcomes 6 months prior to and 6 months following enrollment month • Data is limited to individuals who entered the program as of June 30, 2019



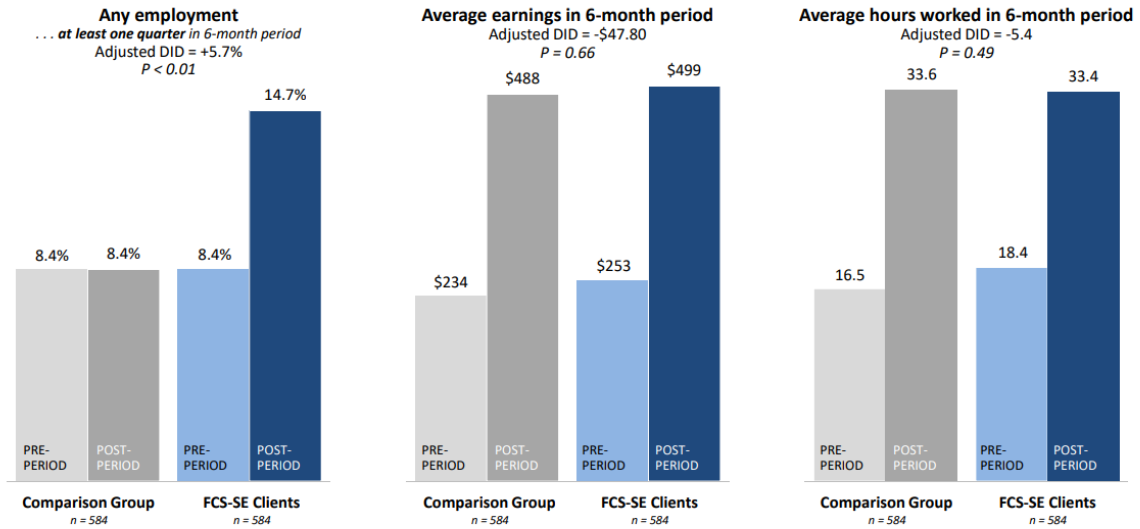
SOURCE: Integrated Client Repository (ICDR).
DSHS | Facilities, Finance, and Analytics Administration | Research and Data Analysis Division • JUNE 2021

Source: DSHS

Table 5: AL TSA supported employment outcomes: employment and earnings

AL TSA Supported Employment Outcomes: Employment and Earnings

Comparison of outcomes 6 months prior to and 6 months following enrollment month • Data is limited to individuals who entered the program as of June 30, 2019



SOURCE: Integrated Client Repository (ICDR).

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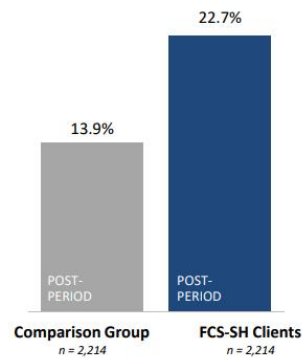
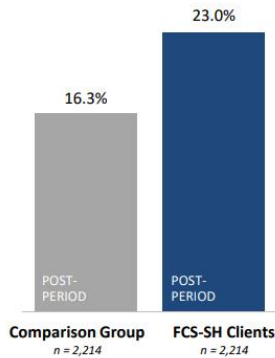
Table 6: HCA supportive housing outcomes: housing status

HCA Supportive Housing Outcomes: Housing Status

Comparison of outcomes 6 months prior to and 6 months following enrollment month • Data is limited to individuals who entered the program as of June 30, 2019

Transitioned Out of Homelessness and Did Not Return
... as of the last month of the 6-month period
Adjusted Difference = +6.5%
P < 0.001

Housed in a Commerce-Funded Project
Adjusted Difference = +8.5%
P < 0.001



SOURCE: Integrated Client Repository (ICDR).

DSHS | Facilities, Finance, and Analytics Administration | Research and Data Analysis Division • JUNE 2021

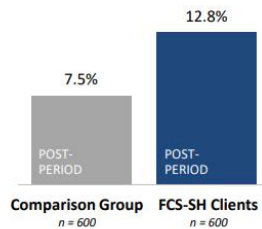
Source: DSHS

Table 7: AL TSA supportive housing outcomes: housing status

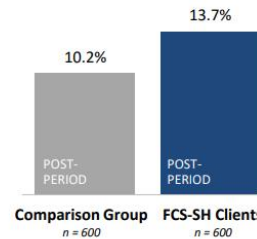
AL TSA Supportive Housing Outcomes: Housing Status

Comparison of outcomes 6 months prior to and 6 months following enrollment month • Data is limited to individuals who entered the program as of June 30, 2019

Transitioned Out of Homelessness and Did Not Return
... as of the last month of the 6-month period
Adjusted Difference = +2.7%
P = 0.12



Housed in a Commerce-Funded Project
Adjusted Difference = +1.2%
P = 0.52



SOURCE: Integrated Client Repository (ICDR).

DSHS | Facilities, Finance, and Analytics Administration | Research and Data Analysis Division • JUNE 2021

Source: DSHS

Meaningful improvement in access to and quality of SUD treatment

In the first year of Washington’s SUD IMD amendment (2018-2019), several SUD access and treatment performance measures showed meaningful and statistically significant improvements. These included increased initiation of alcohol and other drug dependence treatment and access to preventive services for individuals with SUD. The number of individuals receiving substance use treatment increased.

System savings and new capacity under SUD/MD IMD amendments

As a result of the SUD IMD and MH IMD amendments and associated funding through FFP, the state can address a long-standing need: increase access to the vital service of inpatient and residential behavioral health care for individuals who cannot have their needs safely met in community settings.

The findings from the interim evaluation²² validate these promising results identified by RDA and the Washington State CFC. All five MTP initiatives are working together to bring value to Washington’s health and wellness system while also maintaining budget neutrality. In addition, this progress has been achieved in the face of monumental challenges brought on by COVID-19.

Ready and nimble support for COVID-19 pandemic response

When the COVID-19 pandemic began, each MTP initiative was well-positioned to respond to local and regional needs in a systematic way, through provider networks and robust community engagement mechanisms that were in place before the pandemic. CMS approved certain flexibilities early on, which

²² The independent external evaluator for MTP is responsible for assessing the impacts and overall performance of MTP. Preliminary findings are noted in Appendix B. On December 11, 2020, HCA received CHSE’s interim report, as required in the MTP special terms and conditions. The interim report findings further support these promising practices.

allowed for additional relief to extend to providers and community organizations implementing projects. Flexible options for receiving and performing services were offered to enrollees and providers.

Through their community-based work, ACHs have developed a unique foundation to respond to and understand emerging community needs. Because of this experience, ACHs have played a key role in COVID-19 relief efforts by:

- Helping individuals receive food and health care.
- Assisting small providers and CBOs shift to telehealth and/or improve access to services.
- Distributing personal protective equipment, including over 4.4 million masks.
- Partnering with local health jurisdictions and CBOs to alleviate uncertainty by informing community providers and families about the virus, testing, new state flexibilities, available resources, and federal relief.
- Addressing SDOH by supporting efforts to provide food, housing, language access, legal support, and other needs.

IHCPs and AIHC were forced to quickly pivot to address the pandemic. The flexibility provided by the MTP demonstration allowed IHCPs and AIHC to shift primary focus to COVID-19 and maintain progress in serving AI/ANs associated with the IHCP-specific Projects.

In response to the pandemic, LTSS expanded care options for older people, while keeping them at home where risk of exposure is less than in congregate care facilities. Services like home-delivered meals, personal care, respite care, and errands to the grocery store and pharmacy have allowed at-risk populations to follow public health guidelines to stay home. FCS has continued to provide critical services to individuals seeking to obtain and maintain housing and employment.

SUD IMD provided additional flexibility for funding for expanded SUD treatment in participating health care facilities. This financial support has continued throughout the COVID-19 pandemic. MH IMD supported the development of extended services in participating facilities for enrollees with serious mental health conditions.

The access to SUD and mental health treatment—enhanced by these initiatives—is especially critical because forecasting predicts a rise in behavioral health issues as the pandemic continues. According to a June 2020 report released by DOH, ongoing behavioral health impacts are expected to come in phases as the pandemic continues and people are impacted by the isolating effects.

MTP also played a significant role in systemwide pandemic response efforts, not linked to individual MTP initiatives, such as:

- ACHs provided training and technical assistance opportunities, including infrastructure grants, to support providers in increasing telehealth and virtual visit access for enrollees and billing appropriately for these visit types.
- FCS providers, homeless service providers, homeless outreach teams, and behavioral health outpatient facilities helped distribute thousands of cell phones, purchased through FCS funds, to support access to telehealth and community resources because many in-person services closed.
- The FCS team also participated in an agencywide effort to deliver loaner laptops and Zoom technology supports to the provider community. This program helped providers shift services to telehealth when in-person services were not possible. Nearly 650 laptops were distributed; a significant number of FCS providers continued to use the laptops well into DY6. Since the start of the pandemic, the Zoom licenses HCA offered to providers have helped with 356,850 patient

visits, which totaled 20.80 million minutes. Behavioral health providers used 17.41 million of those minutes.

- State agencies partnered with ACHs and LTSS and FCS providers to disseminate information on new guidelines, state and federal support opportunities, changes to billing requirements and codes, and best practices to support providers in adopting the latest treatment and care recommendations throughout the pandemic.
- During the pandemic, health care providers and social service entities have needed to transition to fewer in-person visits, while at the same time the social needs of their enrollees have increased. MTP initiatives responded by assisting providers in navigating reimbursement and payment issues, including temporary supports and COVID-19 capacity building investments provided through DSRIP.
- FCS, MAC, and TSOA programs have continued to serve enrollees during the COVID-19 pandemic. These programs shifted to remote assessments and telephonic service delivery and allowed remote personal care or respite when feasible. Providers were given enhanced provider rates in response to the pandemic.
- MTP initiatives have worked to support food banks, meal delivery services, community action agencies, local coalitions, and other programs that support at-risk community members as people navigate pandemic impacts that fall outside of what the traditional health system can deliver.

Lessons learned

Value of statewide direction to drive to comprehensive outcomes

The DSRIP program (Initiative 1) was comprehensive and spanned eight primary project areas with many interventions and models within those eight project areas. ACHs implemented a wide array of interventions and had a large amount of latitude in how they created partnerships and worked within their communities. This was a strategy to test approaches for capacity building and delivery system reform, but also highlighted the value of statewide strategic direction to move toward more comprehensive outcomes. Significant health disparities and inequities persist in Washington.

Informed by the experience from MTP, HCA seeks to provide stronger strategic statewide direction on health equity and addressing health disparities in MTP 2.0. Developing community-informed approaches will remain a foundational concept of ACHs. The state and ACHs, however, will evolve with MTP 2.0. Within each region, ACHs will continue to lead renewal strategies to meet HRSN, facilitate community-based care coordination, and advance health equity within a statewide strategy.

Need for care coordination and social needs supports

Across the care continuum, and especially during the COVID-19 pandemic, it became clear that community-based care coordination—nonclinical care coordination that connects people and families to HRS—was fragmented, under-resourced, and had clear gaps in its ability to reach certain people and connect them to certain services. The need for services became more pronounced during the pandemic, and it was also clear there were disparities in being able to access and benefit from those services.

ACHs worked to improve these issues, including by supporting community-based providers, hiring and training community-based workforce, and working with multi-sector community entities to address gaps in services and help more people access the services. These efforts reinforced the need for a cohesive, statewide, Medicaid community-based care coordination system with additional payment flexibility to support community-based workforce and service gaps.

Clear need for more robust health and CIE statewide

ACH efforts to establish partner networks and a meaningful role in community health transformation were challenged by a lack of comprehensive health information exchange (HIE) and CIE.²³ Certain ACHs invested in CIE to support care coordination. These MTP investments became more significant in the height of the pandemic: several ACHs leveraged their CIE investments to partner with DOH's Care Connect Washington program to help residents in isolation and quarantine who tested positive for COVID-19.

These systems have regional capabilities that respond to the specific needs of people in isolation and quarantine. The capabilities of these systems may be leveraged in a CIE strategy with additional capabilities, which are necessary to support future robust community-based care coordination.

The lack of necessary data-sharing infrastructure and capacity to coordinate care and access health and HRSN is not limited to ACHs; it persists for most partner MCOs, Tribes, providers, and CBOs. A statewide HIE and CIE strategy is needed to continue advancing Medicaid transformation goals. The strategy needs to address gaps, which include:

- Data exchange services that can support individuals' consent to share behavioral health information, pursuant to 42 CFR Part 2.
- Behavioral health, human resources, and CBOs' lack of experience adopting information technology and data exchange tools and services.
- Capabilities to establish directories that support closed loop referrals for CBOs, LTSS, FCS, and HRS.
- Capacity to securely share health-related information across partners to support community-based care coordination.

The state's strategy intends to expand the scope and scale of CIE support for community-based care coordination statewide. To effectively establish and implement the strategy, the state will consider how best to leverage its public and private HIE and CIE investments: OneHealthPort, Washington State's HIE and Clinical Data Repository; DOH's Care Connect Washington program; ACH investments that support community-based care coordination; and private investments by health insurers and others.

Importance of adequate community-based workforce for achieving whole-person care

Workforce shortages are one of the top challenges surrounding MTP implementation, including psychiatrists, clinical social workers, and rural health care providers. These individuals are core to supporting MTP whole-person care. ACHs and MCOs report these workforce shortages were further exacerbated by COVID-19.

Several other issues are contributing to workforce shortages, including competitive job markets, recruitment challenges tied to limited housing, and strain tied to vaccine mandates. Community health workers (CHWs) play an important role in ACH and regional progress toward community care coordination and whole-person care. Sustaining payment mechanisms and retention of CHWs is an area of emphasis for MTP 2.0.

²³ A CIE is an ecosystem comprised of multi-disciplinary partners that use a technology service to deliver enhanced community care planning that integrates data from multiple sources and makes bi-directional referrals to provide proactive, holistic, person-centered care.

Continued need for coverage and supports for vulnerable populations and critical life stages

While HCA made early coverage strides before and after the passage of the ACA, coverage gaps still exist for people and their families at critical life stages, including times of transition. MTP strategies and projects facilitated capacity building and supporting transformation in the Medicaid system as a whole; however, some individuals were left out, such as those transitioning from justice-involved settings, children under age six, and postpartum individuals who are dropped from coverage.

It also became clear that those seeking LTSS services were not always able to access them fast enough because of delays in eligibility determination. Additionally, certain older adults with behavioral health conditions don't have the legal guardian supports needed to leave facilities, even if they did not need an institutional level of care.

Many of these coverages and supports gaps are noted by state agencies and the Washington State Legislature, who worked together to design and direct strategies for these groups. During the 2022 legislative session, the Legislature directed HCA to seek waiver authority in the MTP demonstration renewal.

Looking toward the future

Through these first six years of MTP, HCA and DSHS, with the support of our federal partners at CMS, built considerable capacity through the implementation of new programs and initiatives. ACHs established themselves as legal entities, implemented projects, and built networks of traditional and nontraditional providers, while also lifting up community voices and focusing on health equity.

HCA and DSHS developed protocols for and implemented FCS, MAC, and TSOA, providing needed services for vulnerable Medicaid enrollees and testing new ways of paying for and delivering critical services. The IMD amendments helped bolster treatment services for those most in need and make SUD and MH treatment more accessible and effective.

The successes and lessons learned during the initial MTP demonstration, as well as new needs and opportunities that emerged during the COVID-19 pandemic, have helped Washington refresh its aims and goals, and identify a pathway that builds on this MTP foundation.

Section 3: continuing demonstration features and changes requested to the demonstration

Building on the success of MTP, Washington is pursuing a combination of new and continuing strategies to address three primary goals through MTP 2.0. The following table outlines the demonstration proposals Washington will implement under MTP 2.0, mapping each to its corresponding goal. These include proposals to:

- Continue initiatives from the original MTP.
- Implement new proposals to improve access, equity, and whole-person care drawn from lessons learned in MTP and the COVID-19 pandemic.
- Continue an evolving program—Taking Action for Healthier Communities (TAHC)—which represents a new phase of work for Washington's ACHs as they deepen their partnerships with

MCOs and the communities they serve. TAHC also includes evolving strategies to support the Indian health care and social needs systems, with alignment to the overall goals of TAHC.

Table 8: overview of MTP 2.0 proposals

Primary goal	Policy/program name	Status within this renewal request
Goal 1: expanding coverage and access to care, ensuring that people can get the care they need	1.1 Continuous Apple Health enrollment for children	New
	1.2 Re-entry coverage for continuity of care	New
	1.3 Apple Health postpartum coverage expansion	New
	1.4 SUD and mental health IMD: supports for people receiving SUD and mental health treatment (formerly MTP Initiatives 4 and 5)	New and continuing
Goal 2: advancing whole-person primary, preventive, and home- and community-based care	2.1 MAC and TSOA programs (formerly MTP Initiative 2)	Continuing
	2.2 Program innovations for LTSS <ul style="list-style-type: none"> • Rental subsidies • Coordinated personal care • Guardianship and decision-making supports • Presumptive eligibility 	New
	2.3 Washington Integrated Care Assessment (WA-ICA)	New
Goal 3: accelerating care delivery and payment innovation focused on HRSN	3.1 TAHC (formerly MTP Initiative 1): <ul style="list-style-type: none"> • Community-based care coordination hub (“Community Hubs”) • HRS • Health equity programs • Community-based workforce 	Evolving
	3.2 FCS (formerly MTP Initiative 3)	Continuing

Goal #1: expanding coverage and access to care, ensuring that people can get the care they need

Core to centering health equity, Washington seeks to expand coverage and improve access. Coverage and access strategies proposed under MTP 2.0 are tailored to life stages and transitions between them. A lack of coverage or access to services may have a negative, cumulative effect on achieving health and wellbeing through subsequent life stages.

Access to coverage and services reduces the need for costly, invasive care and improves health outcomes and community integration. High-risk, historically marginalized populations may benefit most from strategies tailored to address life stages and transitions.

Coverage does not automatically lead to access to health care and HRS. Coverage, however, is a foundational step toward access. Coverage also permits HCA to analyze data that may inform future interventions and provide critical care during times of intense need and transition. HCA believes these strategies will result in smarter spending, provide critical supports where they are most needed, and positively impact health outcomes and wellbeing.

1.1 Continuous Apple Health enrollment for children (new)

Request

Washington is seeking new federal authority to provide continuous enrollment in Medicaid for young children who have incomes below 215 percent of the federal poverty level (FPL) at the time of application through the first six years of life.

Policy/program description

Continuity of coverage for young children provides an essential base for providers and health plans to focus their efforts on primary and preventive care and early diagnosis and treatment of problems that will improve long-term health and wellbeing. Over the past two years, COVID-19 disrupted early childhood services and programs, severely impacting the development, and emotional and behavioral health of children and youth. In particular, children ages zero to five from lower income households, single-parent families, and Black households, as well as young children with disabilities, experienced significant increases in emotional or behavioral problems, including depression.²⁴

Now, more than ever before, we need to ensure uninterrupted coverage and access to health care and HRS for children. Continuous enrollment will keep young children connected to coverage and care without the risk of coverage losses and the discontinuity in care. Through this proposal, Washington seeks to ensure that young children get the care they need when they need it, and that they begin school ready to learn.

Coverage gaps among children eligible for subsidized coverage (often referred to as “churn”) have been shown to reduce children’s access to preventive and primary care, increase their unmet health care needs, and result in disruptions in continuity of health care services.²⁵ This is particularly problematic for young children, given how significantly the early years impact lifelong growth and development.²⁶

For example, early detection of and timely intervention for developmental delays, including screenings conducted during early childhood well visits, has been shown to positively impact health, language and

²⁴ Jones, Kaitlyn. The Initial Impacts of Covid-19 on Children and Youth. Aug. 2021.

<https://aspe.hhs.gov/sites/default/files/documents/188979bb1b0d0bf669db0188cc4c94b0/impact-of-covid-19-on-children-and-youth.pdf>.

²⁵ Sugar, S., Peters C., DeLew. N., Sommers, BD. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic (Issue Brief No. HP-2021-10). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. April 12, 2021. Available at <https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf>

²⁶ Magie, K., Shuell, J., Hron, J., Dodge, R., McCormick, C., Hertwig, R., Putnam, C. (2019, February 07). Preventing early childhood adversity before it starts: Maximizing Medicaid opportunities. Available at <https://www.chcs.org/maximize-medicaid-opportunities-prevent-early-childhood-adversity-starts/>

communication, and cognitive development.²⁷ There is also considerable evidence that a strong foundation of coverage and continuity of care can help children be school-ready, ensure timely referrals to early intervention and potentially lower special education and child welfare costs.²⁸

Washington adopted the 12-month continuous coverage state plan option for children. While that policy is effective in maintaining coverage during the 12 months between redeterminations, even with a streamlined renewal process, coverage losses at redetermination continue to be an issue for children. An analysis of Washington's enrollment data shows that approximately 11 percent of children under the age of six experience Medicaid coverage gaps in a given year.²⁹

Coverage gaps appear to fall disproportionately on children of color. The state's data show, for example, that white Hispanic Medicaid enrollees ages 0-6 experienced 46 months of disruption every five years per 100 children. This is significantly lower than the same aged Black Hispanic Medicaid enrollees who experienced 63 months of disruption every five years per 100 children.

Washington is seeking to ensure continuous Apple Health (Medicaid) coverage for children during the first six years of their lives. Apple Health covers children up to 215 percent FPL with Medicaid funds and up to 317 percent FPL with Children's Health Insurance Program (CHIP) funds.

The proposed continuous enrollment policy will apply to Medicaid-enrolled children with incomes up to 215 percent FPL at the time of application. The state is proposing to establish an income eligibility threshold of 215 percent to reduce the possibility of a child becoming ineligible for Apple Health by exceeding the CHIP income threshold of 317 percent FPL during the first six years of life.

This proposal is aimed at ending churn for young children and is not designed to change eligibility limits for Apple Health. As described below, residency will continue to be monitored, and children who move out of state will not retain coverage. Washington estimates that an average of 24,862 young children will receive continuous enrollment on an annual basis as a result of this proposal. The total local and federal funds to implement continuous enrollment is estimated to be \$26,951,000, annually.

Demonstration objective and rationale

This demonstration request will end churn among Medicaid-enrolled children through age six, enabling their families and providers to better address their primary and preventive health care needs. This request will also ensure that coverage disruptions do not prevent children from receiving any ongoing treatment and services they require during the critical early years of development and growth. This request seeks to:

- Ensure continuous coverage and retention for young children.

²⁷ Center on the Developing Child at Harvard University. The Foundations of Lifelong Health are Built in Early Childhood, July 2010. Available at <https://46y5eh11fhgw3ve3ytpwxt9r-wpengine.netdna-ssl.com/wp-content/uploads/2010/05/Foundations-of-Lifelong-Health.pdf>; American Speech-Language-Hearing Association. Roles and Responsibilities of Speech-Language Pathologists in Early Intervention: Technical Report, 2008. Available at <http://www.wiu.edu/ProviderConnections/pdf/SpeechTechnicalReport.pdf>; Guralnick MJ, Bricker D. The Effectiveness of Early Intervention for Children with Cognitive and General Developmental Delays. In: The Effectiveness of Early Intervention for At-Risk and Handicapped Children. San Diego, CA: Academic Press; 1987:115-173. Available at https://depts.washington.edu/chdd/guralnick/pdfs/Guralnick_Chapter4-The_Effectiveness_of_EI-1987-AcademicPress.pdf; Hebbeler K, Spiker D, Bailey D, et al. Early intervention for infants and toddlers with disabilities and their families: participants, services, and outcomes, January 2007; Hebbeler, K. First five years fund briefing. presentation given at a congressional briefing on June 11, 2009, to discuss education that works: The impact of early childhood intervention on reducing the need for special education services.

²⁸ Currie, J., Early Childhood Intervention Programs: What Do We Know?, April 2000. Available at <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.492.8316&rep=rep1&type=pdf>

²⁹ Based on analysis of HCA data, February 22, 2021.

- Promote longer-term access to and continuity of physical health care, behavioral health care, and HRS.
- Improve short and long-term health outcomes for these children.

Demonstration implementation

Washington is seeking to implement continuous enrollment for children ages 0-6 by quarter (Q) 3 of 2023.

1.2 Re-entry coverage for continuity of care (new)

Request

Washington is requesting approval to authorize federal Medicaid matching funds for the provision of a set of targeted Medicaid services including but not limited to the services described below to be provided in the 30-day period prior to release for eligible justice-involved populations, as well for individuals confined in state hospitals or IMDs who are discharging to the community. In addition, services will include a 30-day supply of medication, including MOUD, and DME for individuals to have in hand as they are released or discharged into the community. The goal is to provide transition services that benefit the individual in their specific circumstance upon release and best support continuity of care. The set of services covered in the pre-release period may change during the course of Washington’s negotiations with the federal government.

Jails/Prisons:

- Physical and behavioral assessments
- Lab work
- Case management/care coordination
- Medications for Opioid Use Disorder treatment
- Medications during the pre-release period.

IMD/state hospitals

- Physical assessments
- Lab work
- Case management/care coordination
- Medications for Opioid Use Disorder treatment
- Medications during the pre-release period.

Policy/program description

The goal of this program is to prepare incarcerated individuals for successful re-entry into their communities by providing services that enhance connection to and continuity of health care and HRS. At the direction of the Washington State Legislature through House Bill 1348 and Senate Bill 5304, HCA is pursuing FFP to provide Medicaid benefits to individuals who are incarcerated during the 30 days prior to their release and re-entry into the community. This waiver authority is requested for adults and youth incarcerated in state prisons, jails, or youth correctional facilities.

Statutory workgroups are working on the policy details for the re-entry program proposed for individuals incarcerated in jails or prisons. These workgroups include state agency staff, legislative staff, advocates, health care providers, managed care plans, correctional facilities, and business partners—and with ongoing stakeholder engagement.

HCA is also directed, through the same House and Senate bills, to pursue FFP for the provision of Medicaid benefits for individuals confined at a state hospital or IMD in the 30-day period prior to their discharge. This is often a referral or order for continued outpatient services with a behavioral health agency.

Apple Health enrollees who enter a correctional facility in Washington have their coverage suspended until their release. While incarcerated, they have access to a limited Medicaid benefit that covers acute, inpatient hospital stays outside of the carceral³⁰ facility. An incarcerated individual has full Apple Health coverage reinstated when exiting a correctional facility. After release from incarceration and re-entry to the community, there is often a lag in their coverage going into effect. Apple Health enrollees who become confined to a state hospital or IMD have their Apple Health coverage terminated. Their Apple Health coverage is reinstated through a discharge plan. As a result, incarcerated or confined individuals seeking services or medications upon release or discharge often experience barriers to accessing care and lack care coordination to assist with their re-entry.

Incarcerated individuals experience additional delays and missed opportunities in meeting their care needs because MCOs do not know when individuals eligible for Apple Health will be re-entering the community. MCOs also do not receive an assessment of the new enrollee's health care or health care-related needs before being released from a correctional facility or discharged from a state hospital or IMD. HCA will continue to improve continuity of care for Apple Health enrollees with FFS coverage by further developing the practice of care coordination for their re-entry services. This lack of coordination and continuity delays access to health care in the high-risk period immediately following incarceration or confinement.

The lack of coordination also results in some incarcerated individuals languishing in a correctional facility when they should be referred for behavioral health treatment. Judges are reluctant to release individuals without an established plan for SUD or SMI treatment and effectuated Medicaid eligibility recorded by HCA. Successful and safe re-entry from a correctional facility depends on an individual's ability to have coverage, a re-entry care plan, and access to services and medications that meet their needs before release and upon re-entry to the community.

Individuals confined to a state hospital or IMD also experience delays due to gaps in transition planning. Individuals confined to a state hospital or IMD may leave with a court order and discharge plan, which includes an intake appointment with a behavioral health agency. Better coordination within 30 days before discharge will likely decrease or eliminate gaps in transitioning from a state hospital or IMD to the intake appointment with a behavioral health agency.

This proposed demonstration program would provide Apple Health benefits for eligible individuals for up to 30 days before discharge from a state hospital or IMD or release from a state prison, jail, or youth correctional facility (pretrial or post-conviction). All eligible youth and adults who are preparing to re-enter the community from a correctional facility or discharge from a state hospital or IMD will be eligible for re-entry services regardless of health status.

This demonstration program proposes to enhance access to and continuity of care by enabling earlier access to incarcerated or confined individuals so that care coordination staff may:

- Assess health care needs.
- Develop a re-entry care plan for pre- and post-release or pre- and post-discharge services.

³⁰ Carceral: of or relating to prison or imprisonment, or to other formal methods of social control.

- Work with the correctional facility, state hospital, and IMD to ensure the provision of medications for opioid use disorder treatment.
- Facilitate referrals and transportation for re-entry physical, behavioral, and specialist appointments and treatments.
- Arrange for prescriptions or durable medical equipment upon release into the community.

A re-entry assessment by care coordination staff will also identify an individual’s unmet social needs, such as stable housing and affordable food, and connect individuals to HRS supported by ILOS or waiver funding.

Washington estimates that this demonstration project would provide pre-release and re-entry services through Apple Health coverage for 4,000 incarcerated individuals released from prison each year. The estimate is based on state data, which indicates that approximately 8,000 people are released from prison each year and assumes that approximately half of this group will qualify for Apple Health. The state also estimates that 120,000 unique individuals are incarcerated each year in a jail setting and this results in an estimated 220,000 additional enrollments and releases from jail, annually.

Washington estimates from 2021 state data that 11,500 individuals were detained for involuntary behavioral health treatment at a state hospital or IMD. If half of those individuals qualify for Apple Health, Washington would provide re-entry services to another 5,750 individuals.

Demonstration objective and rationale

The proposed demonstration program will address the significant health care needs of Washington’s justice-involved or confined population. It will also advance the state’s efforts to reduce health disparities and advance health equity and ensure that these high-risk Apple Health enrollees receive needed health coverage and care before re-entry. The proposal to enhance re-entry coverage for continuity of care through re-entry aligns with and promotes the objectives of Apple Health and will:

- Improve physical and behavioral health outcomes following re-entry of Apple Health enrollees.
- Reduce ED visits and hospitalizations.
- Initiate continuity of care and medication adherence.
- Reduce overdose rates and deaths.
- Reduce relapse or recidivism (re-offense) for incarcerated individuals.

Washington is one of only eight states in the nation to have experienced growth in its incarcerated population throughout the 2010s, despite a notable decrease in violent crimes (peaking in the early 1990s) and property crimes (having peaked in the late 1980s).³¹

There are significant racial disparities among justice-involved Apple Health enrollees, with a disproportionate representation of Black and Indigenous People of Color (BIPOC) compared to Washington’s general population. While Black individuals make up four percent of Washington’s population, they make up 18 percent of justice-involved Apple Health enrollees. Similarly, AI/AN individuals represent 14 percent of justice-involved Apple Health enrollees, despite being just 1.6 percent of the general population.

Justice-involved Apple Health enrollees reportedly experience:

- Higher rates of behavioral health treatment needs in comparison to the general Apple Health population (58 percent to 42 percent).

³¹ About Time: How Long and Life Sentences Fuel Mass Incarceration in Washington State

- Higher rates of SUD (61 percent to 18 percent).
- Higher rates of co-occurring disorders (41 percent to 13 percent).

Behavioral health needs are exacerbated for Medicaid enrollees involved in the justice system. The Prison Policy Initiative reports significant mental health impacts of incarceration throughout the nation due to disconnection from family, loss of autonomy, boredom and lack of purpose, and unpredictability of surroundings.

Justice-involved individuals, especially those leaving incarceration, are at high risk of poor health outcomes. They experience disproportionately higher rates of physical and behavioral health diagnoses and are at higher risk for injury and death. Studies show that 75 percent of formerly incarcerated individuals with an OUD will relapse within three months after release.³² Additionally, formerly incarcerated individuals in Washington are 129 times as likely to die of an overdose in the first two weeks after their release, compared to the general population.³³

Washington has a history of implementing successful re-entry programs. The Washington State Institute for Public Policy completed a study in 2015 that compared the effectiveness of over 40 programs that report recidivism as an outcome. They concluded that Washington's Offender Reentry Community Safety Program had a marked decrease in recidivism compared to other programs.³⁴

This proposed demonstration program builds on and aligns with actions taken by the Washington State Legislature through Senate Bill 5304 and House Bill 1348 to initiate Apple Health coverage before release or discharge. Initiating Apple Health coverage 30 days before release or discharge promotes continuity of care during the re-entry process. These bills improve the prospect of minimizing delays in receiving health care, maximizing care coordination, and improving transitions for incarcerated individuals re-entering their community and confined individuals transitioning to receiving treatment in a community-based setting through behavioral health agency.

This proposed demonstration program also aligns with federal priorities. In October 2018, Congress passed the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act, which creates a new opportunity for states to apply for a Section 1115 demonstration waiver to provide Medicaid coverage within 30 days of release. Section 5032 of the SUPPORT Act requires the U.S. Department of Health & Human Services to issue a state Medicaid director letter regarding opportunities to design Section 1115 demonstration waiver projects that allow for Medicaid coverage for incarcerated individuals within 30 days of release.

Consistent with the SUPPORT Act, this proposed demonstration program, is a critical part of Washington's efforts to advance equity and reduce disparities, one of the six pillars articulated by the CMS Administrator,³⁵ in health outcomes for Apple Health enrollees.

Demonstration implementation

Washington seeks to begin implementation of covered continuity of care services 30 days before re-entry for incarcerated and confined individuals starting in Q1 of 2024 by phasing in specific prisons or

³² Substance Abuse and Mental Health Services Administration, Evidence-Based Resource Guide Series: <https://store.samhsa.gov/sites/default/files/d7/priv/pep19-matussecjs.pdf>

³³ [Release from Prison — A High Risk of Death for Former Inmates](#)

³⁴ https://www.wsipp.wa.gov/ReportFile/1667/Wsipp_The-Effectiveness-of-Reentry-Programs-for-Incarcerated-Persons-Findings-for-the-Washington-Statewide-Reentry-Council_Report.pdf

³⁵ My First 100 Days and Where We Go From Here: A Strategic Vision for CMS, <https://www.cms.gov/blog/my-first-100-days-and-where-we-go-here-strategic-vision-cms>

jails and state hospitals or IMDs for individuals with coverage through FFS or managed care. Washington seeks to expand the program starting in Q1 of 2025 for all eligible individuals in state prisons, jails, and youth correctional facilities (pretrial or post-conviction) and state hospitals and IMDs.

Washington is preparing to convene in early 2023 an implementation planning process with key partners, including state agencies responsible for Medicaid managed care, benefits and eligibility, corrections, juvenile justice, and behavioral health; correctional facilities; behavioral health providers; MCOs; counties; tribal health programs; community-based organizations; people with lived experience; and Tribal representatives. Throughout 2024 and 2025, Washington will implement the proposed solutions of the planning process through phasing-in services by target populations, which will include implementation of the FFS population. Washington looks forward to working with CMS to shape a successful approach to re-entry coverage for continuity of care with MTP 2.0.

1.3 Apple Health postpartum coverage expansion (new)

Request

Washington is requesting approval to authorize federal Medicaid matching funds to provide 12 months of continuous postpartum coverage for eligible individuals. The state intends to combine this waiver authority with the American Rescue Plan Act (ARPA) State Plan Authority (SPA) option to extend 12 months postpartum Medicaid and CHIP coverage for pregnant people. Together, these two authorities will enable Washington to offer robust and continuous postpartum coverage for all Apple Health populations who need it.

Policy/program description

Washington seeks approval of new waiver authority to provide 12 months of continuous coverage to pregnant and postpartum people with incomes below 193 percent of the FPL who are not eligible for another Medicaid or CHIP coverage group. Today, Washington covers (through Medicaid and CHIP) people who are pregnant with incomes up to 193 percent of the FPL, regardless of citizenship or immigration status.

This coverage currently extends to 60 days after pregnancy, starting the month after the pregnancy ends. Postpartum coverage is continuous, meaning it is in effect regardless of any change in enrollee income. People who apply for Medicaid or CHIP after their pregnancy ends are not currently eligible for postpartum coverage (unless they are otherwise eligible for Medicaid or CHIP).

ARPA, which passed in March 2021, gives states a new SPA option to extend to 12 months continuous postpartum coverage for people enrolled in Medicaid or CHIP while pregnant. Washington developed its SPA to extend this new coverage option, which became effective on April 1, 2022. Consistent with federal guidance about the postpartum coverage option, Washington will extend postpartum coverage to 12 months for individuals who are currently enrolled in Medicaid or CHIP while pregnant, including “lawfully residing” pregnant individuals eligible under Section 214 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

Consistent with federal guidance, Washington’s SPA will extend postpartum coverage to individuals who apply for Medicaid or CHIP during their postpartum period, as long as the individual was eligible for and enrolled in Medicaid or CHIP while pregnant, including during a period of retroactive eligibility. Washington submitted its postpartum SPA in May 2022 and CMS approved the amendment.

ARPA’s postpartum SPA option does not extend to:

- People who apply for Medicaid or CHIP during their postpartum period, but who were not previously enrolled in Medicaid or CHIP during their pregnancy.
- Individuals who receive pregnancy-related services under the CHIP “unborn child option.”

Washington is seeking waiver authority to extend postpartum coverage for these two additional groups of individuals. Taken together, the state’s postpartum SPA and demonstration authorities will enable Washington to provide comprehensive and continuous postpartum coverage to all Apple Health populations who need it.

An eligible individual will maintain coverage for 12 months from the date of delivery, regardless of what point in the postpartum period they enroll in coverage. Eligibility for the extended postpartum period is determined by the date the pregnancy ends. At the end of the continuous 12-month postpartum period, Washington State will redetermine eligibility for other programs. The proposed program will not have an enrollment limit. The proposed program will enroll individuals who do not qualify for Apple Health through other federal eligibility groups.

Benefits: benefits provided in the proposed program will be the full benefit package within the state plan for Apple Health, including comprehensive physical health, behavioral health, oral health, and pharmacy services, as well as Maternity Support Services (MSS) and Infant Case Management (ICM). This includes all current pregnancy benefits, such as screening for possible pregnancy risk factors, delivery, post-pregnancy follow-ups, substance use treatment, and breast pumps. Continuous postpartum coverage will remain in effect regardless of any changes in circumstances.

Delivery system: services will be delivered through the current statewide FFS and managed care delivery systems. Washington projects that if approved, the proposed program would extend postpartum coverage for:

- 5,000 individuals who are not currently or were not enrolled in Apple Health while pregnant and apply for coverage during their the postpartum 12-month period.
- 2,500 individuals who are on Apple Health while pregnant and who would have dropped off of any type of coverage or would have enrolled in family planning services prior to the extension of the postpartum coverage.
- 4,470 individuals enrolled in only family planning services who had a pregnancy end within 12 months and are therefore eligible for postpartum coverage.

Demonstration objective and rationale

The proposed program (combined with ARPA SPA authority), if approved, align with the objectives of Apple Health and will enable Washington to:

- Reduce the maternal mortality and morbidity for Apple Health-enrolled individuals.
- Reduce the infant mortality and morbidity for Apple Health-enrolled individuals.
- Improve health outcomes for postpartum people and their children.
- Reduce racial and ethnic disparities in maternal mortality and morbidity.

The maternal mortality rate in the United States is the highest among developed countries at 17 deaths per 100,000 live births.³⁶ Washington State is ranked 17th in the nation in terms of maternal mortality, with a pregnancy-related mortality rate of 11 deaths per 100,000 live births. Nearly one-third of all

³⁶ CDC. Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017. Available at <https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm>; CDC. Maternal Mortality in the United States: Changes in Coding, Publication, and Data Release, 2018; and The Commonwealth Fund. Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries.

pregnancy-related deaths and many suicides and accidental overdoses in Washington occurred between 43 and 365 days postpartum.

Additionally, approximately 50,000 people across the country experience serious complications from childbirth each year, resulting in increased medical costs, longer hospitalization stays, and long-term health effects.³⁷

The maternal mortality and morbidity crisis, nationally and in Washington State, is disproportionately impacting BIPOC individuals. Nationally, non-Hispanic Black women are 2.5 times more likely to suffer a pregnancy-related death than non-Hispanic white women, and 3.1 times more likely to suffer a pregnancy-related death than Hispanic women.³⁸

In Washington, AI/AN individuals had a higher maternal mortality ratio than any other racial and ethnic group in the state from 2014 to 2016. The COVID-19 pandemic has further exacerbated existing health disparities and is expected to contribute—both directly and indirectly—to increased rates of maternal mortality and morbidity for BIPOC individuals.

In 2019, a Washington State Maternal Mortality Review Panel conducted a review of maternal deaths in Washington from 2014 through 2016. The panel concluded that at least 60 percent of pregnancy-related deaths were preventable. The panel identified access to health care services and gaps in continuity of care, especially during the postpartum period, as factors that contribute to preventable pregnancy-related deaths.

In their October 2019 report to the Legislature, the panel recommended ensuring funding and access to postpartum care and support through the first year after pregnancy. The panel also recommended addressing SDOH, structural racism, provider biases, and other social inequities to reduce maternal mortality in priority populations.³⁹

Medicaid is the single largest payer of pregnancy/births, covering over 42 percent of births nationally and 37 percent in Washington.⁴⁰ By combining Medicaid demonstration and ARPA SPA authorities to ensure continuous postpartum coverage, Washington will provide comprehensive coverage and care during the vulnerable postpartum period.

Continuous postpartum coverage will provide individuals with access to stable and consistent care through the first year postpartum—a powerful tool for improving maternal and infant health. This demonstration aligns with federal priorities related to improving maternal and child health and reducing maternal and infant health disparities for people of color.

Demonstration implementation

Washington State is seeking waiver authority to implement its demonstration-based postpartum coverage expansion starting January 2023. Washington is currently expanding postpartum coverage through the ARPA SPA option.

³⁷ CDC. Severe Maternal Morbidity in the United States. Available at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html#anchor_how.

³⁸ CDC. Maternal Mortality in the United States: Changes in Coding, Publication, and Data Release, 2018.

³⁹ <https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs//141-010-MMRPMaternalDeathReport2014-2016.pdf?uid=6255c7ced59c5>

⁴⁰ <https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22washington%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

1.4 SUD and MH IMD: supports for people receiving SUD and mental health treatment (new and continuing - formerly Initiatives 4 and 5)

Request

Washington requests to continue its use of expenditure authorities granted under Social Security Act Section 1115(a)(2) MTP demonstration (Project Number 11-W-000304/0) to receive federal matching funds for covered state plan services for Medicaid enrollees receiving SUD and mental health treatment services in IMDs. In addition, Washington requests new expenditure and waiver authorities to provide Contingency Management (CM) to qualifying individuals.

Policy/program description

Sec. 1905. [42 U.S.C. 1396d] of the Social Security Act restricts Medicaid FFP for services when individuals under 65 years of age are admitted to facilities with more than 16 beds, if more than 50 percent of the patients are admitted in order to receive psychiatric care. Such facilities are defined by the Act as IMDs.

Congress has traditionally withheld funding services in IMDs for adults between the ages of 21 to 65 years of age due to concerns ranging from creating dependence to the quality of care provided in such facilities. Limiting funding in this manner has led to access problems and expenses that impact the behavioral health system.

In 2017, CMS announced a Section 1115 demonstration waiver opportunity to expand access to SUD services with coverage of SUD IMD services conditioned on specified milestones.⁴¹ The following year, CMS announced a similar 1115 waiver opportunity and required milestones for IMD services intended for persons experiencing SMI/SED.⁴² CMS provided common tools and guidance in support of monitoring and evaluation for the SUD and SMI/SED waiver opportunities to promote study and comparisons of outcomes.

The goals and milestones of both waiver opportunities aligned with Washington's ongoing behavioral health system redesign, which aimed to create a system that is responsive, flexible, and tailored to the needs of each individual to reduce health inequities and improve health outcomes. In 2018 and 2020, Washington sought and was approved for the SUD and MH IMD waiver authorities, respectively.

Washington seeks continued expenditure authorities for both SUD and SMI/SED services delivered in IMDs. This flexibility will allow the state to continue improving care, expanding services, and support improved transitions between levels of care within the community.

These expenditure authorities are critical to sustain improvements to Washington's behavioral health system, which has been impacted by the opioid crisis and the COVID-19 pandemic. The state has aligned its SUD systems with all required milestones of the 1115 SUD waiver. The MH IMD waiver is being implemented and Washington is requesting to continue the opportunity to realize the full potential of this waiver opportunity.

Washington will leverage this authority to continue ongoing SUD and MH IMD work, such as:

- Assuring access to critical levels of care for OUD and other SUDs.

⁴¹ CMS. SMD # 17-003 RE: Strategies to Address the Opioid Epidemic, November 2017. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>

⁴² CMS. SMD # 18--011 RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance, November 2018. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>

- Using evidence-based, SUD-specific patient placement criteria.
- Improving care coordination and transitions between levels of care.
- Ensuring high-quality of care in psychiatric hospitals and residential settings through an ongoing partnership with DOH.
- Maintaining requirements around licensure and accreditation.
- Maintaining requirements around screening for and addressing comorbid physical health conditions and SUD.
- Ensuring that psychiatric hospitals and residential treatment settings provide intensive pre-discharge care coordination services.
- Implementing a process to assess the housing situation of individuals transitioning to the community and connecting those who are homeless or have unsuitable or unstable housing with community providers.
- Maintaining requirements for psychiatric hospitals and residential treatment settings to have protocols to ensure contact is made with each enrollee within 72 hours of discharge and to conduct additional follow-ups.
- Pursuing strategies to prevent or decrease the lengths of stay in EDs among enrollees with SMI or SED.
- Implementing strategies to improve health information technology (HIT) and develop and enhance interoperability and data sharing.
- Increasing the availability of non-hospital, non-residential crisis stabilization services.
- Implementing a system to track the availability of inpatient and crisis stabilization beds, as an integral part of the state's 988 crisis response system.
- Maintaining requirements that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool.
- Increasing integration to support early identification and engagement in treatment.
- Investing in specialized settings and services, including crisis stabilization services.

In addition, Washington seeks to pilot CM in a limited number of participating outpatient treatment sites for Medicaid enrollees with qualifying stimulant use disorders. Individuals in CM receive small motivational incentives for meeting treatment goals, which may include negative drug tests. CM is the most effective intervention for stimulant use disorders, proven to increase stimulant non-use and treatment attendance, and is a critical component of Washington's strategy to address rising stimulant and polysubstance use.

The CM pilot will provide small motivational incentives to qualifying Medicaid enrollees who demonstrate non-use of stimulants as evidenced by a negative urine drug test. Motivational incentives will be in the form of low denomination gift cards that qualifying enrollees can exchange for goods and services from a variety of retail stores. CM incentives will be subject to a cumulative limit of \$599 per 12-month period for qualifying individuals. Washington will provide training and implementation assistance to participating treatment sites to ensure they are prepared to administer CM.

Demonstration objective and rationale

The proposed program will enable Washington to maintain and expand access to a full continuum of SUD and mental health treatment services. Consistent with the objectives of the Medicaid program, the demonstration will:

- Assist Washington in increasing identification, initiation, and engagement in treatment of Apple Health enrollees diagnosed with OUD or other SUD and SMI.

- Increase adherence to, and retention in OUD/SUD/SMI treatment.
- Reduce overdose deaths, particularly those due to OUD and stimulant use.
- Reduce inappropriate or preventable utilization of ED and inpatient hospital settings through improved access to a continuum of care services in additional settings that, absent this proposed program, would be ineligible for payment for most Medicaid enrollees.
- Expand access to evidence-based treatment for Apple Health enrollees with stimulant use disorder through contingency management, the most effective intervention to support stimulant non-use.

Demonstration implementation

Washington seeks to continue its SUD and MH IMD programs as part of MTP 2.0. The state plans to provide behavioral health providers with EHRs and intends to fully implement by 2024. CM will be implemented mid-2023 and participation is expected to ramp up over the course of the proposed program. CM incentives will be subject to a cumulative limit of \$599 per 12-month period for qualifying individuals. Participating treatment sites have been identified and engaged in planning efforts over the past year.

Goal #2: advancing whole-person primary, preventive, and home and community-based care

Washington has a broad and deep history of efforts to achieve whole-person, value-based care for Apple Health enrollees. Through efforts over the last several years to integrate physical and behavioral health and implement VBP, the state has worked to streamline systems of care and work toward approaches that meet people where they are. Whole-person care efforts continue through hands-on assessment strategies, providing a template for providers to continue on the journey to integrate care and use person-centered practices.

Additionally, Washington has spent many years working to support people in the setting of their choice, especially older adults who depend on professional and informal caregivers to meet their needs. Led by ALTSA, programs and strategies continue to focus on removing the institutional bias that makes it simpler for a person to be cared for in an institution than in their own home or other setting of their choice. Work on these strategies is ongoing, and there is a continuing need for innovative approaches to meet the needs of these populations.

It is important to recognize the strategies below represent only a portion of the work Washington is leading and engaged in related to whole-person care and paying for health strategies. The 1115 waiver is an important vehicle but is specific to waiver of federal regulations and related waiver-dependent expenditure authority.

2.1 MAC and TSOA (continuing - formerly Initiative 2)

Request

Washington requests to continue its use of waiver and expenditure authorities granted under Social Security Act Section 1115(a)(2) MTP demonstration (Project Number 11-W-000304/0) to operate the MAC and TSOA programs. These included waiver and expenditure authorities to establish the MAC and TSOA program for individuals ages 55 or over, providing these enrollees with services not available under the Medicaid benefit package. In addition, waiver and expenditure authorities allowed Washington to support unpaid caregivers.

Policy/program description

Washington is a national leader in providing LTSS to help people remain in their homes and communities, saving billions of dollars over the past two decades. The state's LTSS system has sustained an AARP ranking of second in the nation for its high performance, while at the same time ranking among the lowest (34th) in cost. However, Washington's population is aging, which increases the number of individuals who will be in need of these services. By 2040, the number of people 65 and older will more than double.

As we age, we often need assistance with daily tasks, such as bathing and medication reminders to stay in our own homes and communities, rather than expensive institutional care. While Washington will continue to provide more intensive services to those who need them, the MAC and TSOA programs will help the state prepare for the "age wave." MAC and TSOA expand options for people receiving LTSS so they can stay at home and delay or avoid the need for more intensive services. MAC and TSOA also support family members in caring for their loved ones while increasing the wellbeing of caregivers.

MAC includes a benefit package for individuals who are eligible for Medicaid but not currently accessing Medicaid-funded LTSS. The benefit package provides services to unpaid family caregivers. It is designed to assist them with the necessary supports to continue providing high-quality care to their family member, while at the same time attending to their own health and wellbeing. Individuals who will be eligible for MAC must:

- Be age 55 or older.
- Eligible for Categorically Needy (CN) or Alternative Benefit Plan (ABP) services.
- Meet functional eligibility criteria for HCBS as determined through an eligibility assessment.
- Choose not to receive the LTSS Medicaid benefit currently available under optional state plan or HCBS authorities.

TSOA includes a benefit package for individuals "at risk" of future Medicaid LTSS use, who currently do not meet Medicaid financial eligibility criteria. Targeting this population is designed to help individuals avoid or delay impoverishment and the need for Medicaid-funded services. The TSOA benefit package provides services and supports to unpaid family caregivers as well as services and supports to individuals without unpaid caregivers. Individuals who will be eligible for TSOA must:

- Be age 55 or older.
- Not be receiving Medicaid coverage.
- Meet functional eligibility criteria for HCBS as determined through an eligibility assessment.
- Have income up to 400 percent of the Supplemental Security Income federal benefit rate.
- Have countable resources less than \$64,710 (the current monthly private nursing facility (rate of \$10,785 x six months). This amount will be adjusted annually based upon changes to the monthly private pay rate for nursing facilities.

MAC and TSOA include the following benefits:

- **Caregiver assistance services:** services that take the place of those typically performed by an unpaid caregiver.
- **Training and education:** assist caregivers with gaining skills and knowledge to care for the recipient.
- **Specialized medical equipment and supplies:** goods and supplies needed by the care receiver.
- **Health maintenance and therapies:** clinical or therapeutic services for caregivers to remain in their caregiving role or care receiver to remain at home.

- **Personal assistance services:** supports involving the labor of another person to help the recipient (TSOA individuals only).

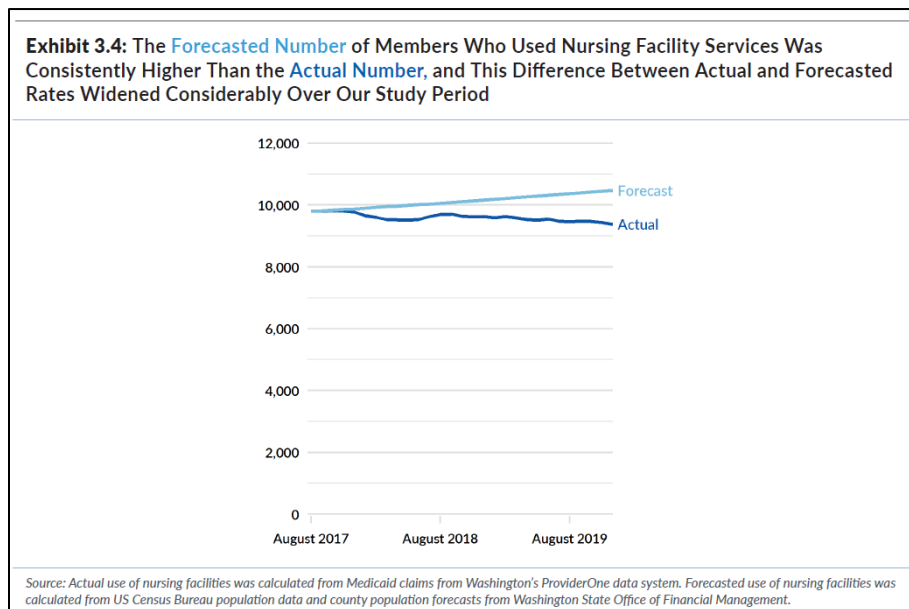
These two programs are essential for providing a cost-effective option to assist the growing number of aging enrollees receive the necessary supports to remain living in the community setting of their choice.

Enrollment in these two programs has increased over the first five years of the initial demonstration period, illustrating the demand for these services. At the same time, the state has observed slower growth in its traditional LTSS programs.

Oregon Health and Science University’s Center for Health Systems Effectiveness (CHSE), MTP’s independent external evaluator, noted in their Interim Report (December 2020)⁴³ that even though enrollment was slow in the beginning phases of implementation, enrollee satisfaction with MAC and TSOA was high. The evaluators discovered that before enrolling in MAC, individuals had high rates of ED visits, hospitalizations, and readmission rates. MAC enrollees showed fewer adverse health outcomes after receiving benefits under this program. Study results also concluded that “both programs have successfully targeted people with high needs for support care.”

CHSE shared in their Rapid Cycle-Monitoring Report (March 2022)⁴⁴ that MAC and TSOA may have contributed to the lower usage of nursing facilities since the implementation of these programs. This is illustrated in the figure below.

Figure 6: forecasted and actual number of members using nursing facility services



One of the final conclusions from the 2022 report indicates that “Washington State is likely to see a steady increase in the use of all LTSS as the population grows and ages. TSOA and MAC may help to offset this increase.”

⁴³ Oregon Health Sciences University, Center for Health Systems Effectiveness. Medicaid Transformation Project Evaluation. Interim Report. December 13, 2020

⁴⁴ Oregon Health Sciences University, Center for Health Systems Effectiveness. Medicaid Transformation Project Evaluation. Rapid Cycle Report. March 2022

Demonstration objective and rationale

This next generation system of care will help protect people's savings and provide more support for family members and other unpaid caregivers. These unpaid caregivers provide approximately 80 percent of care to people in need of LTSS. The majority of Washingtonians are uninsured for LTSS, with no affordable options for coverage. Individuals and their families often have no practical way to prepare financially for future LTSS needs, except by impoverishing themselves so they are eligible for full-scope Medicaid benefits.

To highlight the importance of supporting unpaid caregivers, if just one-fifth of these caregivers stopped providing care, it would double the cost of LTSS in Washington State. Providing care for a family member can be among the most rewarding things a person can do, but it also has challenges. A high proportion of caregivers show increases in stress and effects on their own physical and mental health. This demonstration request seeks to:

- Preserve and promote choice in how individuals and families receive services.
- Support families in caring for loved ones while increasing the wellbeing of caregivers.
- Delay or avoid the need for more intensive Medicaid-funded LTSS when possible.

Demonstration implementation

Washington seeks to continue operating MAC and TSOA in MTP 2.0 to ensure that these important program options remain available for aging enrollees and their families. The state will make minor changes to financial eligibility criteria to reflect updated standards in both programs and would change the income eligibility standard for TSOA.

2.2 Program innovations for LTSS (new)

HCA, as the state's Medicaid agency, works in collaboration with ALTSA to implement, and operate LTSS for the aged, blind, and disabled population in Washington State.

Home and Community Services (HCS), a division within ALTSA, strives to promote, plan, develop, and provide LTSS that are responsive to the needs of persons with disabilities and the elderly. Low-income individuals and families are given priority attention. HCS assists people with disabilities and their families in obtaining appropriate quality services to maximize independence, dignity, and quality of life.

HCS works with aging and disability advocates, including the State Council on Aging and Area Agencies on Aging (AAA), to ensure a client-focused service delivery system. HCS actively develops needed and innovative long-term care services in a variety of settings, including in-home and residential (such as adult family homes, assisted living, and adult residential care), to meet the preferences of older and younger people with disabilities.

HCS leads applicants through a person-centered planning process to determine functional and financial eligibility for programs and services. This process includes participation in an individualized assessment, which helps to determine support needs and client's choice of service(s), provider(s), and setting (in-home or residential).

2.2.1. Rental subsidies

Request

States do not have the authority to cover and pay for rent and rental subsidies under the Medicaid state plan. Washington State requests waiver expenditure authority to provide rental subsidies for a period of up to three years for Medicaid eligible individuals qualifying for LTSS offered through ALTSA who have more complex medical and behavioral health needs. After the three-year mark, those who have not yet

been able to obtain a federal housing voucher will be given a 100 percent state-funded subsidy until they are able to access a federal voucher.

Policy/program description

Housing is a well-documented SDOH. Research has linked housing instability to poor mental health, chronic illness, human immunodeficiency virus (HIV) and other infectious diseases, SUD, and high mortality. Individuals experiencing unstable housing also experience frequent hospital readmissions and place a burden on ED services.⁴⁵ Because of the relationship between safe housing and health, unstable housing contributes to unhealthier individuals and burdens health systems.

Health systems are important stakeholders in efforts to address SDOH, including housing instability. Study results highlight the need for greater focus on upstream strategies, funding consistency, and reliable evaluation of housing interventions performed by health systems. However, these results also raise concerns about the uncertainty of these interventions through the current pandemic and economic crisis.⁴⁶

As these foundational statements suggest, a more holistic approach to meeting an individual's medical needs is what Washington wants to achieve. Although rental subsidies are not a traditional medical intervention, they are a critical and evidence-based intervention to overcoming health disparities based on intergenerational poverty and related housing instability.⁴⁷

CMS and Washington have previously partnered through FCS under MTP 1.0 to demonstrate that supportive housing helps people live healthier lives and avoid more intensive and costly services. These innovative services are demonstrating the positive health effects that safe, secure housing can provide to people in need when paired with existing supportive services. Ensuring affordability of housing units through rental subsidies makes independent living a reality for AL TSA clients.

AL TSA currently receives legislatively authorized state general funds to offer rental subsidies (referred to as "the AL TSA subsidy") to individuals residing in institutional settings (nursing facilities and state hospitals) wishing to relocate to their own independent housing. When possible, Washington pairs state subsidies with supportive housing through FCS as part of the existing MTP demonstration. These state funds are extremely limited and can vary from one legislative session to another. This request for federal funding authorization for rental subsidies proposes to blend state and federal resources as detailed below, to create a collaborative and sustainable rental subsidies program.

Demonstration objective and rationale

The AL TSA subsidy enables recipients to transition into independent housing with a lease. As a result, recipients are able to receive cost effective in-home services while living in the community and applying for a permanent federal subsidy opportunity. In today's extremely competitive rental market, the wait to locate a permanent federal voucher can often be lengthy, sometimes extending beyond seven years.

AL TSA began supporting individuals with state-funded rental subsidies in 2012 by rebalancing funds from Washington's Money Follows the Person (MFP) grant. The AL TSA subsidy evolved and expanded in 2016, 2019, and again in 2020 with state-appropriated dollars. These vouchers have proven to be

⁴⁵ Prescribing Housing: A scoping review of health system efforts to address housing as a social determinant of health (Population Health Management, 2021)

⁴⁶ Prescribing Housing: A scoping review of health system efforts to address housing as a social determinant of health (Population Health Management, 2021)

⁴⁷ Health equity: Tenant-based housing voucher programs (Community Preventive Services Task Force, August 2021). Available at: <https://www.thecommunityguide.org/sites/default/files/assets/One-Pager-Housing-Vouchers-508.pdf>

successful in offering clients their choice of independent housing and providing cost savings for both the state and federal governments.

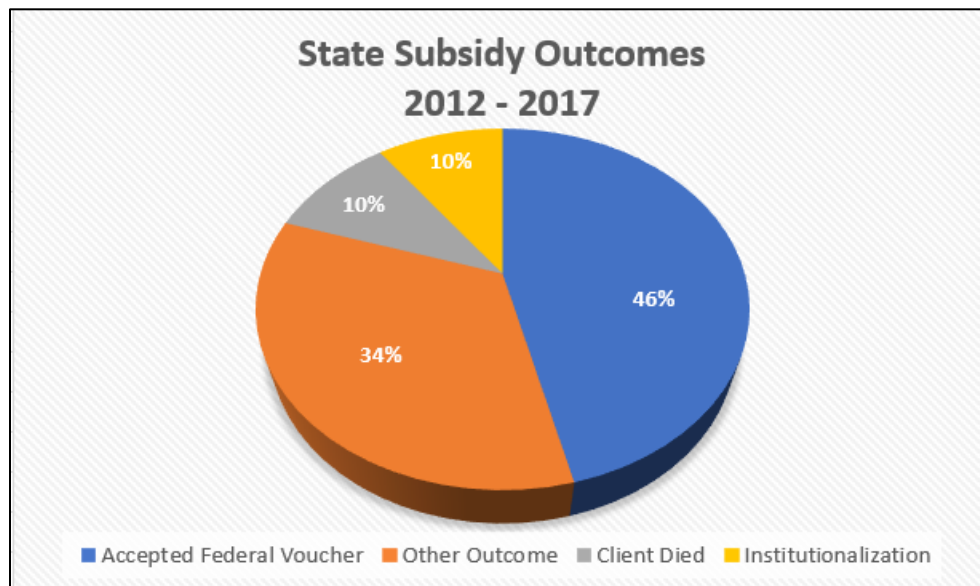
For those AL TSA subsidy clients who transition from skilled nursing facilities (SNFs) and state hospitals into their own home, the subsidy is very cost effective in comparison to SNF or state hospital expenses (data below from 2019 expenses):

Table 9: monthly cost savings associated with transitioning enrollees

Transitioning enrollees	Cost of institutional care	Costs of providing services to transitioning enrollees		Savings
		Cost of subsidy	Cost of LTSS supports	
From SNFs	\$5,808	\$755	\$2,238	\$2,815/month
From state hospitals	\$24,000	\$755	\$2,828	\$20,417/month

AL TSA partners with public housing authorities to transition clients from state rental subsidies onto federal vouchers (i.e., U.S. Department of Housing and Urban Development (HUD) Housing Choice Vouchers). Between 2012 and 2017, nearly half of all AL TSA subsidy recipients transitioned onto a federal voucher. These are not readily accessible, and it does take time for people to access them.

Figure 7: state subsidy outcomes



With the recent pandemic-fueled increase of new housing vouchers through the U.S. Department of Housing and Urban Development, AL TSA has seen an increase in the number of people transitioning from state-paid subsidies to federal support. Washington State hopes this trend continues.

Washington has been able to leverage recent MFP flexibilities to obtain federal funding for certain rental subsidies, though its reach is limited. During the course of the MFP grant, Washington State has been able to transition many original “demonstration” housing services and supports into the 1915c waivers and state plan. Under the new MFP guidance issued in March 2022 and effective in January 2022, MFP recipients may be offered up to six months of short-term rental assistance and associated utility

expenses to bridge the gap between when an MFP participant transitions to their chosen community-based setting and when federal, state, or local housing assistance is secured.

MFP participants fall within a narrow eligibility category, which requires that individuals enrolling in MFP must be discharged from an institutional setting where they have resided for at least 60 days. The state will be pairing the six-month MFP subsidies with FCS supportive housing services for those who are determined eligible. Yet, the need for rental subsidies extends well beyond this subset of the AL TSA FCS eligible population and well beyond the six-month mark.

To remedy this gap, Washington is requesting expenditure authority to provide rental subsidies to LTSS clients who do not meet MFP eligibility and choose independent living as their setting of choice. Particularly for individuals with complex behavioral and physical health needs, residential options (such as adult family homes and assisted living) are not always sustainable, resulting in frequent cycling between institutionalization, homelessness, emergency care, and failed placements. Independent living coupled with FCS and other LTSS offers an alternative to residential options and with these rental subsidies could mitigate a great deal of this cycle in a cost-effective manner.

Washington looks to MTP 2.0 to offer those seeking more independence up to three years of rental subsidies authorized under this Demonstration. After the three-year mark, those who have not yet been able to obtain a federal housing voucher will be given a 100 percent state-funded subsidy until they are able to access a federal voucher.

Through this demonstration, AL TSA seeks to offer rental subsidies to those who tend to have more complex medical and behavioral health needs as identified through their individualized assessment and fall under one of these three eligibility categories:

- Individuals in institutional settings eligible to receive AL TSA services who wish to transition to an in-home setting, but their limited income requires that they be able to access rental subsidies while they wait for affordable housing assistance.
- AL TSA clients requiring residential care who wish to live independently but have no viable path to move.
- AL TSA clients in the FCS Supportive Housing program under this demonstration (See 3.2) who need a rental subsidy in addition to FCS services to afford independent housing.
- Medicaid enrollees receiving rental subsidies under this Demonstration will have access to Medicaid covered state plan and waiver services that enable them to reside independently in the community. These services include, but are not limited to skilled nursing, specialized medical equipment/supplies, and independent skills training. Individuals with behavioral health conditions will also be connected to behavioral health services through their MCO. All AL TSA clients would also have access to any in-home LTSS needed, based on their individualized assessment.

Demonstration implementation

The policy, procedures, and mechanisms developed for these projects have been in place since 2013, when AL TSA began using MFP rebalancing funds to support housing and transitional needs for clients leaving institutional settings.

Since Washington has implemented a subsidy plan, AL TSA is fully prepared to extend MFP standards of quality assurance to these new housing subsidies, including:

- Coverage of a comprehensive set of housing-related services and supports, including pre-tenancy services, tenancy sustaining services, and home modifications.
- Develop, strengthen, and maintain partnerships with state and local housing agencies.

- Continue building local outreach and referral networks.
- Ensuring access to housing assistance once the housing coverage under the demonstration funding is no longer available, including for any individuals who do not qualify for federal housing assistance.
- Assuring that rental assistance is being administered by a state or local housing agency, rather than by the Medicaid agency or a Medicaid MCO.

With the existing and successful infrastructure created for the implementation of these housing services, if approved, HCA is confident, in partnership with AL TSA, that this project can be brought to scale with a proposed implementation in spring of 2023.

2.2.2 Coordinated personal care

Request

Washington is seeking expenditure authority to provide coordinated personal care services for Medicaid eligible individuals qualifying for LTSS offered through AL TSA. The proposed program would include allowing the state to waive the electronic visit verification (EVV) requirements that exist under the 1915c and 1915k authorities.

Policy/program description

Personal care services provide one-to-one assistance to individuals, either hands-on or through verbal direction, to accomplish tasks of daily living (eating, bathing, dressing, etc.) that people cannot perform without assistance.

Washington has built a well-developed personal care service delivery system that allows enrollees the flexibility to choose between individual providers, hired and supervised directly by enrollees, and caregivers who are paid and supervised through personal care agencies. Some enrollees use a combination of home care agency workers and individual providers to receive the necessary services. These services are provided as part of a care plan created to meet an enrollee's individual needs.

As provided currently, personal care service delivery is structured to:

- Meet specific needs of individual enrollees.
- Be delivered in a 1:1 fashion.
- Be scheduled based on a care provider's availability and the enrollee's preference.

Today, enrollees in Washington requiring in-home care can choose to receive services through a licensed home care agency or an individual provider. In-home care enrollees are authorized a specific number of hours per month based on their functional impairments and unmet needs. To schedule services, home care agencies generally convert the monthly hours into a weekly schedule, dependent on client need/preference. Caregivers are then identified who have the skill and availability to meet the enrollee's needs and schedule.

Services are typically scheduled in weekly blocks of time based on the number of authorized monthly hours. The focus of the care plan is to assist the enrollee with authorized activities of daily living and instrumental ADL within the scheduled visit. The caregiver works for the enrollee during assigned intervals, anywhere from one to seven times per week, depending on the number of authorized hours. The caregiver is available to meet the enrollee's needs when they are there. Once the shift is over and the caregiver has left, the enrollee has little, if any, access to paid caregivers.

There are several barriers and limitations within this one-to-one service delivery model today, including:

- Challenges to accommodate schedule changes

- Difficulty meeting the unscheduled or urgent needs of enrollees.
- Lack of access to services outside of scheduled appointments.
- High turnover rates for home care agency aides.

In-home personal care is key to supporting a growing number of people who wish to age in place, as well as younger people with disabilities who want to live independently. It is one of the most important tools, in the array of LTSS that ALTA has, to help people live independently in their own homes.

A large part of Washington’s success in serving enrollees in a community-based setting rather than in institutional settings is based on the availability of personal care for the in-home setting. The state seeks to provide in-home personal care—coordinated personal care—to those living in an in-home community setting within close proximity to other eligible care recipients and who may need short-term support more than once a day. These individuals would be eligible for state plan personal care services or Community First Choice personal care services.

The coordinated personal care model is designed to improve personal care service delivery based on geographic efficiencies of scale, while retaining the individual nature of personal care services. The benefits of using this service delivery model are:

- Using a person-centered approach that aligns with when enrollees need the assistance and when they are ready and available to receive assistance.
- Increasing client satisfaction, as seen in the long-running Cluster Care pilot. (More information on this pilot is included below.)
- Increasing utilization of authorized personal care hours for enrollees on services, reducing no-shows and lowering levels of unmet needs.
- Better utilizing currently limited caregiver resources and increasing client satisfaction, as seen in the long-running Cluster Care pilot.
- Providing opportunities for increased supports for medication management, hygiene, and nutrition, as well as cognitive check-ins and reduction in symptoms of anxiety.
- For enrollees having challenges with retaining housing, this model can be instrumental in providing enough support to maintain long-term independence in a community setting.
- Increasing caregiver efficiency and providing more consistent paid work hours with less travel time.
- Supporting enrollees who struggle with maintaining relationships with their caregivers.
- Supporting aging in place as increasing needs can be accommodated more easily over time.
- Proactively minimizing an enrollee’s need for emergency medical interventions by promoting ongoing communication of health and behavioral concerns as they arise.
- Increasing caregiver longevity and stability and providing the supports of a team-based approach in service delivery.

Demonstration objective and rationale

The demonstration will support a growing number of people who wish to age in place, as well as younger people with disabilities who want to live independently in the community. MTP 2.0 seeks to illustrate efficiencies in personal care service delivery, and improvements in enrollee and caregiver satisfaction, by using a model where personal care hours are delivered to enrollees living in proximity to one another.

In 1997, Cluster Care was being modeled in New York, Massachusetts, and California. Based on this research, and a pilot project that has been running since March 1999 in Washington, Cluster Care seems to have the following advantages over the “one-to-one” models of care:

- Increased enrollee access to services by making services available seven days a week for extended times of the day.
- Increased number of days per month and times per day enrollees can be seen without an increase in costs. In the first year of the pilot, enrollees were seen an average of 2.5 times per day. The average number of days enrollees received services in a month increased from 13.17 to 25.
- Increased enrollee satisfaction.
- Improved enrollee safety and service oversight by increasing the number of times enrollees received services each day and each month.
- Increased ability for enrollees to age in place. Enrollees were able to remain independent in their homes longer and return home from hospital stays more quickly due to the availability of care seven days a week.
- Increased home care aide availability and reduced turnover. Aides reported higher job satisfaction.
- Improved service efficiency. Staffing levels in the first year of the pilot ranged between 70-80 percent of authorized hours.
- Maintained or reduced costs while improving service delivery.
- Non-Medicaid residents within the building were able to purchase hours through the Cluster Care model. Due to economies of scale, the home care agency allowed private-pay residents to purchase hours in half-hour increments rather than the minimum of two to four that is standard in the industry.

Demonstration implementation

There are many apartment buildings in Washington that have a sufficient number of residents who are Medicaid enrollees with sufficient authorized hours to make a coordinated personal care model work, if most of the enrollees were with a single provider. To be viable from an enrollee's perspective, coordinated personal care must provide more flexibility and access to care than what they currently receive. Higher volumes of hours with a single provider would also enable agencies to attain efficiencies in the service delivery model. In the Cluster Care pilot, the home care agency reported savings in recruitment, training, and travel time costs associated with the project.

For implementation, AL TSA would collaborate with both the FCS Supportive Housing network to determine where a consolidation of enrollees needing in-home care reside and with contracted home care agencies who serve in those areas. Washington proposes implementation of the coordinated personal care services model in summer of 2023.

2.2.3 Guardianship and decision-making supports

Request

Washington is seeking expenditure authority to provide guardianship and legal decision-making supports for individuals qualifying for LTSS offered through AL TSA.

Policy/program description

Guardianship services are performed by the Office of State Guardian on behalf of individuals who have no family members or friends willing, able, or suitable to help them. These duties include ensuring the person resides in a place that will meet their needs, providing consent for medical and financial decisions, as well as providing supported decision making for ADL.

The Office of Public Guardianship (OPG) acts as a conduit to provide qualified surrogate decision-makers for low-income adults in need of guardianship and/or conservatorship. The OPG contracts with certified

professional guardians and conservators to provide guardianship and/or conservatorship services when no one else is willing or able to serve.

Established in 2007 as a pilot program, OPG originally served enrollees in five counties (Clallam, Grays Harbor, Okanogan, Pierce, and Spokane). The program was expanded to serve King County in 2009, Snohomish County in 2010, and Clark, Kitsap, and Thurston counties in 2011. The program was permanently funded in 2019 and is now available statewide.

In 2011, the Washington State Institute for Public Policy reported that an estimated 4,000-5,000 individuals are in need of and eligible for public guardianship/conservatorship services. Currently, the OPG has capacity to serve two to three percent of this estimated need.

Some individuals seeking discharge from state hospitals, acute care hospitals, and SNFs to LTSS have health and/or behavioral health conditions that impact their ability to make informed decisions and may require a legal guardian or other decision-making supports. The process of establishing guardianship takes time.

It is further complicated when there is not a family or friend of the individual who is able to step in to perform these functions, and professional services are needed. Locating a supported decision-maker or guardian who will accept this role for an individual who is high-risk or has high needs and may not have the income to pay for the service often means these individuals remain stuck in institutional settings.

HCS is responsible for the transition of individuals from state hospitals, acute care hospitals, and SNFs into the community if those individuals need LTSS. The support of guardianship is needed to make informed decisions for the health and safety of the individual and is often a barrier to discharge to a less restrictive setting. It can take up to 60 days to establish a guardianship; sometimes it may take longer. This creates a barrier to discharge to the appropriate level of care and prolonged stays in an inpatient setting when the individual no longer requires this level of care.

Although Medicaid allows some limited reimbursement for guardians out of the enrollee's own income, if the enrollee contributes toward the cost of their care, this allowance does not cover the total amount of initial establishment costs and legal fees. For low-income Medicaid enrollees who do not have sufficient income to pay guardian fees, it is difficult to find a guardian, and OPG has limited resources to meet the demand for guardianship services.

Demonstration objective and rationale

Access to guardianship at discharge from state hospitals, acute care hospitals, and SNFs ensures enrollees who have health or behavioral health conditions have the ability to compensate a guardian to assist with these complicated transitions. It will reduce some of the barriers to discharge and will support an enrollee's transition to a less-restrictive, more appropriate setting of their choice. Any delay in appropriate discharges extends an individual's stay in a more restrictive setting places a burden on health care systems and increases costs for the state and federal Medicaid partners.

Demonstration implementation

Currently, HCS does not have the authority to compensate guardians at the state's expense; individuals can only use their own resources to compensate their guardianship needs. Authority through a Section 1115 demonstration would be used to fund OPG programs and staff. It would compensate OPG-contracted guardians who provide the decision-making support during these times of transition, where a guardian may be necessary to provide informed consent for transition and medical care purposes. Washington proposes an implementation date in fall of 2023.

2.2.4 LTSS Presumptive eligibility

Request

Washington is seeking expenditure authority to utilize presumptive eligibility (PE) for individuals applying for LTSS offered through ALTSA. Washington requests that expenditures for LTSS PE services be allocated to the corresponding 1915(c), 1915(k), and state plan Medicaid Personal Care (MPC) programs and excluded from the budget neutrality calculation.

Policy/program description

PE allows the state to accept an applicant's attestation of income and resources and a physician's statement of disability for the applicant to receive Medicaid benefits and LTSS while a full eligibility decision is being determined. A presumptive functional eligibility assessment will determine if the individual appears to meet nursing facility level of care (NFLOC) or MPC level of care as defined in state rule.

Washington residents should have the same opportunity for timely access to community based and in-home LTSS as they have to Medicaid institutional services. HCS is responsible for determining functional and financial eligibility for residents to receive community based LTSS. Both the functional and financial eligibility processes under current CMS rules must be completed prior to the authorization of services and ability to pay for services through Apple Health.

Financial eligibility for Medicaid-funded LTSS requires verification of income and assets, including any inappropriate transfer of assets and home equity and a disability determination for those not already determined disabled, age 65+, or blind. Functional eligibility requires a face-to-face assessment, review of medical records, and collaboration with the enrollee, their family, and contacts. This assessment determines if functional impairments are due to mental health issues, dementia, and other diagnoses. and the creation of a person-centered service plan prior to authorization of services.

Administered by the state or its delegate, under this proposed program, services will be offered to individuals who have been determined presumptively eligible through either the NFLOC PE benefit package or the MPC PE benefit package. Both benefit packages, outlined below, will be offered to individuals through a person-centered planning process. Individuals who later become CN or ABP Medicaid-eligible will no longer be eligible for LTSS PE services.

Services offered under these benefit packages will not duplicate services covered under private insurance, Medicare, state plan Medicaid, or through other federal or state programs. LTSS PE services will be terminated at the end of the PE period when individuals are later determined not to meet CN or ABP eligibility criteria.

The **LTSS NFLOC PE benefit package** will include a subset of services available under the 1915(c) Community Options Program Entry System (COPES) waiver and the 1915(k) Community First Choice state plan option:

- Personal care services (in both residential and in-home settings), which are included in the EVV system implementation.
- Nurse delegation.
- Personal Emergency Response System (PERS) for individuals living in their own home.
- Home-delivered meals (limit of two per day) in settings where the individual is directly responsible for his or her own living expenses.
- Specialized medical equipment and supplies.
- Assistive/adaptive technology and equipment.

- Community transition or sustainability services, which are nonrecurring goods and services, set-up items and services that assist with a move from an acute care hospital, or diversion from a psychiatric hospital stay to an in-home setting. These may include:
 - Security deposits that are required to lease an apartment or home.
 - Activities to assess need, arrange for, and obtain needed resources, including essential household furnishings.
 - Set-up fees or deposits for utility or services access, including telephone, electricity, heating, water, and garbage.
 - Services necessary for health and safety, such as pest eradication, and one-time cleaning prior to occupancy.
 - Moving expenses.
- Minor home accessibility modifications or improvements that are of direct medical or remedial benefit to the participant and are not of general utility. Modifications that add to the total square footage of the home are also excluded from this benefit, except when necessary to complete the modification.
- Community choice guide: specialty services which provide assistance and support to ensure an individual's successful transition to the community-based setting and/or maintenance of independent living.
- FCS Supportive Housing services, defined in WAC 182-559-150, which include an active search and promotion of access to and choice of safe and affordable housing that is appropriate to the enrollee's age, culture, and needs.

The **LTSS MPC PE benefit package** will include:

- Personal care services (in both residential and in-home settings) which are included in the EVV system implementation.
- Nurse delegation in licensed residential settings (adult family home and assisted living facility).

Individuals applying for in home and community based residential LTSS PE will need to attest to meet:

- The functional eligibility criteria for HCBS
- 1915(c) criteria:
 - State residency
 - Social security number (SSN)
 - Aged, blind, or self-attestation of disability
 - The individual's separate non-excluded monthly income is equal to or less than the Special Income Level or net available income is no greater than the effective one-person medically needy income level.
 - The individual's separate, non-excluded resources are at or below \$2,000, or for a married couple, that non-excluded resources (calculated as of the first point at which the individual is deemed to have the status of an "institutionalized spouse") are at or below a combination of \$2,000, plus the current state Community Spouse Resource Allowance, based on the individual's self-attested statement of their household resources.
- 1915(k) criteria:
 1. The client is a current recipient of CN or ABP Medicaid coverage
 2. State residency
 3. SSN

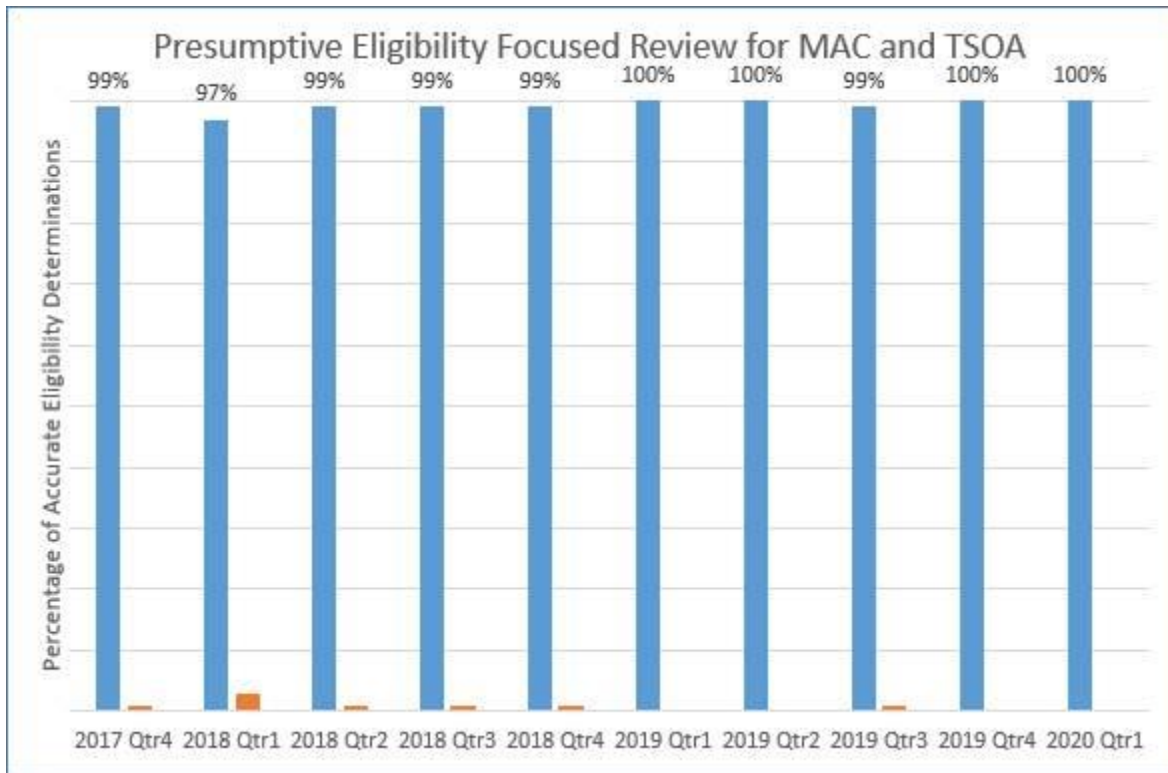
4. The applicant is aged, blind, or self-attestation of disability
5. The single individual's non-excluded monthly income is equal to or less than the Categorically Needy Income Level (CNIL) or, for a married couple with non-institutional spouse, the individual's non-excluded income is equal to or less than the CNIL with spousal impoverishment protections.
6. The individual's separate non-excluded resources are at or below \$2,000, or for a married couple with a non-institutional spouse, that non-excluded resources (calculated as of the first point at which the individual is deemed to have the status of an "institutionalized spouse") are at or below a combination of \$2,000, plus the current state Community Spouse Resource Allowance, based on the individual's self-attested statement of their household resources.

Demonstration objective and rationale

Extending PE to cover individuals applying for in-home and community based residential LTSS would mean applicants would be able to access immediate, essential services prior to a final financial eligibility determination and a full functional eligibility assessment. This would mitigate the institutional bias that currently exists in Medicaid. This PE extension would include access to appropriate LTSS through Community First Choice, state plan MPC, and 1915(c) waivers and Medicaid medical coverage.

ALTA has demonstrated successful use of the PE process for nearly six years as part of the MAC and TSOA programs under the current MTP demonstration, as seen below.

Figure 8: presumptive eligibility focused review for MAC and TSOA



Demonstration implementation

To provide an expedited process similar to the MAC and TSOA PE process that would cover individuals needing in-home and community based residential LTSS, Washington believes an 1115 demonstration is the best option. It is necessary that individual providers, home care agency providers, and community residential providers—vital partners in the LTSS delivery system—are confident in accepting PE enrollees during these transitions. Guaranteeing timely payment to providers supports equal opportunity in access to services. Washington proposes implementation in early 2023.

2.3 WA-ICA (new)

Request

Washington is seeking new federal expenditure authority to support provider clinical behavioral health integration assessment, technical assistance and coaching, and targeted provider incentives for clinical integration.

Policy/program description

This program builds upon the successful implementation of IMC during the initial MTP demonstration and recognizes the ongoing importance of integrated physical and behavioral health care. During the first five years of MTP, clinical integration was secondary to financial and administrative integration, which required significant coordination and implementation as foundational to achieving IMC. With the successful implementation of IMC statewide in January 2020, Washington is well-positioned to continue advancing a centralized effort for physical and behavioral health integration at the provider level.

In the past, many health care providers completed integration assessments through their ACHs or MCOs. The purpose of these assessments was to determine levels of integration within a practice and identify where coaching support may be needed. However, without a standard assessment tool and more robust assessment support, gaps would remain, and assessments would be inconsistent and redundant.

The standard assessment process will address gaps and inconsistencies, allowing partners and the state to clearly define and track progress.

HCA, ACHs, and MCOs formed an Integration Assessment Workgroup in July 2020 to work together—in consultation with Washington providers—to identify a standard assessment for clinical integration for the outpatient physical health and behavioral health settings and create an implementation plan for deploying the tool. The work evaluated a number of tools, including the Maine Health Access Foundation (MeHAF) integration assessment tool leveraged in ACH projects under MTP.⁴⁸

The workgroup ultimately selected the WA-ICA, an evidence-based practice self-assessment of clinical integration, which is based on the assessment tools developed in New York State by Dr. Henry Chung and colleagues.⁴⁹ Washington began a soft launch of the new integration assessment tool in 2022 and under MTP 2.0, is requesting support to continue and scale implementation of the tool.

⁴⁸ Over the course of 2018-2021 progress was observed among participating sites, showing movement from “limited” toward “moderate” integration levels. HCA analysis of self-reported MeHAF results showed a 36% increase in overall integration of primary and mental/behavioral health care, but it is important to note that the MeHAF pilot was limited to approximately 600 unique provider sites. The Integration Assessment Workgroup considered these limitations tied to MeHAF in assessing behavioral health sites in its decision to implement the WA-ICA.

⁴⁹ Work of Dr. Henry Chung and colleagues is summarized in these reports: [Continuum-based Framework for Behavioral Health Integration into Primary Care](#) and [Continuum-based Framework for General Health Integration into Behavioral Health](#)

This demonstration will allow the state to develop a centralized, HCA-administered process for provider behavioral health integration assessment. This will include assessment template deployment, assessment support, data collection and analysis, and targeted practice coaching. In addition, the program will include a limited incentive pool to support smaller practices advancing along the integration continuum.

This incentive strategy will prioritize small to medium-sized practices, including rural providers and behavioral health providers in historically marginalized communities. The existing WA-ICA supports provided by ACHs under MTP would phase out after 2022 without MTP 2.0 funding.

Demonstration objective and rationale

Through WA-ICA, Washington is proposing a whole-person approach to care by supporting providers in addressing physical and behavioral health needs in one system. This approach offers better coordinated care for patients and more seamless access to the services they need through team-based care, co-location, and other processes to support integrated care. Washington has made significant progress in VBP, but the state recognizes there is limited capacity among providers and clinical sites related to integrated care models and practices, especially behavioral health providers and other small to mid-sized sites.

Demonstration implementation

Washington began a soft launch of the new integration assessment tool in 2022 and is requesting demonstration expenditure authority to continue and scale implementation of the tool and related technical assistance resource and funding in 2023. Practice sites will be phased in through provider cohorts in six-month intervals from 2023-2025.

A practice incentive strategy will be implemented, beginning mid-2023, including criteria for targeting incentives. In addition, ACHs will identify practices that require coaching and technical assistance support. Part of this strategy is to incentivize practices to advance along the integration continuum. ACHs, in their regional convening and health equity initiative planning roles, will be asked to support prioritization of incentives and coaching, as needed.

Practice coaching will be implemented through a combination of methods, including virtual and in-person learning opportunities. Washington will contract with a central organization to manage, coordinate, support, and route funding for practice coaching opportunities. In addition, the state will contract with an organization to support centralized data management functions, such as template deployment, data collection and analysis, and reporting. ACHs will be asked to support provider communications, engagement, incentive distribution, and coaching and technical assistance, as needed.

Goal #3: accelerating care delivery and payment innovation focused on HRSN

During the MTP demonstration period, Washington worked to develop and build capacity within and across the nine regional ACHs, as well as partnerships with Tribes and IHCPs, MCOs, and traditional and nontraditional Medicaid providers. These investments have formed a strong foundation of locally driven engagement with communities in policy design and program implementation. Concurrently, through FCS, Washington tested the provision of a targeted set of housing and employment supports for high-risk Medicaid recipients with complex physical and/or behavioral health needs with promising early findings on reductions in hospitalizations and ED utilizations.

Through the implementation experience of FCS, HCA, in partnership with ALTA, has created a comprehensive network of housing and employment supports across Washington, resulting in increased and more reliable access to these critical SDOH. It is clear that the need for these services continues, with additional groups identified who could benefit from these services and supports. (The FCS program is discussed further in Section 3.2.)

Washington’s experience with MTP and COVID-19 underscored the:

- Connections needed to support the whole person.
- Impact of HRSN (e.g., food and nutrition, housing and utilities, transportation) on health outcomes.
- Importance of strengthening engagement and capacity of community-based partners.
- Importance of adding infrastructure and support for addressing HRSN.

Washington seeks to leverage Medicaid to coordinate, resource, and support HRSN. This will better position the state to reduce disparities, sustainably and systematically improve population health, and reduce avoidable Medicaid costs.

3.1 Taking Action for Healthier Communities (TAHC) program (formerly Initiative 1 - evolving)

To achieve a system that cares for the whole person and advances health equity, Washington will build on the groundwork laid through MTP and further invest in multi-sector, community-based partnerships and approaches to better support individuals and families, clarify system roles, and reduce administrative complexity. Through the 1115 waiver authority—and complemented by other Medicaid state plan and managed care authorities—Washington is establishing the TAHC program.

TAHC will offer a comprehensive approach to strengthening and expanding community connections to HRS and supports proposed under this 1115 demonstration; these include the continuing LTSS and FCS⁵⁰ initiatives (described in Sections 2.2 and 3.2, respectively), as well as an expanded menu of HRS for both managed care and FFS enrollees described in this section, to address a broader range of health-related needs.

By supporting meaningful connections among communities, service providers, and managed care plans, TAHC will ensure that: Medicaid enrollees are able to access the services they need; care across the health care and HRS continuum is coordinated; and regional capacity to offer these services grows over time. This vision is critical to Washington’s goals of addressing long-standing underinvestment in marginalized communities and populations, removing systemic barriers to health, and advancing health equity.

Described below are the four components of TAHC:

- Community-based care coordination hub for HRS (Community Hubs and Native Hub)
- HRS
- Health equity programs
- Community-based workforce

⁵⁰ hca.wa.gov/about-hca/medicaid-transformation-project-mtp/initiative-3-foundational-community-supports-fcs

Washington’s regional ACHs will play a critical implementation role within the TAHC program, and the four components outlined above. ACHs are uniquely positioned in supporting strong community engagement and multi-sector collaboration. They provide a lens that recognizes the importance of health equity and SDOH.

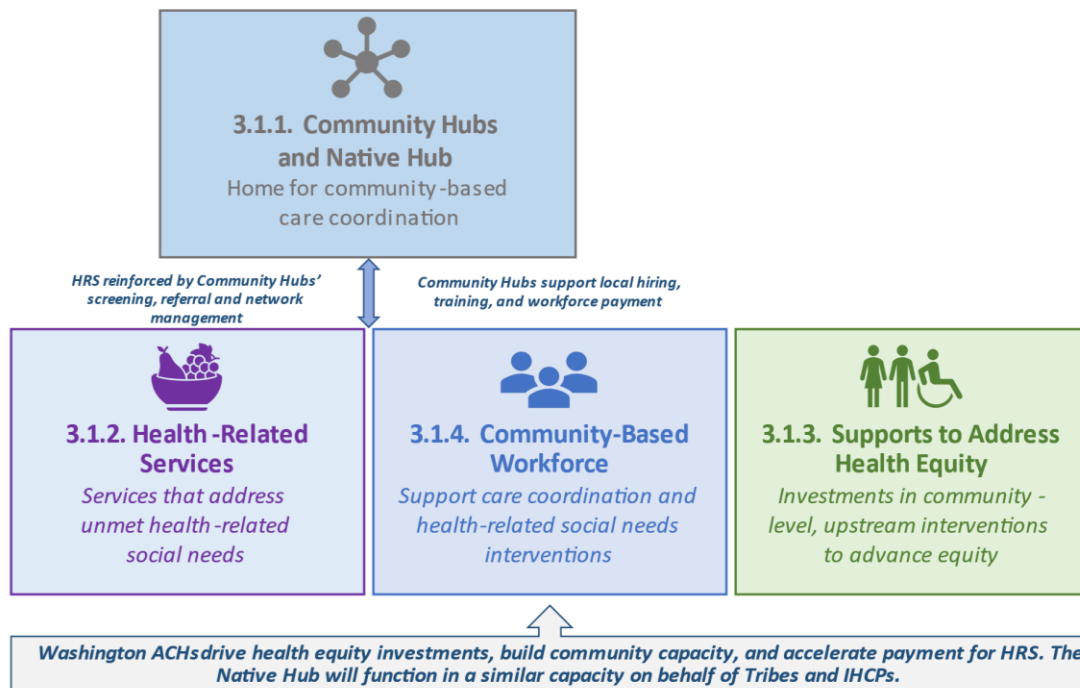
The core ACH functions of community engagement, convening, strategy development, and program management will be required to realize the goals of the TAHC program. Leveraging these strengths and the capacity developed over the course of MTP, ACHs will oversee:

- Community Hubs, including design and maintenance of screening, referral, and follow up processes.
- CBO capacity building and network development, and other facilitation and collaboration to support HRS.
- Local, community-based initiatives to reduce disparities and advance health equity.
- Regional strategies for community-based workforce expansion.

ACHs are an integral part of the Washington’s Medicaid transformation efforts. There are nine ACHs covering the state, each serving a distinct region. Each ACH is unique, but they share a common approach to improving the health of their communities and transformation of health care delivery. They are all tackling complicated problems through cross-sector collaborations and investments in innovative approaches.

—Washingtonach.org

Figure 9: TAHC diagram



3.1.1 TAHC: Community Hubs

Request

Washington requests expenditure authority for the development and operation of Community Hubs and a Native Hub. These hubs are centers for community-based care coordination that focus on HRSN that will provide screening for and referral to community-based services for Apple Health enrollees. Hubs will collaborate with other existing care coordination entities.

Policy/program description

The Community Hub is an evolution of work that began in MTP—embedded within the ACH infrastructure—and will align with recent efforts by DOH’s Care Connect Washington program.⁵¹

MTP and Care Connect funding established a solid foundation of CIE that TAHC will leverage and expand upon to ensure Community Hubs have effective data sharing capabilities between CBOs and health care organizations.

The state will explore managed care flexibilities and contracting levers to support increased payment for community-based workforce through the Community Hub model. This demonstration will provide an implementation path that will be reinforced through MCO contracts and other accountability mechanisms, including the development of definitions and standards to support training and payment of community-based workers. (See 3.1.4 for further discussion on community-based workforce under TAHC.)

It is important to note that ACHs are not evolving into Community Hubs. Rather, the ACH organizational infrastructure will remain, and each ACH will oversee, manage, and coordinate Community Hub functions. These functions will be performed by an ACH or entity contracted by the ACH.

Community Hubs will use CIE and resource and referral processes to support the coordination of and connection to community resources and organizations for Apple Health enrollees. Community Hubs will be instrumental in identifying unmet needs within the community and at the individual level.

Community Hubs will work with networks of community organizations to ensure individuals are connected to the needed community services and supports, including promoting and coordinating HRS, as the state looks to expand services that address unmet social needs throughout Washington.

Hub governance and oversight: 10 Community Hubs will be established in total—nine overseen by existing ACHs—and a Native Hub that will be developed and overseen by a to-be-determined entity. HCA will partner with Tribes to identify and select the appropriate Native Hub oversight entity. Guidance and coordination for creation of the Native Hub will be provided through the Governor’s Indian Health Advisory Council to serve the state’s tribal community statewide, in recognition of the government-to-government relationship with Tribes and tribal sovereignty.

Each ACH will be responsible for developing and managing the functions of a Community Hub. Washington’s current managed care system has up to five MCOs per region. Community Hubs will offer regional efficiencies of delivering a suite of community-based navigation and referral services through a “no-wrong-door” approach: an Apple Health member (FFS or managed care) would receive these services through regional Community Hubs, and the Native Hub would serve AI/AN individuals who are often enrolled as FFS enrollees.

The state will leverage the strengths of MCOs and ACHs in the development of regional Community Hubs. For example, MCOs have the ability to efficiently develop and operate payment mechanisms. ACHs focus on prioritizing and meeting community needs and work across organizations and sectors to

⁵¹ <https://doh.wa.gov/emergencies/covid-19/care-connect-washington>

achieve alignment. This enhanced partnership between ACHs and MCOs will provide statewide alignment that builds upon the strengths of each to increase the delivery of services by community organizations.

Table 10: Community Hub and Native Hub roles

Function	MCO Strengths	Community Hub (and the network of community organizations) Strengths	Native Hub Strengths
Care coordination	Clinical care coordination and complex case management	Community navigation, resource, and referral coordination; and community-based workforce recruitment, training, and capacity building	Tribal care coordination, including community navigation, resource, and referral coordination
Payment	Payment for community-based workforce through Community Hubs (to be phased in)	Training, contracting, and reimbursement support for community-based organizations along with managed care payment (as waiver payments are phased out)	Tribal contracting and reimbursement of community-based workforce through demonstration payment
Data and information exchange	Aligned standards, SDOH screening, and resource/referral processes (two-way); economies of scale and alignment to mitigate duplication and vendor fatigue; and eligibility data and information exchange		Work on tribal data and information exchange will involve close partnerships with tribes, IHCPs and AIHC to address governance and Tribal data sovereignty

Hub functions: Community Hubs will augment the state’s existing clinical care coordination infrastructure, connecting individuals to community resources and organizations that address social and preventive care needs, including primary care. Community Hubs will provide vital support to both the health system and the community through the following standardized functions:

- Identify and engage individuals who are likely to have multiple health and social needs.
- Screen individuals for SDOH needs and determine the appropriate organizations with the resources and knowledge to address those specific needs.
- CIE that connects and enables data sharing between MCOs, CBOs, providers, Tribes, and care coordinators, including programs like FCS and LTSS.
- Receive and close referrals for FCS, LTSS, and HRS, as well as local organizations and programs that can meet HRSN (Supplemental Nutrition Assistance Program (SNAP), Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), food pantries, AAAs, etc.).
- Support and maintain a network of partners (e.g., CBOs) to provide HRS and participate in Community Hub referrals to respond to social needs.
- Connect Apple Health enrollees and their families with the appropriate partners to address identified SDOH needs.
 - Facilitate community-based workforce (e.g., CHWs) payment through contracts with CBOs.

- Contract with a network of community partners and facilitate FFS payment to these nontraditional providers and reinforcement to address capacity limitations.
- Follow-up to ensure patients are connected and facilitate completion of the SDOH interventions or other referrals, including referrals to MCO care management, primary care, etc.
 - Track outcomes of patients receiving community-based services.

Populations of focus: while this model will eventually serve as a shared resource to all Medicaid enrollees in need of these services, Washington will stage implementation of the Community Hub based on populations of focus, which could include the following:

- Individuals transitioning out of the criminal justice system or state hospitals and IMDs.
- Pregnant individuals and families with young children up to age six.
- Individuals and families impacted by SUD.
- Youth and their family members experiencing unmet social needs.
- Individuals and family members impacted by local public emergencies and adverse events, including adverse climate events.

These populations align with the populations of focus in other MTP 2.0 policies and programs. This will create greater alignment across strategies and allow the state and partners to develop additional experience addressing the needs of specific populations and evaluating interventions. Over time, additional populations may be added as Community Hubs are able to scale and sustain their services.

Hub funding: under MTP 2.0, Washington is requesting funding to support the development and operations of the Community Hubs:

- **Planning, development, and implementation funding** will help the state develop or expand the infrastructure to support: screening for needs, building a referral network, and tracking progress (e.g., governance structure refinement, data and IT for screening tool and referrals, ongoing tracking, and oversight). Planning will include the development of definitions, standards, and contracting arrangements necessary to sustain payment through managed care in future years. HCA will outline the key milestones that ACHs will need to reach during the first year of MTP 2.0 (2023, also referred to as DY7) to implement Community Hubs in DY8 (2024). Additionally, HCA will partner with Tribes and IHCPs to ensure appropriate preparations occur for implementation of the Native Hub. Each ACH and the Native Hub oversight entity will submit an implementation plan to HCA detailing existing readiness and plans to meet the specified milestones. HCA will determine the amount and timing of the development and implementation funding based on those implementation plans.
- **Operational funding** will support ongoing operations of the Community Hubs, such as conducting identification and screening activities, maintaining referral network, and training of community-based workforce. Similar to planning, development, and implementation funding, HCA will outline key milestones that ACHs and the Native Hub oversight entity will need to demonstrate.
- **CBO capacity building funding** will be distributed by the Community Hub to increase capacity of CBOs and community-based providers across the state (e.g., workforce needs, workflow development, operational requirements and oversight, closed-loop referral, billing systems/services).
- **CIE infrastructure funding** will establish a statewide strategy of regional CIE capabilities and support standard CIE functionality necessary to operationalize Community Hubs. Current investments will contribute to a legislatively directed, comprehensive, and statewide CIE review.

The review will incorporate MTP, Care Connect Washington, and other CIE capabilities. Future infrastructure investments will be centered upon governance and shared standards that supports interoperability that may be scaled across regions as the state implements a comprehensive CIE strategy.

Hub sustainability: Washington believes successful implementation of the Community Hub/Native Hub model will bring a clear path to sustainability, as there are significant economies of scale to be achieved through regionally based care coordination supports. This includes aligned training, CBO contracting, and community-based workforce capacity development.

Currently MCOs, health systems, and providers offer targeted and fragmented approaches to community-based care coordination and related community-based workforce training, recruitment, and payment. Community Hubs and the critical community-based workforce will be sustained over time as the state addresses payment strategies through HRS and more direct community-based workforce payment accountabilities within managed care contracts.

Demonstration objective and rationale

With the increased emphasis on HRS and opportunities to address unmet needs, Washington requires greater coordination with community organizations and infrastructure to better manage resource access and referral processes. Disparate programs, services, and care coordinators continue to make it difficult for individuals and families to access the resources they need.

Community Hubs are an evolution of work that began under the MTP demonstration in which the state identified community-based care coordination as a significant opportunity to improve the health and wellbeing of Apple Health enrollees. This experience further confirmed the need for centralized and standardized infrastructure and functions, stronger engagement of community partners, investment in community partners' capacity, and clearer description of roles and relationships between community partners and clinical care coordination partners (e.g., MCOs).

Through the MTP waiver renewal, Washington will build a system of community-based workforce capacity and test investments in standardized regional Community Hub infrastructure. At the same time, the state will address sustainable payment policies, to sustain community-based and culturally competent care coordination as payment is transitioned from the waiver to managed care.

Demonstration implementation

Washington is seeking to implement Community Hubs under the following timeline:

- In the first year of MTP 2.0 (DY7), HCA will undertake a CIE landscape assessment and recommend a strategy to the Washington State Legislature that considers previous MTP, Care Connect program, and private investments and identifies areas in need of further investment to support Community Hubs.
- DY7 will also include the development of community-based workforce standards for training, contracting, and payment.
- In DY8, consistent with commensurate Legislative direction, HCA plans to conduct a request for proposal to support CIE efforts in regions lacking infrastructure and capacity.
- January 2023 through December 2024: Hub planning, establishment, development, implementation, and capacity building.
- January 2025 through December 2027: Hub Operations and implementation of managed care payment strategies to phase out MTP demonstration funding for community-based workforce payment.

3.1.2 TAHC: HRS

Request

Washington requests expenditure authority to offer HRS to which Community Hubs (including the Native Hub) (described in Section 3.1.1) will be able to refer Apple Health enrollees, in addition to existing community programs and resources. These services will build on and supplement LTSS and FCS services (described in Sections 2.2 and 3.2). Washington looks forward to working with CMS to confirm and align authorities as needed in support of these services, and specifically seeks 1115 expenditure authority for:

- Payment for HRS to be made available to Apple Health FFS enrollees.
- Payment for any HRS that is not approved by CMS as ILOS through the managed care delivery system.

Policy/program description

The FCS and LTSS initiatives funded through MTP, and continuing in this MTP demonstration renewal, provide a strong base of housing and home and community-based services to eligible enrollees. However, other HRSN, including food insecurity and poor environmental conditions that can lead to or exacerbate health issues, remain unaddressed by existing efforts.

Likewise, while Washington has piloted medical respite services, the State generally lacks a strong continuum of appropriate settings to support certain high-need enrollees, such as individuals who are unhoused/lack stable housing and individuals with SUD, outside of hospitals and other institutions. Together, an array of new services and settings under TAHC will begin to fill these gaps and greatly reduce the unmet needs across populations facing the greatest health disparities in the state.

Washington is seeking Medicaid authority to offer an additional suite of HRS and supports to which Community Hubs will be able to refer Apple Health enrollees, building on and supplementing FCS and LTSS services described in Sections 2.2 and 3.2, and addressing remaining gaps in HRS in the care continuum. Washington will submit the majority of these services for approval under managed care ILOS authority for enrollees in managed care.

Washington is requesting 1115 waiver authority to offer these same services to eligible FFS Apple Health enrollees in order to ensure parity between managed care enrollees and Washingtonians enrolled in Medicaid without a managed care plan, so as to not further contribute to existing inequalities.

The populations eligible for HRS will also be consistent across Washington's FFS and managed care delivery systems to the extent possible. Eligibility will consider both social and health risk factors. Consistent with the approval of ILOS and HRS in other states, eligibility criteria will recognize the value of preventing health deterioration and addressing HRSN before adverse outcomes and related high-cost health care utilization materialize. This approach is critical to ensure a whole-person and enrollee-centered approach, and to begin to address historical disparities in access to care.

For more details on the proposed services and the populations eligible, see Appendix A.

MCOs and ACHs will partner at the regional level to develop and leverage the Community Hub model, as directed by HCA. This will ensure collaborative and connected enrollee engagement and outreach, as well as coordinated referral and service authorization processes across services.

As part of these efforts, Community Hubs will have special focus and expertise on culturally competent coordination and language support services. Washington envisions that Community Hubs will also support overall CBO network development, capacity building, and training to support implementation of HRS. This will include a specific emphasis on common reporting and billing challenges faced by CBOs.

MCOs will administer and facilitate payment for ILOS-approved services, while ACHs, through their Community Hubs, will facilitate payment for equivalent services for the FFS population. The state will also explore other innovative ways that ACHs and MCOs can work together to implement certain HRS, including building upon ACH expertise and utilizing existing provider networks engaged through ACHs. Other partnership opportunities could include coordinated referral systems, verification of closed loop referrals, and building community provider capacity for billing and data exchange in support of MCO and state oversight of certain services.

HCA expects MCOs to have expertise and experience administering HRS focused on behavioral and physical health care and more medically oriented services, such as respite. Alternatively, ACHs have expertise and experience to offer with community oriented HRS, such as nutrition and transportation. Many community oriented HRS will benefit from ACHs' local expertise and relationships with communities and community organizations.

Demonstration objective and rationale

To address gaps and broaden the continuum of available HRS and supports in Washington, the state seeks waiver authority to cover the following services for FFS Apple Health enrollees:

- Medically tailored meals and medically supportive foods
- Medical respite
- Housing transition navigation services
- Housing tenancy and sustaining services
- Housing deposits
- Nursing facility transition/diversion to assisted living facilities
- Community transition services/nursing facility transition to a home
- Stabilization centers
- Day habilitation programs
- Caregiver respite services
- Personal care and homemaker services
- Environmental accessibility and remediation adaptations (home modifications)

For more details on these potential services and populations eligible, see Appendix A.

Demonstration implementation

Washington is seeking to implement HRS under the following timeline:

- The first year of MTP 2.0 (DY7) will focus primarily on readiness activities necessary to begin offering the HRS approved for MTP 2.0. This includes clarifying the ACH and Community Hub role in all HRS, facilitating coordinated planning by MCOs and ACH Community Hubs, developing service delivery and network capacity (supporting community provider awareness and preparations), and executing contracts with ACHs.
- In addition to these readiness activities, a prioritized subset of three to five HRS are expected to launch in DY7 (2023) of MTP 2.0 through ACHs for FFS populations. In addition, medical respite will launch for all eligible populations, given the state's prior implementation and experience in these areas.
 - HCA will aim to roll out the corresponding subset of ILOS-authorized HRS for managed care populations on the same timeline to ensure streamlined implementation and collaboration between ACHs and MCOs.

- Additional collaborative planning and stakeholder engagement on the prioritization and roll out of all other HRS will occur during DY7, and HCA will finalize the roll out schedule for all HRS in DY7.
- HCA will also work to update and finalize managed care contracts and rate certifications as needed, following CMS review and approval of any ILOS-authorized HRS.
- In DY8 (2024) of MTP 2.0, a select set of new HRS will go-live through ACHs for FFS populations, as determined in DY7 planning described above.
 - HCA will aim to roll out the corresponding ILOS-authorized HRS on the same timeline.
- Building on lessons-learned from the launch of select services, a third set of HRS will go-live through ACHs for FFS populations in DY9 (2025).
 - HCA will continue to align the implementation timelines of ILOS-authorized HRS. HCA expects that all services will be live by December 2027.
- Throughout MTP 2.0, HCA will monitor uptake of ILOS-authorized HRS, including data tied to Community Hub referrals, and reinforce expectations and accountability to ensure identified needs are being addressed.

3.1.3 TAHC: supports to address health equity

Request

Washington requests demonstration expenditure authority to fund the development of local, community-based initiatives administered through ACHs and the Native Hub to reduce disparities and advance health equity.

Policy/program description

Payment for health care benefits and social supports provided to Apple Health enrollees through MTP have improved the health of Washingtonians. The [December 13, 2020, MTP Interim Report](#), for example, noted improvements in measures related to SUD and chronic conditions. But the MTP investment in these benefits and social supports are not reaching all Washingtonians, especially people of color.

Persistent racial and ethnic disparities in health care and in health outcomes existed before the COVID-19 pandemic, and disparities in health equity among Apple Health enrollees worsened during the pandemic. The December Interim Report noted that across 44 measures, Black Apple Health enrollees experienced lower quality in 38 of the measures. In particular, the report found significant racial and ethnic disparities in mental health treatment and chronic illness care quality for AI/AN and Black enrollees.

The March 2020 Rapid-Cycle Monitoring Report similarly found that “...we continue to see some notable inequities in health care access and quality among the subpopulations examined in this report,” reporting that, “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 OUD, and more likely to be prescribed opioids compared with other groups.”

It is clear that the promise of MTP, and particularly the aims set out for the MTP waiver renewal, will not be achieved without specific, focused health equity initiatives to ensure that the reach of MTP extends to all communities throughout Washington State. By implementing these health equity initiatives through the ACHs, the state seeks to ensure that investment will be focused on local needs and outcomes, informed through community engagement and Community Hubs. The desired outcome is for health equity programs to develop structural solutions that improve health equity across the Medicaid population and entire communities.

ACHs and the Native Hub will be tasked with engaging with communities to plan and implement health equity initiatives. ACHs have developed deep and experienced relationships with CBOs and are well-placed to lead the implementation of health equity initiatives throughout Washington. Several ACHs have effectively used DSRIP program funds under MTP, sometimes blended or braided with other community funding, to address SDOH, inequities, and other community needs. The Native Hub will work with tribes to support equity investments, recognizing each tribe best understands the unique challenges and opportunities surrounding health disparities among tribal members.

One example is CBO payments provided by Better Health Together ACH to support organizations run by BIPOC individuals to improve health and wellbeing for their local communities. Another example is Healthier Here's requirements for all contracted partners to have an equity lens applied to their work with the ACH, to ensure all community investments further regional equity goals. A third example is Elevate Health's ability to leverage upfront investment to ensure historically underfunded community organizations have an equal footing to participate in grants and other opportunities that require a higher degree of initial infrastructure and capital.

While each region has implemented equity-focused strategies to address upstream needs during different points of the DSRIP program, a cohesive, statewide investment approach to addressing disparity has not occurred. This has resulted in pockets of funding and innovation but not to the degree necessary to address these overarching issues. ACHs, including their implementation of Community Hubs, are ideally positioned to take on the management of this investment strategy because of their regional equity experience, local knowledge of community needs, and commitment to involving community voice in decision-making and fund distribution.

Initiative planning, development, and implementation: health equity investments will benefit from inclusive development and ACHs' expertise in convening community partners to achieve results. Within the first year of MTP 2.0 (DY7), HCA will partner with ACHs and the Native Hub to develop statewide guiding principles and goals for health equity initiatives that will guide further development of regional and community-based principles, goals, and strategies.

ACHs will work with CBOs, MCOs, and other local partners, including Apple Health enrollees and their families, to develop goals and strategies for new health equity initiatives at the local level. These initiatives will help to address the upstream factors that will prevent unnecessary services and reduce costs. These initiatives will also allow for a targeted approach to reduce disparities in the community through local and community driven strategies.

In addition to developing statewide guiding principles and goals to improve health equity in the Apple Health population, HCA will set standards for community engagement, accountability, and non-duplication with other federal or state funds (including with other activities funded through this demonstration) to ensure efficient and effective use of funds in a way that promotes better, more equitable health for Apple Health enrollees. Health equity investment funds will ultimately be distributed to ACHs and tribes and IHCPs, and as part of initiative planning, HCA will also spearhead development a funding methodology and protocol, subject to federal review and approval, for distribution of funds.

In DY8 of MTP 2.0, HCA will begin supporting the implementation of health equity initiatives with demonstration funds. HCA envisions these initiatives could include targeted efforts to reduce disparities in access and outcomes in health and HRS, expand diversity of the health workforce, enhance access to culturally responsive care, and other activities identified through collaboration with communities to advance and center health equity in Washington's health care system.

Initiative funding criteria and guardrails: ACHs will convene community stakeholders with the essential expertise, knowledge, and community awareness to assist in developing health equity strategies. Communities will play a key role in determining how funds will be best distributed to enhance the success of these initiatives.

Leveraging the infrastructure of the Community Hub, ACHs will have the option to implement health equity initiatives with their staff or by developing agreements among CBOs or coalitions who meet the standards of program development and implementation. ACHs will aim to avoid duplication or silos when achieving the goals of the health equity programs by convening local stakeholders, CBOs, and other ACHs in collaborative efforts across the community.

The Native Hub will coordinate investments and/or projects to improve health and wellbeing among tribal members.

Initiative measurement and accountability: HCA will ensure appropriate oversight of health equity programs. Each planned project that utilizes equity funding must identify key process and outcome measures related to equity goals that will be tracked and reported. HCA will work with the independent external evaluator (IEE) to develop standards for measurement and accountability, and the IEE will assist HCA in evaluation of equity projects. Uses of equity funding will be reported on a schedule developed by HCA in collaboration with ACHs.

In addition, HCA will leverage existing meetings with ACHs to create opportunities for dialogue, coordination, and mutual learning around the ongoing use of equity funds. With the insights and assistance of these stakeholders, ACHs will also develop specific, measurable goals that include processes for receiving feedback and implementing learnings for health equity programs.

The state is examining the new National Committee on Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS)-proposed measures related to social needs screening and intervention. The state is also tracking the approach for stratification of HEDIS measures by race and ethnicity to support advancing health equity, as well as other federally recognized measures on systems transformation. The state will continue to explore how these measures might be used by the state or ACHs to monitor health equity programs and provide meaningful information on progress and outcomes.

Demonstration objective and rationale

This expenditure authority will bolster Washington's efforts to reduce longstanding and persistent health disparities through coordinated, locally driven approaches and enable Washington to further the overall objective of advancing health equity for Apple Health enrollees. The expenditure authority further promotes the objectives of Medicaid by increasing efficiency and quality of care through initiatives to transform service delivery networks at the community level. This includes increasing access to health care services, supporting better integration, and improving health outcomes, including across racial and ethnic groups.

Demonstration implementation

Washington is seeking to implement health equity supports through ACHs and tribes and IHCPs under the following timeline:

- In 2023 (DY7): developing health equity initiative guiding principles, goals, and standards at state-level; and health equity initiative planning and development at community-level.
- In 2024–2027 (DY8-DY11): health equity initiative implementation and measurement.

3.1.4 TAHC: community-based workforce

Request

Washington requests expenditure authority to support capacity expansion of community-based workforce through Community Hubs and expenditure and waiver authorities to pilot a model for reimbursement of community-based workforce.

Policy/program description

Washington State has identified a need for expanding the availability of community-based workforce to support care coordination, HRS, and the state's advancement of health equity. There are several identified barriers that impact the state's community-based workforce, including limited access to training/certification and career pathways for culturally competent candidates, and lack of sustainable payment at livable wages.

Community-based workforce, defined broadly to include CHWs, peer specialists, patient navigators, and doulas, is currently supported through Medicaid in limited ways: peer specialists and counselors are covered under Medicaid behavioral health benefits and CHWs may be supported by Medicaid MCOs under care coordination or administrative funds.

Under MTP 2.0, Washington seeks to:

- Expand capacity of the community-based workforce.
- Test models for sustainable reimbursement of community-based workforce by connecting managed care payment to the proposed Community Hub model.

Capacity expansion of community-based workforce: Community Hubs will serve as regional centers that support community-based workforce capacity expansion. With an emphasis on recruiting, training, and deploying workers with lived experience and community presence to build equity, diversity and cultural competency, Community Hubs will engage in the following:

- **Training for community-based workforce.** Community Hubs will plan and develop training curriculum and practicum model offerings in local and regional settings. Training and practicum models will be accessible and scalable across regions throughout the state to meet local, regional, and statewide needs. The state plans to also build on existing work led by FCS that focuses on capacity building of the direct service worker workforce. Plans to offer CHW training to FCS staff in their regional community will enable staff to meet a wider range of social support needs. This will create an enhanced foundation for success in attaining and sustaining housing and employment services.
- **Recruitment and retention of community-based workforce.** Community Hubs will address recruitment and retention practices, including targeting diverse candidates with lived experience and promoting team-based care within various settings. Expansion of community-based workforce will emphasize a "grow your own" strategy operated through the Community Hub model. This strategy will support a sustainable pathway to recruit and retain candidates from local communities that best reflects the communities being served.
- **Payment innovations and standards for sustainability.** Payment has been a key challenge in the state, as Washington has not committed to a certification process for community-based workforce. While preserving a flexible definition of community-based workforce, this has resulted in limited community-based workforce recruitment and payment, including limitations on local and culturally appropriate care coordination. The state has an opportunity to expand and encourage Medicaid payment for community-based workforce through the managed care contract and care coordination accountabilities. To date, payment for these workers has been

largely limited to administrative expenditures and alternative payment models due to perceived payment barriers and policy gaps. The state will explore policies, flexibilities, and contracting levers to support increased payment for community-based workforce through the Community Hub model. MTP 2.0, through the Community Hub model and pediatric primary care pilot (more information below), will provide an implementation path ahead of contracting and accountability vehicles. This will include the development of definitions and standards to support training and payment of community-based workers, while not unnecessarily narrowing or medicalizing definitions and payment.

Testing models for sustainable reimbursement of community-based workforce in pediatric primary care: the Washington State Legislature authorized a pilot program to expand CHW services in pediatric primary care clinics with significant Medicaid patient populations.⁵² The legislation provided \$2 million in state funding to support a grant program that will reimburse for CHW services like outreach, informal counseling, and social supports for HRSN. The legislation also directed the state to seek available federal matching funds and explore opportunities for sustainable reimbursement.

The state requests waiver and expenditure authorities to allow for federal matching funds for this pilot program, which will be available to a pediatric population and on a non-statewide basis. Washington will also be coordinating across other non-waiver Medicaid authorities (e.g., state plan and managed care contract) for reimbursement of community-based workforce.

In addition, to the extent that CMS advises the state that waiver authority is necessary to implement certain program elements (e.g., training in lieu of formal licensure or certification process), the state will incorporate a request into the MTP 2.0 demonstration.

Demonstration objective and rationale

Increasing the community-based workforce and expanding workforce diversity and cultural competency are essential to provide coordinated care, reduce health disparities across all delivery systems, and improve outcomes for Medicaid enrollees.

As detailed by NCQA and the Penn Center for Community Health Workers (PCCHW), there is significant evidence that CHWs can improve health, shrink disparities, and reduce unnecessary utilization and spending with an estimated [return on investment] ROI of \$2.47 for Medicaid payers.

—[NCQA and Penn Medicine white paper](#)

Currently MCOs, health systems, and providers offer limited and fragmented approaches to community-based care coordination and related community-based workforce training, recruitment, and payment. Increased capacity and expansion of payment will result in a more robust and less fragmented community-based care coordination system, building on the strengths of the regional Community Hubs and the Native Hub.

⁵² 2022 Supplemental Operating Budget, SB 5693. Washington State Legislature, 2022 Regular Session. <https://app.leg.wa.gov/bills/summary?BillNumber=5693&Initiative=false&Year=2021#documentSection>

Demonstration implementation

Washington is seeking to implement community-based workforce components under the following timeline:

- In 2023 (DY7) of MTP 2.0, HCA will conduct an analysis and recommendation of community-based workforce reimbursement programs and strategies. In collaboration with key external partners, DY7 will also include identifying a plan for recruitment/retention, training, and deployment of community-based workforce through the Community Hubs' contracting and network maintenance across community organizations.
- DY7 will also include a temporary payment for community-based workforce currently funded under MTP. Initial payment will be made available during the DY7 planning process to preserve payment and capacity where Community Hub functions exist today, including continued payment for community-based workforce.
- In 2024 (DY8), HCA will implement the recommended plan and structure to support community-based workforce payment, including alignment between demonstration payment and future managed care payment mechanisms.
- 2023–2024 (DY7-DY8): establishment and implementation of workforce development plan toward programs for recruitment/retention, training, and deployment of CHWs.
- 2025–2027 (DY9-DY11): reimbursement under new strategies, including considering options to expand CHW and community-based workforce development programs.

3.2 FCS (formerly Initiative 3 – continuing)

Request

Washington requests to continue its use of waiver and expenditure authorities granted in the MTP demonstration for the FCS program. FCS provides supportive housing and supported employment services to high-risk Medicaid recipients with complex physical and/or behavioral health needs through Community Support Services (CSS, also called supportive housing) and Individual Placement and Support (IPS, also called supported employment).

These services are designed to promote recovery through self-sufficiency and integration into the community, and to reduce the need for high-cost intensive services by helping individuals find and maintain stable housing and competitive employment.

Washington requests three enhancements to the FCS program:

- Expand supportive housing eligibility to those 16 and older.
- Expand supported employment eligibility criteria to include additional justice-involved risk factors.
- Provide one-time transition fees to enrollees exiting certain treatment facilities who were homeless the month prior to their admission.
- Extend the eligibility of the CSS service authorization from 6 to 12 months.

The FCS program aligns with the increased emphasis on HRS to address unmet needs. The state consulted with the Technical Assistance Collaborative and determined that it would be best to continue operating FCS without significant policy changes. The state could include testing of the enhancements requested above within the continued evaluation of the FCS program. These ongoing and new flexibilities will help the state identify appropriate authorities and ways to sustain the FCS program so it can continue to grow.

Policy/program description

FCS aims to reduce barriers that prevent Medicaid enrollees with SMI, SUD, long-term care needs, and chronic health conditions from finding and maintaining stable housing and competitive employment. FCS is a partnership between HCA and AL TSA that provides services to specific populations eligible through certain health-based needs and specific risk factors that put people at risk of cycles of homelessness and unemployment.

FCS is rooted in the principles of health, home, purpose, and community, which are fundamental to an individual's ability to recover, improve their health and wellness, and live their life to its full potential.

The CSS program follows Substance Abuse and Mental Health Services Administration's (SAMHSA) model of Permanent Supportive Housing (PSH). The model provides evidence-driven principles and best practices that aim to support an individual's short- and long-term goals in finding and obtaining independent housing. The program embraces the housing-first model, where individuals find independent housing with no specific requirements for abstinence or treatment. Services include pre- and post-tenancy supports like housing assessment and planning; outreach to landlords; assisting with housing applications; and education, training, and coaching.

Complementary to the PSH model, the IPS program follows the IPS evidence-based model, developed by Rutgers University. IPS is founded on principles that value individual choice, rapid job placement, and the belief that every person who wants to work can, regardless of the barriers they might experience. Services include employment assessments and planning, outreach to employers, assisting with job applications, as well as education, training and coaching that helps someone remain employed.

The primary goals of this application are to continue FCS and increase its reach and impact. MTP. 2.0 aims to highlight the role of community-based organizations and a nontraditional provider network in their ability to perform these Medicaid services. An additional five years will allow Washington to continue to solidify the FCS program and identify a sustainable future for these services.

HCA identified three areas to expand FCS, informed by stakeholder engagement. Although small in scope, the goal of these enhancements is to broaden eligibility and fill gaps in the recovery support services delivery system. The enhancements also provide additional supports that aim to reduce chronic homelessness among individuals who receive inpatient treatment. HCA proposes the following enhancements for this renewal period:

- Expand the age restriction for supportive housing eligibility to 16 years and older, which will offer the ability to provide pre-tenancy supports to transition-age youth and youth exiting foster care.
- Expand the risk factors for supported employment to include people exiting jail, prison, or who have a status of "on parole," which will provide more wraparound supports for people exiting these institutions and reduce recidivism.
- Provide the ability to use Medicaid funds to pay for one-time transition fees (including first and last month's rent, application fees, and/or basic home goods) for FCS enrollees exiting inpatient mental health or SUD treatment who were homeless the month prior to receiving treatment. This enhancement aims to reduce the rate at which people who receive inpatient treatment return to homelessness within a year of treatment.
- Extend the service authorization length for CSS from 6 to 12 months to support individuals longer with pre- and post-tenancy support service. This enhancement also aligns with legislative directive from ESHB1866, or the Apple Health and Homes Act, that creates brick and mortar permanent supportive housing (PSH) units for CSS enrollees.

Expanding the age restriction for supportive housing eligibility to 16 years and older is estimated to increase FCS enrollment by slightly more than one percent. Although proportionally small, this change would allow the FCS program to create stronger links with providers serving the broader “transition-aged youth” population, ages 16-25. HCA identified several opportunities for enhanced coordination across service delivery systems including the foster system, juvenile rehabilitation, and other institutional and state-funded systems of care serving transition-age youth.

Adding a new risk factor for supported employment would result in a similarly minor increase in FCS enrollment. However, HCA identified gaps in administrative data for individuals exiting Washington State Department of Corrections (DOC) facilities who would likely benefit from and be eligible for FCS services in the absence of other qualifying risk factors for supported employment. This enhancement aims to further align FCS with new initiatives outlined by the state’s proposed re-entry coverage program (see Section 1.2).

The FCS program currently has limited ability to serve individuals receiving inpatient treatment, and this renewal aims to improve access to crucial housing support funds that reduce the likelihood of discharging a person to homelessness.

Finally, extending the length of the CSS authorization period from 6 to 12 months aligns with recent legislation in ESHB1866, known as the Apple Health and Homes Act. The bill creates PSH units and a housing benefit for certain FCS-enrolled individuals receiving CSS services, renewable in 12-month increments, and directs HCA to extend supports through CSS to a minimum of 12 months. Alignment with House Bill 1866 would increase the annual budget by an estimated \$7,519,000 to account for the estimated 2,567 enrollees who’s initial 6-month authorization would shift to 12-months in calendar year (CY) 2023.

Demonstration objective and rationale

Homelessness and unemployment are two SDOH that disproportionately impact individuals experiencing behavioral health disorders, chronic health conditions, and those in need of aging and long-term care services. Homelessness is traumatic, cyclical, and puts people at risk of behavioral health issues, SUD, and poor health outcomes. Homelessness and unemployment interfere with one’s ability to receive health care and behavioral health and social services, maintain and manage medication, and jeopardizes the chances for a successful recovery.⁵³ Similarly, long-term unemployment has been linked to poor physical and significant behavioral health conditions, including depression, anxiety, and chronic stress.⁵⁴

People experiencing lengthy unemployment are also more likely to develop stress-related conditions including stroke, heart attack, heart disease, and arthritis.⁵⁵ It is fundamental to someone’s physical and behavioral health to have housing and employment. A person cannot be healthy without a stable roof over their head, and it is difficult to stay housed without purpose and structure, which is offered through employment. Both housing and employment are key to a healthier Washington.

In 2020, more than 100,000 individuals in Washington State experienced homelessness, including individuals predominantly experiencing SMI, SUD, or co-occurring disorders.⁵⁶ RDA also found that

⁵³ [Homelessness & Health: What’s the Connection?](#) National Health Care for the Homeless Council. 2019.

⁵⁴ [How Does Employment – or Unemployment- Affect Health?](#) Robert Wood Johnson Foundation. 2013.

⁵⁵ Ibid.

⁵⁶ [Supplemental Point in time count.](#) Research and Data Analysis. 2021.

Note: counts are a snapshot of unhoused individuals in January 2021. These counts are not representative of the total unhoused population for the year and may miss information on individuals receiving services. Counts do not include individuals receiving inpatient treatment at the time of the count, who would otherwise qualify as unhoused.

individuals experiencing behavioral health disorders are more than twice as likely to experience homelessness, housing instability, arrest rates than the average Medicaid recipient in Washington.⁵⁷

In 2020, nearly 30 percent of individuals (ages 18 years and older) with an identified SUD treatment need experienced homelessness within a year,⁵⁸ along with 14 percent of Medicaid recipients with an identified mental health service need.⁵⁹ When it comes to employment, only 40 percent of Medicaid recipients with identified mental health treatment needs and 39 percent of individuals with SUD treatment needs had any income reported in 2020.⁶⁰ Through its targeted services, FCS provides a unique opportunity to address the unique needs of these individuals and provide a viable pathway out of homelessness and poverty.

Continuing and expanding FCS will allow HCA to continue to improve the delivery and increase the value of services provided to Apple Health enrollees, especially those who are most vulnerable. MTP 2.0 gives Washington the opportunity to develop better integrated, sustainable services focused on improved health outcomes to serve populations who are chronically homeless and/or unemployed with a behavioral health, SUD, or co-occurring treatment need, and/or a long-term disability or care need.

FCS will continue to help successfully transition individuals out of homelessness; reduce ED utilization and hospitalization of high-cost Medicaid recipients; increase wages and hours worked of populations who are otherwise not able to maintain stable employment. FCS will also continue to improve health equity and access to recovery support services to underserved populations and increase and improve services that support the aging population.

Extended waiver and expenditure authority will allow HCA and ALTA to continue to:

- Serve populations who are chronically homeless and/or unemployed with a mental health, SUD, or co-occurring treatment need, and/or a long-term disability or care need.
- Help successfully transition individuals out of homelessness.
- Reduce ED utilization and hospitalization of high-cost Medicaid recipients.
- Reduce the need for high-cost inpatient and outpatient treatment/services.
- Increase wages and hours worked of populations who are otherwise unable to maintain stable employment.
- Improve health equity and access to recovery support services to underserved populations.
- Increase and improve services that supports Washington's aging population.
- Manage and distribute short-term (state-funded) housing subsidies to help people transition out of institutional settings.
- Help successfully transition individuals out of IMD and other inpatient or institutional settings.
- Distribute mobile phones and tablets to FCS enrollees to apply for jobs, housing, and navigate community resources.
- Connect youth exiting state-funded systems of care to crucial support services to reduce homelessness and rates of incarceration.
- Improve access and reduce barriers to individuals receiving routine medical, primary care, and other preventive health services.

⁵⁷ [Comparison of Physical Health and Social Outcomes among Medicaid Beneficiaries with and without Behavioral Health Diagnoses](#). Research and Data Analysis. 2019.

⁵⁸ [Medicaid Enrollees with Substance Use Disorders](#). Research and Data Analysis. 2022.

⁵⁹ [Medicaid Enrollees with Mental Health Service Needs](#). Research and Data Analysis. 2022.

⁶⁰ Ibid.

Since its inception in 2018, FCS has enrolled more than 22,000 participants. FCS created a network of more than 165 contracted providers who support program participants statewide at over 450 service locations. Using two evidence-based practices and provider fidelity reviews, FCS staff have also established a rigorous quality improvement process that allows for reliable data collection and program evaluation. Findings by RDA show promising and statistically significant increases in wages and hours worked, and successful transitions out of homelessness among participants.

In the first 18 months of FCS implementation, from January 2018 to June 2019, the program demonstrated early outcomes of statistical significance. In their July 2021 evaluation,⁶¹ RDA's key findings included:

- People enrolled in supported employment services found employment at a higher rate, earned more money, and worked more hours.
- Supportive housing services helped people transition or begin to transition out of homelessness or housing instability.
- Statistically significant increases in the percent of individuals housed in housing projects funded by the Department of Commerce.

Earlier findings looking at the first nine months of the program also included promising reductions in hospitalizations and ED utilization, although those early trends were not observed in the July 2021 findings.⁶² HCA believes that more work around quality of services, care coordination, and engagement can continue to improve on the early results. Note: the early results showing these reductions were based on a limited dataset and short evaluation period. HCA hopes to observe that over time, longer-term results will show the impact of these services.

The FCS enrollment growth trends are being sustained over time and the provider network continues to expand. Historically, CSS and IPS have grown an average of four percent and three percent, respectively, month-over-month. At the end of 2021, the FCS program had just over 10,000 monthly enrollments in CSS and IPS services. By December 2022, HCA anticipates nearly 10,500 monthly enrollments across both programs, including more than 20 percent enrolled to receive both services at the same time.

A renewal of these services will provide the ability to create more linkages that address gaps in the homelessness relief system and provide viable paths out of poverty. FCS plays an increasingly important role in the state's recovery support services. Starting July 2021, the Washington State Legislature appropriated about \$3 million per year in short-term housing subsidies to help individuals transition out of institutional settings, to be managed by FCS. Expenditure authority under FCS to provide one-time transition costs to help individuals transition out of these settings will complement these efforts.

FCS program staff have also begun working with programs across the spectrum of recovery support services, poverty reduction, and housing sectors to remove barriers that perpetuate health inequity. As a result of these efforts, recent legislation in Washington State has created [pathways to tangible housing for FCS enrollees](#). This has removed disincentives from returning to work for individuals receiving rental assistance through different state-funded programs.

For the renewal of this program, HCA identified three small, yet significant, enhancements that impact the eligibility criteria for the IPS and CSS benefits, as well as create a new resource to fill a gap that prevents eligible individuals from stable housing.

⁶¹ [The Foundational Community Supports Program: Preliminary Evaluation Findings – July 2021 Update](#). Research and Data Analysis. 2021

⁶² [The Foundational Community Supports Program: Preliminary Evaluation Findings](#). Research and Data Analysis. 2020

The first phase of this work began in late 2021 (DY5) and in DY6. The FCS team held regular stakeholder meetings and solicited feedback from program staff, providers, MCOs, and others to identify gaps and opportunities to improve and expand on the work FCS built during the first four years of implementation. The second phase of this work, in DY6, identified which areas had data to support why pursuing these enhancements would increase the impact of FCS.

The first enhancement would expand the age restriction for the CSS benefit to individuals 16 and older, down from 18 and older, to engage and serve individuals more broadly experiencing homelessness in the transition-age youth and youth exiting foster care age. HCA consulted with national technical assistance organizations, include Corporation for Supportive Housing and the Technical Assistance Collaborative to gauge how the enhancement aligned with national effort to engage this population using age and culturally appropriate housing interventions.

This also aligns with ongoing efforts within HCA to create a link between the different systems of care more broadly used by individuals 16 to 25 years of age.⁶³ Based on 2020 data, RDA estimates this enhancement to increase the population eligible for CSS services by roughly one percent. Although this figure may seem small, this change would enable otherwise eligible individuals to engage with services earlier and reduce long-term patterns of homelessness.

The second enhancement aims to add a new risk factor to the eligibility criteria for the IPS benefit, and expand access to services for individuals exiting jail, prison, or who have a status of “on parole.” Among its many goals, the IPS evidence-based practice aims to reduce arrest rates and rates of recidivism, an observed result for FCS participants in the first two years of implementation.⁶⁴

While analyzing this potential enhancement, RDA found this change would also increase the total eligible population for FCS by one percent. This enhancement, while seemingly small, also fills a gap in eligibility for individuals exiting prison. These individuals are “unknown” to Washington’s Apple Health administrative data due to being incarcerated for more than one year. Washington estimates that roughly 7,700 additional individuals will be eligible for FCS services and expects that a small percentage would become FCS enrollees, and thus, have a negligible effect on FCS expenses.

The third enhancement aims to cover one-time transition fees for individuals eligible for CSS services to help enable FCS enrollees establish a basic household. To be eligible for these funds, an individual must be exiting behavioral health inpatient treatment and have been homeless the month prior to receiving treatment. Discharge from these settings is often challenging or even prohibited without an identified place for an individual to reside post treatment.

The housing search can be a lengthy and expensive process, and these funds aim to cover costs that prohibit individuals from otherwise being able to obtain stable housing, such as security deposits, first and last month’s rent, and basic home goods. Additionally, pairing these funds with CSS services could potentially help reduce the length of inpatient stays, allowing for earlier connections to housing resources and support services.

Using the same 2020 data, RDA estimates 2,700 additional individuals would be eligible to receive this benefit. It is important to note that this enhancement is not intended to pay for ongoing rental support, but a means by which FCS can assist individuals connecting to longer term rental assistance programs, such as Washington’s Community Behavioral Health Rental Assistance program, and federal voucher

⁶³ [Safe and Supportive Transition to Stable Housing for Youth Ages 16-2](#). Washington Health Care Authority. 2021

⁶⁴ [Medicaid Transformation Project Evaluation - Interim Report](#). Oregon Health & Sciences University. 2020. P. 148

programs. This enhancement does not overlap with the state’s request for rental subsidies detailed in section 3.2.2.

The fourth enhancement aims to extend FCS service authorizations from 6 to 12 months in alignment with the Apple Health and Homes Act, ESHB1866 that passed during the 2022 legislative session. The bill establishes a housing benefit, renewable in 12-month increments, that pays for the creation of PSH units for individuals receiving CSS services. The Apple Health and Homes Act is a joint effort between HCA, DSHS, and the Department of Commerce that brings together brick and mortar PSH units, support services, and capital funds to address chronic homelessness.

FCS’ role in this legislation is to provide CSS tenancy sustaining service to support individuals in maintaining their housing throughout the duration of their tenancy in a unit funded by this legislation. As such, HCA is directed by the bill to extend the authorization period for CSS to a minimum of 12 months to align with these efforts.

Demonstration implementation

By December 2022, nearly 10,500 individuals will be enrolled in FCS. MTP 2.0 will allow the FCS program to provide services to these individuals seamlessly. With a statewide provider network in place, FCS is well-positioned to grow and expand its reach through the enhancements outlined above. Through simple changes in eligibility and program policy, FCS will be able to serve any eligible individual who is 16 years or older as well as those individuals exiting a correctional facility.

The FCS program continues to gain attention within the state as an intervention worthy of ongoing investment. During the 2022 legislative session, the [Apple Health and Homes Act](#) created large investments in brick-and-mortar housing funded by the state to support the needs of individuals eligible for and enrolled in CSS services. With lack of housing options identified as one of the barriers to program success,⁶⁵ this legislative directive creates policy changes that align with the FCS program by creating another option for enrollees to receive tangible housing, solely due to their eligibility for services and history of homelessness.

Waiver and expenditure authorities

Washington State is requesting the following federal waiver and expenditure authorities, some of which have been previously approved in the initial MTP demonstration. Under the authority of Social Security Act Sections 1115(a)(1) and (a)(2), Washington requests the following waiver and expenditure authorities for MTP 2.0 through December 31, 2027. These waiver and expenditure authorities are necessary to enable the state to continue, expand, and evolve policies and programs that:

- Ensure equitable access to whole-person care, empowering people to achieve their optimal health and wellbeing in the setting of their choice.
- Build healthier, equitable communities, with communities.
- Pay for integrated health and equitable, value-based care.

To the extent that CMS advises the state that different or additional authorities are necessary to implement the programmatic vision and operational details described above for MTP 2.0, the state is requesting such waiver or expenditure authority, as applicable. Washington’s negotiations with the federal government, as well as state legislative/budget changes, could lead to refinements in these authorities as Washington moves forward.

⁶⁵ [Interim Findings on Washington’s Medicaid Transformation Project](#). Oregon Health & Sciences University. 2020. P. 7.

Table 11: goals and waiver/expenditure authority

Primary goal	Policy/program name	Status within this renewal request	Waiver/expenditure authority
<p>Goal 1: expanding coverage and access to care, ensuring that people can get the care they need</p>	<p>1.1 Continuous Apple Health Enrollment for children</p>	<p>New</p>	<p>Waiver authority</p> <ul style="list-style-type: none"> • Annual re-determination – 42 CFR 435.916: to enable the state to waive the annual redetermination requirements and requirements for individuals to report and the agency to act on changes, other than a change in residence to out of state. <p>Expenditure authority</p> <ul style="list-style-type: none"> • Continuous enrollment for children: expenditures to allow federal financial participation for the continuous enrollment of children without regard to whether a child’s family income exceeds eligibility limits.
	<p>1.2 Re-entry coverage for continuity of care</p>	<p>New</p>	<p>Waiver authority</p> <ul style="list-style-type: none"> • Freedom of choice – Section 1902(a)(23)(A): to the extent necessary to enable the state to restrict freedom of choice of provider for individuals who receive benefits under the demonstration. <p>Expenditure authority</p> <ul style="list-style-type: none"> • Re-entry coverage for continuity of care: expenditure authority as necessary to receive federal reimbursement for costs not otherwise matchable for certain services rendered to individuals who are incarcerated 30 days prior to their release, or individuals confined at a state hospital or IMD in the 30-day period prior to their discharge. Services may include: health care needs assessments, re-entry care plan development, provision of MAT, arrangement for referrals and transportation to post-release physical, behavioral, and specialist appointments and treatments, and provision of

Primary goal	Policy/program name	Status within this renewal request	Waiver/expenditure authority
			prescriptions for needed medications and DME.
	1.3 Apple Health postpartum coverage expansion	New	<p>Expenditure authority as necessary to receive federal reimbursement for costs not otherwise matchable:</p> <ul style="list-style-type: none"> • For extending the postpartum eligibility period from the end of the month in which the 60th postpartum day ends to the end of the 12th month following the end of pregnancy to: (1) people who apply for Medicaid or CHIP during their postpartum period, but who were not previously enrolled in Medicaid or CHIP during their pregnancy, and (2) individuals who receive pregnancy-related services under the CHIP “unborn child” option. • To support continuous eligibility without regard to changes in circumstances through the end of the 12-month extended postpartum eligibility period for (1) people who apply for Medicaid or CHIP during their postpartum period, but who were not previously enrolled in Medicaid or CHIP during their pregnancy, and (2) individuals who receive pregnancy-related services under the CHIP “unborn child” option.
	1.4 SUD and MH IMD: supports for people receiving SUD and mental health treatment (formerly MTP Initiatives 4 and 5), including CM interventions	Continuing	<p>Waiver authority</p> <ul style="list-style-type: none"> • State wideness/uniformity – Section 1902(a)(1) and 42 CFR §431.50: to permit the state to provide contingency management interventions to individuals on a geographically limited basis. • Amount, duration, scope, and service – Section 1902(a)(10)(B): to permit the state to provide contingency management interventions to qualifying adults that are not otherwise available to all beneficiaries in the same eligibility group.

Primary goal	Policy/program name	Status within this renewal request	Waiver/expenditure authority
			<p>Expenditure authority</p> <ul style="list-style-type: none"> • Residential and inpatient treatment for individuals with SUD: expenditures for otherwise covered services provided to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an IMD. • Residential and inpatient treatment for individuals with SMI: expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment for an SMI who are short-term residents in facilities that meet the definition of an IMD. • CM interventions: to provide contingency management through small incentives via gift cards to individuals with qualifying stimulant use disorders.
<p>Goal 2: advancing whole-person primary, preventive, and home- and community-based care</p>	<p>2.1 MAC and TSOA programs (formerly MTP Initiative 2)</p>	<p>Continuing</p>	<p>Waiver authority</p> <ul style="list-style-type: none"> • Reasonable promptness – Section 1902(a)(8): to enable the state to limit the number of individuals receiving benefits through MAC or TSOA. • Freedom of choice – Section 1902(a)(23)(A): to the extent necessary to enable the state to restrict freedom of choice of provider for individuals receiving benefits through the MAC or TSOA program. • Amount, duration, scope, and service – Section 1902(a)(10)(B): <ul style="list-style-type: none"> ○ To permit the state to provide benefits for the TSOA expansion population that are not available in the standard Medicaid state plan benefit ○ To permit the state to provide benefits not available in the standard Medicaid state plan benefit to individuals who have

Primary goal	Policy/program name	Status within this renewal request	Waiver/expenditure authority
			<p>elected and enrolled to receive MAC benefits.</p> <p>Expenditure authority</p> <ul style="list-style-type: none"> • MAC unpaid caregiver supports: expenditures for costs to support unpaid caregivers serving individuals who are receiving MAC benefits. • MAC services for eligible individuals: expenditures for individuals ages 55 and older who are eligible for the standard Medicaid benefit package, meet the functional eligibility criteria for HCBS under the state plan, but elect to receive MAC services specified in the demonstration. • TSOA unpaid caregiver supports: expenditures for costs to support unpaid caregivers serving individuals who are receiving TSOA benefits. • TSOA for eligible individuals: expenditures for services that are an alternative to long-term care services and supports for individuals ages 55 or older who are not otherwise eligible for CN or ABP Medicaid; meet functional eligibility criteria for HCBS under the state plan; and have income up to 400% of the supplemental security benefit rate established by Section 1611(b)(1) of the act. • PE for MAC and TSOA: expenditures for each individual presumptively determined to be eligible for MAC or TSOA services, during the presumptive eligibility period described in the demonstration. In the event the state implements a waitlist, the authority for PE terminates.
	<p>2.2 Program innovations for LTSS</p> <ul style="list-style-type: none"> • Rental subsidies 	New	<p>Waiver authority</p> <p>Freedom of choice – Section 1902(a)(23)(A): to the extent necessary to enable the state to restrict freedom of choice of provider for</p>

Primary goal	Policy/program name	Status within this renewal request	Waiver/expenditure authority
	<ul style="list-style-type: none"> • Coordinated personal care • Guardianship and decision-making supports • PE 		<p>individuals enrolled in Community First Choice and participating in the coordinated personal care LTSS enhancement.</p> <p>EVV – Section 1903(l)(1): to enable the state to waive the EVV requirements for individuals enrolled in the Community First Choice program and receiving services under the coordinated personal care service delivery system.</p> <p>Reasonable promptness – Section 1902(a)(8): to enable the state to limit the number of individuals receiving rental subsidies and guardianship/supportive decision-making services.</p> <p>Financial eligibility – Section 1902(e)(3): to allow the state to accept attestation of income and resources for enrollment in Medicaid medical services.</p> <p>Expenditure authority</p> <ul style="list-style-type: none"> • Rental subsidies: expenditures to provide up to three years of rental subsidies to support independence and transition to the community of individuals qualifying for LTSS offered through ALTSA who meet certain criteria defined in the demonstration. • Coordinated personal care services: expenditures to provide coordinated personal care services to individuals qualifying for LTSS offered through ALTSA who meet certain criteria defined in the demonstration and without regard to EVV requirements under Social Security Act 1903(l) and provider choice requirements under Section 1915(k) person-centered planning process. • Guardianship and decision-making supports: expenditures to provide guardianship and legal decision-making supports to individuals qualifying for

Primary goal	Policy/program name	Status within this renewal request	Waiver/expenditure authority
			<p>LTSS offered through ALISA who meet certain criteria defined in the demonstration.</p> <ul style="list-style-type: none"> • PE: expenditures to provide PE to individuals applying for LTSS offered through ALISA who meet certain criteria defined in the demonstration.
<p>Goal 3: accelerating care delivery and payment innovation focused on HRSN</p>	<p>2.3 WA-ICA</p>	<p>New</p>	<p>Expenditure authority</p> <ul style="list-style-type: none"> • WA-ICA: expenditures for development of a centralized, HCA-administered process for provider behavioral health integration assessment and an incentive pool to support smaller practices advancing along the integration continuum.
	<p>3.1 TAHC program (formerly MTP Initiative 1):</p> <ul style="list-style-type: none"> • Community Hubs • HRS • Health equity programs • Community-based workforce 	<p>Evolving</p>	<p>Waiver authority</p> <ul style="list-style-type: none"> • State wideness/uniformity – Section 1902(a)(1) and 42 CFR §431.50: to the extent necessary to enable the state to make payments to community hubs for demonstration programs and services that vary regionally in amount and purpose. • Amount, duration, scope, and service – Section 1902(a)(10)(B): to permit the state to provide benefits under HRS that are not available in the standard Medicaid benefit package. <p>Expenditure authority</p> <ul style="list-style-type: none"> • Community Hubs funding to ACHs: expenditures for funding to regionally based ACHs for the development and ongoing operations of Community Hubs, (regional centers for community-based care coordination focused on HRSN that will provide screening for and referral to community-based services for Apple Health enrollees, in collaboration with other existing care coordination entities). • Expenditures related to health equity programs: expenditures for payments to

Primary goal	Policy/program name	Status within this renewal request	Waiver/expenditure authority
			<p>ACHs for planning and to qualified applicants approved under one or more health equity initiatives. Such expenditures may include payments for allowable administrative costs, services, supports, infrastructure, and interventions, which may not be recognized as medical assistance under Section 1905(a) or may not otherwise be reimbursable under Section 1903, to the extent such activities are authorized as part of an approved health equity program.</p> <ul style="list-style-type: none"> • Expenditures related to medical respite: expenditures for medical respite (short-term post-hospitalization residential care and housing services)—as detailed in the service description in the demonstration—for Medicaid enrollees who meet the eligibility criteria specified in the demonstration and any related requirements. • Expenditures related to HRS: expenditures for HRS as detailed in the demonstration, for Medicaid FFS enrollees who meet the eligibility criteria specified in the demonstration. • Community-based workforce capacity expansion: expenditures for payments to Community Hubs for community-based workforce capacity expansion. Such expenditures may include payments for allowable administrative costs, services, supports, infrastructure, and interventions, which may not be recognized as medical assistance under Section 1905(a) or may not otherwise be reimbursable under Section 1903, to the extent such activities are authorized as part of a Community Hub. • CHW in pediatric primary care: expenditures to receive federal matching funds to support CHW

Primary goal	Policy/program name	Status within this renewal request	Waiver/expenditure authority
	3.2 FCS (formerly MTP Initiative 3)	Continuing	<p>services, such as outreach, informal counseling, and social supports for HRSN under a pilot program.</p> <p>Waiver authority</p> <ul style="list-style-type: none"> • Reasonable promptness – Section 1902(a)(8): to enable the state to limit the number of individuals who receive FCS benefits under the demonstration. • Freedom of choice – Section 1902(a)(23)(A): to the extent necessary, enable the state to restrict freedom of choice of provider for individuals who receive FCS benefits under the demonstration. • Amount, duration, scope, and service – Section 1902(a)(10)(B): to permit the state to offer a varying set of benefits to beneficiaries eligible for the FCS program. <p>Expenditure authority</p> <ul style="list-style-type: none"> • FCS: expenditures for home and community-based services (HCBS) and related services as described in this demonstration.

Eligibility impact

The below table outlines the Medicaid eligibility groups that the waiver will impact for each program or policy change. It is important to note that this waiver will not establish more restrictive eligibility standards for the 2 million individuals enrolled in Apple Health. MTP 2.0 aims to expand eligibility for and strengthen access to coverage for Apple Health enrollees as well as improve care delivery.

Table 12: Medicaid eligibility groups affected by MTP 2.0 policies and programs

Eligibility group	Federal citations	Income level	Program or policy change ⁶⁶
Infants and children under age 19	42 CFR 435.118	0% - 215% FPL	1.1 Continuous Apple Health enrollment for children; and 3.1 TAHC
Children under age 19	42 CFR 435.926 42 CFR 435.370	0% - 317% FPL	1.2 Re-entry coverage for continuity of care; 1.4 SUD and MH IMD; 3.1 TAHC; and 3.2 FCS ⁶⁷
Adults	42 CFR 435.119	0% - 138% FPL	1.2 Re-entry coverage for continuity of care; 1.4 SUD and MH IMD; 3.1 TAHC; and 3.2 FCS
Parents/caretaker relatives	42 CFR 435.110	0% - 59% FPL	1.2 Re-entry coverage for continuity of care; 1.4 SUD and MH IMD; 3.1 TAHC; and 3.2 FCS
Pregnant and postpartum individuals	42 CFR 435.116 42 CFR 435.170	0% - 193% FPL	1.2 Re-entry coverage for continuity of care; 1.4 SUD and MH IMD; 3.1 TAHC; and 3.2 FCS
Aged/blind/disabled	42 CFR 435.120 42 CFR 435.1 42 CFR 435.217	0% - 74% FPL	1.2 Re-entry coverage for continuity of care; 1.4 SUD and MH IMD; 3.1 TAHC; and 3.2 FCS

⁶⁶ 2.2. WA-ICA applies to various programs under MTP 2.0 but is not associated with eligibility groups. All eligibility groups may benefit from the system improvements supported by WA-ICA, including advancements in integrated care.

⁶⁷ FCS eligibility includes children 16 years and older.

		Criteria outlined in Washington Administrative Code (WAC): For 1915c waivers: 182-515-1506	1.4 SUD and MH IMD; 2.1 MAC and TSOA programs; and 2.2 Program innovations for LTSS
Modified Adjusted Gross Income (MAGI)	42 CFR 435.119	For CFC (1915k): 182-513-1215	1.4 SUD and MH IMD; 2.2. Program innovations for LTSS; and 2.3 WA-ICA
Foster care and former foster care	42 CFR 435.145 42 CFR 435.150	N/A	1.2 Re-entry coverage for continuity of care; 1.4 SUD and MH IMD; 3.1 TAHC; and 3.2 FCS
Individuals applying for Medicaid/CHIP during the postpartum period, not previously enrolled in Medicaid or CHIP during pregnancy (new)	CMS guidance Senate Bill 5068	0% - 193% FPL	1.2 Re-entry coverage for continuity of care; 1.3 Apple Health postpartum coverage expansion; 1.4 SUD and MH IMD; 3.1 TAHC; and 3.2 FCS
Unborn child option pregnancy coverage (CHIP-funded) (existing)	CHIPRA §111	0% - 193% FPL	1.2 Re-entry coverage for continuity of care; 1.3 Apple Health postpartum coverage expansion; 1.4 SUD and MH IMD; 3.1 TAHC; and 3.2 FCS
“At risk” for Medicaid - also known as TSOA	N/A	0% - 400% FPL	2.1 MAC and TSOA programs

Benefits and cost-sharing impact

MTP 2.0 will not increase or change Apple Health cost sharing and only proposes extended or expanded benefits. Several MTP 2.0 policies and programs will extend availability of existing benefits to additional populations or expand benefits available to impacted populations. A summary of the benefits proposed are included in Table 13 below.

Table 13: benefits for MTP 2.0

Policy/program name	Benefits
1.1 Continuous Apple Health enrollment for children	No impact
1.2 Re-entry coverage for continuity of care	<p>Currently, when an individual becomes incarcerated, their Medicaid benefits package is placed in suspended status, and the full scope of coverage is restored upon release. Waiving the inmate exclusion for 30 days pre-release would extend full benefits to individuals exiting Washington’s carceral system.</p> <p>Apple Health enrollees who become confined to a state hospital or IMD have their Apple Health coverage terminated. Waiving the termination of coverage would extend benefits 30 days prior to their discharge.</p>
1.3 Apple Health postpartum coverage expansion	Extends benefits and services that exist in the current postpartum coverage groups for the new population/eligibility group.
1.4 SUD and MH IMD: supports for people receiving SUD and mental health treatment (formerly MTP Initiatives 4 and 5)	Extends treatment services in participating facilities for enrollees with SUD and SMI/SED, including CM for qualifying enrollees receiving services from a participating site.
2.1 MAC and TSOA programs (formerly MTP Initiative 2)	<p>MAC: provides an alternate benefit package. With the exception of services authorized under PE, services offered under this benefit will not duplicate services covered under the state plan, Medicare, private insurance, or through other federal or state programs. MAC benefits include:</p> <ul style="list-style-type: none"> • Caregiver assistance services: services that take the place of those typically performed by the unpaid caregiver in support of unmet needs the care receiver has for assistance with ADL and instrumental ADL. Services include housework, errands, transportation in conjunction with delivery of a service, respite (in and out of home), home-delivered meals, and home safety evaluations/minor modifications to maintain a safe environment. New services under this category

	<p>include nurse delegation, pest eradication services, specialized deep cleaning, and community choice guide services.</p> <ul style="list-style-type: none"> • Training and education: services and supports to assist caregivers with gaining skills and knowledge to implement services and supports needed by the care receiver to remain at home or skills needed by the caregiver to remain in their role. Services include, for example, support groups, group training, caregiver coping / skill building, and health, financial, or legal consultations. • Specialized medical equipment & supplies: goods and supplies needed by the care receiver, including specialized medical equipment, PERS, and assistive technology. • Health maintenance and therapy supports: clinical or therapeutic services that assist the care receiver to remain in their home or the caregiver to remain in their caregiving role and provide high-quality care. Supports and services include those typically performed or provided by people with specialized skill, certification, or licenses, such as adult day health, counselling, Reducing Disability in Alzheimer Disease (RDAD) and evidence-based (EB) exercise programs, and health promotion and wellness services. <p>TSOA: provides the benefits included under MAC (above), in addition to:</p> <ul style="list-style-type: none"> • Personal assistance services: supports involving the labor of another person to help participants carry out everyday activities they are unable to perform independently. Services may be provided in the person's home or to access community resources. Services include, but are not limited to personal care, nursing delegation, adult day care, and other services. New services under this category include nurse delegation, pest eradication services, specialized deep cleaning, and community choice guide services
<p>2.2 Program innovations for LTSS</p>	<p>Provides new benefits as LTSS:</p> <ul style="list-style-type: none"> • Rental subsidies: rent subsidy vouchers • Coordinated personal care: provision of personal care services in a service delivery model based on geographic efficiencies of scale that retains the individual nature of personal care services. It allows scheduling and service provision flexibility for clients and caregivers in places where personal care hours are being delivered to clients living in proximity to one another. • Guardianship: compensation of OPG-contracted guardians to provide informed consent/supportive decision-making for transition from institutional settings and for medical care purposes. <p>Provides earlier access to certain Medicaid benefits for those applying for LTSS:</p> <ul style="list-style-type: none"> • LTSS NFLOC PE benefit package will include a subset of services available under the 1915(c) COPES waiver and the 1915(k) Community First Choice state plan option:

	<ul style="list-style-type: none"> ○ Personal care services (in both residential and in-home settings) which are included in the EVV system implementation ○ Nurse delegation ○ PERS for individuals living in their own home ○ Home-delivered meals (limit of two per day) in settings where the individual is directly responsible for his or her own living expenses ○ Specialized medical equipment and supplies ○ Assistive/adaptive technology and equipment ○ Community transition or sustainability services: goods and services which are nonrecurring set-up items and services to assist with expenses to move from an acute care hospital or diversion from a psychiatric hospital stay to an in-home setting and may include: <ul style="list-style-type: none"> ▪ Security deposits that are required to lease an apartment or home. ▪ Activities to assess need, arrange for, and obtain needed resources, including essential household furnishings. ▪ Set-up fees or deposits for utility or services access, including telephone, electricity, heating, water, and garbage. ▪ Services necessary for health and safety, such as pest eradication, and one-time cleaning prior to occupancy. ▪ Moving expenses. ○ Minor home accessibility modifications or improvements that are of direct medical or remedial benefit to the participant and are not of general utility. Modifications that add to the total square footage of the home are also excluded from this benefit except when necessary to complete the modification. ○ Community choice guide: specialty services that provide assistance and support to ensure an individual’s successful transition to the community and/or maintenance of independent living. ○ Supportive housing services, defined in WAC 182-559-150, which includes an active search and promotion of access to and choice of safe and affordable housing that is appropriate to the enrollee’s age, culture, and needs. ● The LTSS MPC PE benefit package will include: <ul style="list-style-type: none"> ○ Personal care services (in both residential and in-home settings) which are included in the EVV system implementation ○ Nurse delegation in licensed residential settings (adult family home and assisted living facility)
2.3 WA-ICA	No impact

<p>3.1 TAHC program (formerly Initiative 1)</p>	<p>See Appendix A for a list of HRS.</p>
<p>3.2 FCS (formerly MTP Initiative 3)</p>	<p>Provides a set of HCBS, including CSS and IPS. These services do not pay for housing or for wages or wage enhancements.</p> <p>CSS benefits package: includes services that would otherwise be allowable under a Section 1915(i) authority; are determined to be necessary for an individual to obtain and reside in an independent community setting; and are tailored to the end goal of maintaining individual recipients’ personal health and welfare in a home and community-based setting. CSS services include:</p> <p>Pre-tenancy supports:</p> <ul style="list-style-type: none"> • Conducting a functional housing needs assessment. • Assisting individuals to connect with social services. • Developing an individualized community integration plan. • Participating in person-centered plan meetings. • Providing supports and interventions per the person-centered plan. <p>Tenancy sustaining services:</p> <ul style="list-style-type: none"> • Service planning support and participating in person-centered plan meetings. • Coordinating and linking the recipient to health care and social services. • Entitlement assistance. • Assistance in accessing supports to preserve the most independent living. • Providing supports to assist in the development of independent living skills. • Providing supports to assist the individual in communicating with the landlord and/or property manager regarding the participant’s disability. • Coordinating with the tenant to review, update, and modify their housing support and crisis plan. • Connecting the individual to training and resources that will assist the individual in being a good tenant and lease compliance. <p>The CSS benefit does not include:</p> <ul style="list-style-type: none"> • Payment of rent or other room and board costs. • Ongoing minutes or data plans for cell phone devices. • Capital costs related to the development or modification of housing. • Expenses for utilities or other regular occurring bills. • Goods or services intended for leisure or recreation. • Duplicative services from other state or federal programs • Services to individuals in a correctional institution.

IPS benefit package: includes services that would otherwise be allowable under a Section 1915(i) authority and are determined to be necessary for an individual to obtain and maintain employment in the community. IPS services include:

Pre-employment services:

- Pre-vocational/job-related discovery or assessment
- Person-centered employment planning
- Individualized job development and placement
- Job carving (working with client and employer to modify an existing job description when a potential applicant for a job is unable to perform all of the duties identified in the job description)
- Benefits education and planning
- Transportation (only in conjunction with the delivery of an authorized service)

Employment sustaining services:

- Career advancement services (services that expand opportunities for professional growth, assist with enrollment in higher education or credentialing and certificate programs to expand job skills or enhance career development)
- Negotiation with employers (where a provider identifies and addresses job accommodations or assistive technology needs with the employer on behalf of the individual)
- Job analysis (gathering, evaluating, and recording of accurate, objective data about the characteristics of a particular job to ensure the specific matching of skills and amelioration of maladaptive behaviors)
- Job coaching
- Benefits education and planning
- Transportation (only in conjunction with the delivery of an authorized service)
- Asset development (services supporting the client's accrual of assets that have the potential to help clients improve their economic status, expand opportunities for community participation, and positively impact their quality-of-life experience)
- Follow-along supports (on-going supports necessary to assist an eligible client to sustain competitive work in an integrated setting of their choice)

The IPS benefit does not include:

- Generalized employer contacts that are not connected to a specific enrolled individual or an authorized service
- Employment support for individuals in sub-minimum wage, or sheltered workshop settings
- Facility-based habilitation or personal care services
- Wage or wage enhancements for individuals

- Duplicative services from other state or federal programs
- Ongoing minutes or data plan for cell phone devices

Delivery system impact

Apple Health enrollees will continue to access care during MTP 2.0 through delivery systems defined in the state plan, Section 1932, 1915 (b), 1915 (c), 1915 (k) and other waivers in place. These delivery systems include managed care—MCOs and primary care case management—and FFS. The Demonstration does not seek to make any changes to the existing Apple Health delivery systems apart from the improvements and reforms described below.

MTP 2.0 will build on delivery system reforms Washington has made to-date, aiming to ensure equitable access to whole-person care, empowering people to achieve their optimal health and wellbeing in the setting of their choice; build healthier, equitable communities, with communities; and pay for integrated health and equitable, value-based care. This waiver application proposes to do so by:

- Expanding coverage and access to care, including continuous enrollment for children, re-entry coverage for continuity of care, extending postpartum coverage to 12 months, and continuing the highly successful SUD and MH IMD programs.
- Advancing whole-person primary, preventive, and home- and community-based care, including continuing the MAC and TSOA programs, implementing innovations for LTSS, and further integrating the physical and behavioral health care systems.
- Accelerating care delivery and payment innovation focused on HRSN, including ongoing implementation of the FCS program and new advancements through the TAHC program: implementing Community Hubs, providing funding for equity interventions at the community level, and paying for HRS alongside health services.

Enrollment impact

The state is not proposing any changes to Apple Health eligibility requirements in the Section 1115 demonstration renewal request that would negatively impact enrollment. Current average Medicaid annual enrollment is 1,920,517 for CY2022. Annual Medicaid enrollment is expected to decrease once the public health emergency ends. Washington expects that this decrease will happen over 12 months. The projected Medicaid enrollment provided below includes a subset of the non-expansion adults population. It does not include clients enrolled in Medicare Savings Programs, CHIP, or other medical programs not part of Medicaid.

MTP 2.0 policies, such as continuous enrollment for children, re-entry coverage, and LTSS program innovations are estimated to increase Medicaid enrollment. Preliminary estimates of enrollment impact by MTP 2.0 policy or program are below, for future refinement by HCA.

Table 14: preliminary estimates of enrollment impact

	DY7 (2023)	DY8 (2024)	DY9 (2025)	DY10 (2026)	DY 11 (2027)
Projected Medicaid enrollment	1,625,771	1,590,331	1,564,345	1,540,176	1,517,716

1.1 Continuous Apple Health enrollment for children	24,862	24,705	24,548	24,393	24,239
1.2 Re-entry coverage for continuity of care	222,950	222,950	222,950	222,950	222,950
1.3 Apple Health postpartum coverage expansion	9,470	9,470	9,470	9,470	9,470
1.4 SUD and MH IMD	N/A				
2.1 MAC and TSOA	N/A				
2.2 Program innovations for LTSS	533	800	800	800	800
2.3 WA-ICA	N/A				
3.1 TAHC	N/A				
3.2 FCS	N/A				

Demonstration financing and budget/allotment neutrality

Below is a summary table of Washington’s with-waiver and without-waiver expenditures for MTP 2.0. The state is projected to meet budget neutrality requirements.

To finance the non-federal share of the MTP 2.0 demonstration, Washington intends to use a combination of intergovernmental transfers and general fund dollars, like the initial MTP demonstration. Washington also seeks flexibility from CMS to identify other sources of non-federal funding, including consideration of state and local investments in approved designated state health programs (DSHP) that CMS previously approved.

Table 15: MTP historical expenditures

<u>Without-Waiver Total Expenditures</u>		<u>Actuals plus projections through DY5</u>						Total
		DEMONSTRATION YEARS (DY)						
		1 (1/1 - 12/31/2017)	2 (1/1 - 12/31/2018)	3 (1/1 - 12/31/2019)	4 (1/1 - 12/31/2020)	5 (1/1 - 12/31/2021)	6* (1/1 - 12/31/2022)	
Medicaid Per Capita								
Non-Expansion Adults Only	Total	\$4,528,764,874	\$4,606,639,708	\$3,006,339,736	\$3,208,825,524	\$3,505,752,692	\$3,647,334,630	
	PMPM	\$1,012.82	\$1,046.24	\$694.38	\$722.16	\$751.05	\$751.05	
	Mem-Mon	4,471,441	4,403,043	4,329,531	4,443,372	4,667,802	4,856,314	
TOTAL		\$ 4,528,764,874	\$ 4,606,639,708	\$ 3,006,339,736	\$ 3,208,825,524	\$ 3,505,752,692	\$ 3,647,334,630	\$ 22,503,657,163
<u>With-Waiver Total Expenditures</u>		<u>Actuals plus projections through DY5</u>						Total
		DEMONSTRATION YEARS (DY)						
		1 (1/1 - 12/31/2017)	2 (1/1 - 12/31/2018)	3 (1/1 - 12/31/2019)	4 (1/1 - 12/31/2020)	5 (1/1 - 12/31/2021)	6* (1/1 - 12/31/2022)	
Medicaid Per Capita								
Non-Expansion Adults Only	Total	\$4,127,735,474	\$4,587,790,292	\$2,568,179,713	\$2,622,977,778	\$2,911,837,802	\$2,832,804,746	
	PMPM	\$923.13	\$1,041.96	\$593.18	\$590.31	\$623.81	\$583.32	
	Mem-Mon	4,471,441	4,403,043	4,329,531	4,443,372	4,667,802	4,856,314	
Medicaid Aggregate - WW only								
DSHP		\$192,631,572	\$181,287,442	\$118,941,926	\$50,466,103	\$52,598,437	\$1	
DSRIP		\$242,100,000	\$232,600,000	\$179,180,434	\$143,510,022	\$63,250,000	\$101,679,588	
MAC and TSOA Not Eligible		\$0	\$1,587	\$1,438	\$3,159	\$600	\$0	
TOTAL		\$4,562,467,046	\$5,001,679,321	\$2,866,303,511	\$2,816,957,062	\$3,027,686,839	\$2,934,484,335	\$ 21,209,578,114
Actual Cumulative Variance (Positive = Overspending)		(\$33,702,172)	(\$395,039,613)	\$140,036,225	\$391,868,462	\$478,065,853	\$712,850,295	\$581,228,754
NET VARIANCE - SAVINGS								\$581,228,754

Variance was adjusted to show savings through DY05. Per STC 106, cannot accumulate savings in DY06.

Table 15 continuing: MTP historical expenditures

Expenditure Authorities	DEMONSTRATION YEARS (DY)						Total
	1 (1/1 - 12/31/2017)	2 (1/1 - 12/31/2018)	3 (1/1 - 12/31/2019)	4 (1/1 - 12/31/2020)	5 (1/1 - 12/31/2021)	6* (1/1 - 12/31/2022)	
Medicaid Transformation Project (Hypotheticals)							
Initiative 2: Medicaid Alternative Care and Tailored Supports for Older Adults	\$149,435	\$3,764,589	\$10,106,518	\$17,076,859	\$22,507,413	\$47,453,000	\$101,057,814
Initiative 3: Foundational Community Supports (FCS)	\$0	\$1,282,185	\$7,267,200	\$16,021,557	\$16,241,701	\$22,961,407	\$63,774,050
Initiative 4: Substance Use Disorder Institutions for Mental Diseases (IMD)	\$0	\$459,060	\$2,135,081	\$3,262,506	\$2,836,879	\$16,508,550	\$25,202,076
Initiative 5: Mental Health IMD	\$0	\$0	\$0	\$10,336	\$337,950	\$4,792,708	\$5,140,994
Hep C Rx	\$84,720,557	\$31,135,206	\$23,941,932	\$13,601,930	\$11,749,666	\$11,749,666	\$176,898,957
TOTAL	\$84,869,992	\$36,641,040	\$43,450,731	\$49,973,188	\$53,673,609	\$103,465,331	\$372,073,891

*DY6 are projections.

Table 16: MTP 2.0 projected expenditures (continues on to next page)

Without-Waiver Total Expenditures		Projections					Total
		DEMONSTRATION YEARS (DY)					
		7	8	9	10	11	
Medicaid Per Capita							
Non-Expansion Adults Only	Total	\$3,281,396,456	\$3,495,035,244	\$3,739,530,108	\$4,001,197,284	\$4,281,247,459	
Proposed PMPM	PMPM	\$754.54	\$801.32	\$851.00	\$903.77	\$959.80	
	Mem-Mon	4,348,867	4,361,586	4,394,256	4,427,247	4,460,563	
TOTAL		\$ 3,281,396,456	\$ 3,495,035,244	\$ 3,739,530,108	\$ 4,001,197,284	\$ 4,281,247,459	\$ 18,798,406,551
With-Waiver Total Expenditures							
		DEMONSTRATION YEARS (DY)					Total
		7	8	9	10	11	
Medicaid Per Capita							
Non-Expansion Adults Only	Total	\$2,781,415,702	\$2,952,688,731	\$3,164,576,507	\$3,391,727,785	\$3,635,246,067	
	PMPM	\$639.57	\$676.98	\$720.16	\$766.10	\$814.97	
	Mem-Mon	4,348,867	4,361,586	4,394,256	4,427,247	4,460,563	
Medicaid Aggregate - WW only							
DSHP		\$86,901,142	\$130,301,924	\$132,738,665	\$127,542,163	\$122,516,106	
TOTAL		\$2,868,316,844	\$3,082,990,655	\$3,297,315,172	\$3,519,269,948	\$3,757,762,173	\$ 16,525,654,792
BASE VARIANCE		\$413,079,612	\$412,044,589	\$442,214,936	\$481,927,335	\$523,485,286	\$2,272,751,759
Carry-Forward Savings From Prior Period							\$581,228,754
NET VARIANCE - SAVINGS							\$2,853,980,513

Expenditure Authorities	7 (1/1 - 12/31/2023)	8 (1/1 - 12/31/2024)	9 (1/1 - 12/31/2025)	10 (1/1 - 12/31/2026)	11 (1/1 - 12/31/2027)	
MTP 2.0 (Hypotheticals)						
1.1 Continuous Apple Health Enrollment for Children	\$26,951,000	\$26,781,000	\$26,612,000	\$26,443,000	\$26,276,000	\$133,063,000
1.2 Re-entry coverage for continuity of care	\$99,056,685	\$100,896,000	\$102,770,000	\$104,678,000	\$106,622,000	\$514,022,685
1.3 Apple Health Postpartum Coverage Expansion	\$16,293,195	\$16,293,195	\$16,293,195	\$16,293,195	\$16,293,195	\$81,465,975
1.4 SUD and Mental Health IMD: Supports for people receiving substance use disorder and mental health treatment (Formerly MTP Initiatives 4 and 5)	\$22,917,513	\$24,661,768	\$26,543,045	\$28,572,456	\$30,762,043	\$133,456,825
2.1 Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) programs (Formerly MTP Initiative 2)	\$48,983,000	\$52,463,000	\$55,152,000	\$57,454,000	\$59,863,000	\$273,915,000
2.2 Program Innovations for Long Term Services and Supports (LTSS)	\$33,273,000	\$57,906,000	\$61,518,000	\$61,518,000	\$61,518,000	\$275,733,000
2.3 Washington Integrated Care Behavioral Health Integration Assessment (WA-ICA)	\$3,870,000	\$6,120,000	\$6,660,000	\$6,660,000	\$6,660,000	\$29,970,000
3.1 Taking Action for Healthier Communities – (TAHC) Program (Formerly MTP Initiative 1)	\$83,031,142	\$124,181,924	\$126,078,665	\$120,882,163	\$115,856,106	\$570,030,000
3.2 Foundational Community Supports (FCS) (Formerly MTP Initiative 3)	\$34,634,859	\$35,916,607	\$37,246,426	\$38,626,140	\$40,057,644	\$186,481,676
Hep C Rx	\$13,863,425	\$13,900,608	\$13,862,622	\$13,862,622	\$13,862,622	\$69,351,898
TOTAL	\$382,873,819	\$459,120,102	\$472,735,953	\$474,989,576	\$477,770,609	\$2,267,490,059

Preliminary evaluation results and evaluation design for the renewal

MTP evaluation

CHSE currently serves as the IEE for the state's MTP demonstration and SUD amendment (SUD IMD). A proposed evaluation design for the state's approved mental health amendment (MH IMD) is in review with CMS.

The MTP evaluation employs a parallel mixed-methods design drawing from several data sources (described below). To date, the IEE has provided the following evaluation deliverables:

- [Baseline Evaluation Report](#) delivered in May 2020.
- [Interim Evaluation Report](#) delivered in December 2020.
- [Mid-Point Assessment](#) of the state's SUD amendment, delivered in December 2020.
- [Quarterly progress reports](#) (Rapid-cycle Monitoring Reports) spanning September 2018 to the present.

Evaluation progress and key findings

MTP Initiative 1: Medicaid system performance and ACHs

CHSE's evaluation of Initiative 1 has relied on 1) longitudinal analysis of 44 statewide Medicaid performance measures from 2017 through 2020, 2) a survey of Medicaid primary care providers and hospitals administered in 2019, 3) a difference-in-differences analysis comparing health and social outcomes for priority populations in regions participating and not participating in ACH health improvement projects through 2019, and 4) key informant interviews with ACH representatives, provider organizations, and state and MCO employees through 2021.

To date, the evaluation of **MTP Initiative 1** found the following:

- **Statewide performance:** SUD treatment and prevention and timely prenatal care measures showed improvement as of late 2020. These improvements were sustained after the onset of the COVID-19 pandemic. Measures of the quality of care for chronic conditions improved early in the demonstration but leveled off in later years. Other measures, including those related to SDOH and primary care access, and the use of ED and hospitals were mostly unchanged prior to the pandemic. During the pandemic, in-person care (e.g., ED visits and cancer screenings) declined. Services deliverable via telehealth (e.g., medication management) remained stable or recovered after a short-term dip. Racial and ethnic disparities were apparent in a variety of measures and persisted during the demonstration.
- **Delivery system transformation:** ACHs carried out activities and cultivated partnerships to promote VBP and the adoption of HIT and CIE among providers in their regions. ACHs have also promoted MTP goals through training for existing health care workers, as well as training new CHWs. However, ACHs struggled to identify their role in these regional efforts and sometimes lacked leverage or financing to drive change. The state achieved early targets for VBP participation. The state's ongoing transition to behavioral health IMC created some implementation and billing challenges for substance use providers looking to expand services as part of the SUD amendment. In 2021, ACHs continued to struggle with promoting payment and HIT reforms due to lack of leverage points with payers and providers.

- **Health improvement projects:** ACHs contracted with a variety of organizations to carry out regional health improvement projects. The MTP pay-for-performance measures initially focused ACHs' efforts on clinically based projects, with less emphasis on SDOH. Evaluations of projects through 2019 found relatively few detectable improvements, although these analyses were based on the very early parts of the intervention. Most projects were at an early stage of implementation in 2019, with ACHs focused on capacity building and partnership development. ACHs later contributed to the state's COVID-19 response, leveraging their partner and information exchange networks to meet community needs during the pandemic.

MTP Initiative 2: LTSS

CHSE's evaluation of LTSS focuses on the state's MAC and TSOA programs. The evaluation relied on administrative records, including MAC and TSOA program enrollment, Medicaid claims and encounters, and surveys of MAC/TSOA program participants and their informal caregivers. To date, the evaluation of Initiative 2 found:

- **Enrolling participants:** enrollment in TSOA increased steadily in the years after the program launched. Enrollment in MAC ramped up more slowly and remained low. There is an opportunity to strengthen connections between MTP Initiatives 1 and 2.
- **Meeting participant needs:** one goal of the TSOA program is to delay or reduce the need for more intensive Medicaid-paid LTSS. The analysis of TSOA participant utilization of LTSS found that one-quarter of TSOA participants went on to enroll in traditional Medicaid within six months of participation, but few used traditional Medicaid-paid LTSS. Participant and caregiver satisfaction was high for both programs. Most participants noted the programs helped them avoid moving to a nursing home or adult family home.

MTP Initiative 3: FCS

CHSE's evaluation of FCS focused on outcomes for Medicaid members enrolled in supportive housing, supported employment, or both services, through the FCS program. This analysis relied primarily on FCS program enrollment records and Medicaid claims and encounters. These data were initially supplemented with a small number of key informant interviews to understand the program implementation context. Further qualitative data collection was underway in 2021. To date, the evaluation of Initiative 3 found:

- **Enrolling participants and building a provider network:** enrollment in supportive housing and supportive employment increased steadily in the program's first two years. However, a lack of service providers in rural areas presented challenges for building a provider network. In some areas, housing shortages also presented challenges to meeting participants' needs. Although there was potential for coordination between FCS and ACH health improvement projects, most ACHs were unaware of opportunities to connect the initiatives in the earlier years of the demonstration.
- **Outcomes for participants:** early results for IPS revealed significant increases in employment and SUD treatment penetration. The impact of supportive housing was less clear, which may be related to shortages in affordable housing and difficulties constructing a well-matched comparison group for this population.

MTP Initiative 4: SUD IMD

The evaluation of SUD IMD focused on the state's implementation of its SUD amendment. This analysis relied on Medicaid claims and encounters and other administrative records provided by the state. A

series of key informant interviews were conducted for the SUD amendment mid-point assessment in 2019 and were secondarily analyzed for the interim evaluation. The evaluation of MTP Initiative 4 found:

- **Implementing the SUD amendment:** SUD treatment and mental health providers experienced delayed payments and new administrative burdens that were unintended consequences of MTP's co-occurring transition to IMC. ACHs and MCOs offered support for these challenges, but behavioral health providers were slow to transition to IMC. These challenges impeded the implementation of the SUD amendment.
- **Improving access and quality of care:** despite these challenges, access to and quality of SUD treatment meaningfully improved in Washington in the year following implementation of the SUD amendment. There was evidence of increased treatment capacity across the state. Statewide improvements in SUD care measures continued over time and were sustained through late 2020 after the onset of COVID-19.

Proposed evaluation design

In conjunction with the IEE, Washington will update the existing approved evaluation design to reflect changes in the evaluation timelines and activities to reflect the programs and policies proposed in this renewal application. Currently, CMS is reviewing the addition of the SMI IMD evaluation design to the existing approved evaluation design. While this is being reviewed, the state is tracking updates that will need to be made, following approval, to account for the one-year extension (DY6) of the MTP demonstration, which was granted because of the impacts of the COVID-19 pandemic.

Pending approval of the MTP 2.0 application, the state will work with CHSE to incorporate any needed changes to the evaluation design to account for the one-year extension and proposed renewal activities while meeting the demonstration evaluation requirements set forth by CMS. The state anticipates that these changes will either be (1) minor timeline changes to reflect the renewal timeframe; (2) minor, substantive changes due to proposed program improvements; or (3) development of an evaluation design for new activities.

Minor timeline changes expected

Three of the current programs, the SUD IMD, MH IMD, and MAC and TSOA programs are continuing from the existing MTP demonstration with minimal or no changes to the programs. The impacts on the evaluation design are anticipated to be minimal and will primarily be timeline-related changes. These timeline changes will reflect both the extension year (DY6) and the five-year renewal period.

Changes to reflect program improvements

One current program, FCS, has undergone some program improvements since the original evaluation design was approved by CMS. In addition, some further program enhancements are proposed under the renewal. The state anticipates a need to refine the methodology in the evaluation design to appropriately evaluate this program in addition to timeline-related updates.

Development of evaluation design for new activities

An evaluation design will need to be developed for the new programs and activities proposed under MTP 2.0. This includes the following new programs:

- Continuous Apple Health enrollment for children
- Re-entry coverage for continuity of care
- Expanded Apple Health coverage after pregnancy
- CM Interventions

- Program innovations for LTSS, including rental subsidies, coordinated personal care, guardianship and decision-making supports, and PE
- WA-ICA
- TAHC

Addressing the new and enhanced programs listed above will require a mix of quantitative and qualitative research methodologies. The state will ensure programs support the collection, dissemination, and comparison of valid quantitative data to support the evaluation design. From these, the state must select a preferred research plan for the applicable research question and provide a rationale for its selection.

To the extent applicable, the following items will be addressed within the evaluation design:

- Quantitative or qualitative outcome measures
- Baseline and/or control comparisons
- Process and improvement outcome measures and specifications
- Data sources and collection frequency
- Robust sampling designs (e.g., controlled before-and-after studies, interrupted time series design, and comparison group analyses)
- Cost estimates
- Timelines for deliverables

Demonstration new, continued, and enhanced hypotheses/focus

The state will test the following hypotheses (below) in its evaluation of MTP 2.0. However, the state anticipates it will be necessary to refine these hypotheses within the final evaluation design based on input from the IEE, public comment, and subject matter experts. Health equity will be embedded throughout the evaluation design to the extent possible, including how the health equity investments described in section 3.1.3 advance program goals across MTP 2.0.

Table 17: MTP 2.0 evaluation hypotheses

New, continuing, or enhanced	Hypothesis	Evaluation method/data source
1.1 Continuous Apple Health enrollment for children		
New	MTP 2.0 will reduce churn and gaps in coverage for young children enrolled in Medicaid, including for racial and ethnic groups that experience disproportionately high rates of churn.	Examine enrollment data by age, race, and ethnicity to determine churn over time. Specific evaluation methodology will be submitted upon approval of the application via the revised evaluation design.
New	MTP 2.0 will reduce the uninsured rate for children in Washington, including for racial and ethnic groups that experience disproportionately high uninsured rates.	Examine enrollment data by age, race, and ethnicity to determine changes in insured rates over time. Specific evaluation methodology will be submitted upon approval of the application via the revised evaluation design.
1.2 Re-entry coverage for continuity of care		

New	MTP 2.0 will increase medication adherence for justice-involved, confined to state hospital or treatment facility individuals enrolled in Apple Health.	Analyze administrative/claims data to determine changes in medication adherence over time. Specific evaluation methodology will be submitted upon approval of the application via the revised evaluation design.
New	MTP 2.0 will increase preventive care utilization and reduce ED visits, hospitalizations crisis services, and recidivism.	Analyze administrative/claims data to determine changes in preventive care, ED utilization, hospitalizations, crisis service utilization, and recidivism over time. Specific evaluation methodology will be submitted upon approval of the application via the revised evaluation design.
1.3 Apple Health postpartum coverage expansion		
New	MTP 2.0 will improve access to health care services for postpartum individuals.	Analyze administrative/claims data to determine changes in health care utilization over time. Specific evaluation methodology will be submitted upon approval of the application via the revised evaluation design.
New	MTP 2.0 will reduce churn and gaps in coverage for postpartum individuals and their infants enrolled in Medicaid.	Examine enrollment data by age, race, and ethnicity to determine churn over time. Specific evaluation methodology will be submitted upon approval of the application via the revised evaluation design.
New	MTP 2.0 will reduce the infant mortality rate in Washington.	Analyze administrative/claims data to determine changes in infant mortality rates over time. Specific evaluation methodology will be submitted upon approval of the application via the revised evaluation design.
1.4 SUD and MH IMD		
Continuing	MTP 2.0 will increase SUD inpatient and residential bed capacity, increase Medicaid beneficiary access to inpatient and residential SUD treatment services, and increase the likelihood that Medicaid enrollees receive SUD treatment in the setting most appropriate for their needs.	Measure intervention impacts to SUD measure rates using administrative/claims data. See approved evaluation design for more details. Minor revisions due to timeline changes are expected.
Continuing	MTP 2.0 will increase mental health inpatient and residential bed capacity, increase Medicaid beneficiary access to inpatient and residential mental health treatment services, and increase the likelihood that Medicaid beneficiaries receive mental treatment in the setting most appropriate for their needs.	Measure intervention impacts to mental health measure rates using administrative/claims data. See approved evaluation design for more details. Minor revisions due to timeline changes are expected.

New	Increasing the availability of contingency management will increase the number of Medicaid beneficiaries engaged in treatment for stimulant use disorder.	Analyze administrative/claims data to determine changes in engagement in treatment for stimulant use disorder. Specific evaluation methodology will be submitted upon approval of the application via the revised evaluation design.
New	Engagement in contingency management among Medicaid beneficiaries with stimulant use disorder, including those with co-occurring opioid use disorder will contribute to a decline in overdose deaths.	Analyze administrative/claims data and death records to determine changes in engagement in treatment for stimulant and opioid use disorder, as well as number of deaths from overdose. Specific evaluation methodology will be submitted upon approval of the application via the revised evaluation design.
2.1 MAC and TSOA		
Continuing	MAC program participants will show similar health outcomes to comparable recipients of traditional Medicaid LTSS services.	Measure impacts of change to health outcomes using administrative/claims data. See approved evaluation design for more details. Minor revisions due to timeline changes are expected.
Continuing	Medicaid-paid LTSS cost trends will be lower than expected based on forecasts without MAC and TSOA, derived from baseline Medicaid-paid LTSS utilization rates and the observed changes in per-cap costs and the composition of the Washington State population.	Measure impacts of change to LTSS cost trends using administrative/claims data. See approved evaluation design for more details. Minor revisions due to timeline changes are expected.
Continuing	Individuals receiving the limited scope benefit will better maintain quality of life, as compared to before MTP.	Measure intervention impacts on functional indicators using administrative and survey data. See approved evaluation design for more details. Minor revisions due to timeline changes are expected.
Continuing	Low-needs individuals served in a home setting who are not eligible for nursing home services will have health and safety needs met in the community.	Measure impacts of change in nursing home criteria on utilization of institutional services using administrative data. See approved evaluation design for more details. Minor revisions due to timeline changes are expected.
2.2 Program innovations for LTSS		
New	Rental subsidies will reduce cycling from failed placements among individuals receiving rental subsidies and with complex health care needs.	Analyze administrative/claims data to determine changes in housing stability over time. Specific evaluation methodology will be submitted upon approval of the application via the revised evaluation design.

New	The use of Medicaid funds to support access to guardianship for targeted individuals will result in reducing barriers to discharge, including less-restrictive client transition, and shorter lengths of stay.	Analyze administrative/claims data to determine changes in access to guardianship over time and lengths of stay for individuals awaiting discharge. Specific evaluation methodology will be submitted upon approval of the application via the revised evaluation design.
New	Caregivers providing coordinated personal care to individuals based on geographic proximities will increase utilization of personal care services, while minimizing emergency medical interventions.	Analyze administrative/claims data to determine changes in caregiver utilization rates and emergency medical utilization over time. Specific evaluation methodology will be submitted upon approval of the application via the revised evaluation design.
New	Expedited process for PE to targeted individuals will improve access to and utilization of essential services for clients.	Analyze administrative/claims data to determine changes in presumptive eligibility rate and service utilization rates over time. Specific evaluation methodology will be submitted upon approval of the application via the revised evaluation design.
2.3 WA-ICA		
New	MTP 2.0 will increase the number of Medicaid providers participating in integration assessment.	Pending data availability, specific evaluation methodology will be submitted upon approval of the application via the revised evaluation design.
3.1 TAHC		
New	MTP 2.0 will reduce the avoidable use of intensive services and settings, including use of community hospitals, psychiatric hospitals, SNF, and jails.	Measure intervention impacts on utilization of inpatient and institutional services using administrative data.
New	MTP 2.0 will result in increased SDOH screening and referral to services for Apple Health enrollees.	Analyze administrative data to determine changes in SDOH screening and referral to services over time. Specific evaluation methodology will be submitted upon approval of the application via the revised evaluation design.
New	MTP 2.0 will increase access to and utilization of HRS over time.	Analyze administrative data to determine changes in eligibility rates and service utilization rates over time. Specific evaluation methodology will be submitted upon approval of the application via the revised evaluation design.

New	MTP 2.0 will improve investments in community capacity, including infrastructure necessary to implement HRS, community-based care coordination, and equity programs.	Analyze administrative and survey data to determine changes in infrastructure and community capacity. Specific evaluation methodology will be submitted upon approval of the application via the revised evaluation design.
New	MTP 2.0 will expand the capacity and improve recruitment and retention of the community-based workforce.	Analyze administrative data to determine changes in the composition of community-based workforce. Specific evaluation methodology will be submitted upon approval of the application via the revised evaluation design.
3.2 FCS		
Continuing	Individuals receiving supportive housing or supported employment services will have better outcomes than a comparable population.	Measure intervention impacts on health and social service costs, homelessness, and employment rates using administrative data. See approved evaluation design for more details. Minor revisions due to timeline changes are expected.
Enhanced	Expanding the age restriction for supportive housing eligibility to 16 years and older will improve outcomes and stability for youth, including those exiting foster care.	Measure expanded intervention impacts on outcomes using administrative data. See approved evaluation design for more details. Minor revisions due to timeline and program changes are expected.
Enhanced	Individuals transitioning from a correctional institution and receiving supportive housing or supported employment services will have lower recidivism than comparable populations.	Measure expanded intervention impacts on outcomes using administrative data. See approved evaluation design for more details. Minor revisions due to timeline and program changes are expected.
Enhanced	The use of Medicaid funds to pay for one-time transition fees for targeted individuals will result in increased long-term housing stability and decreased inpatient treatment than comparable populations.	Measure expanded intervention impacts on outcomes using administrative data. See approved evaluation design for more details. Minor revisions due to timeline and program changes are expected.

Public notice and comment

See Appendix H, which summarizes Washington’s public notice process, including a summary of feedback received through tribal consultation and public comment. The summary includes changes applied to the application based on input received, in addition to responses to the comments received.

State contact person

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Appendices

- Appendix A: HRS menu
- Appendix B: budget neutrality
- Appendix C: evaluation interim findings report
- Appendix D: external quality review organization (EQRO) report
- Appendix E: Washington State Register notice
- Appendix F: full public notice
- Appendix G: Dear Tribal Leader Letter
- Appendix H: summary of public notice and Tribal Consultation and Confers

Appendix A: Health-related services (HRS) menu

This list represents HRS the state intends to implement through a combination of ILOS and 1115 waiver authority, and for both FFS and managed care enrollees. This list of services and target populations are meant to target critical gaps that can be addressed as HRS, and reflects input from ACHs, MCOs, and subject matter experts. In developing this list of services and corresponding target populations, the state considered efforts in other states (e.g., CA, NC, and OR) to inform authorities utilized and strategic priorities to address SDOH. The State also considered the evidence base and national literature supporting the cost-effectiveness and medical appropriateness of the proposed services.

The state will work with communities and partners to better understand the specific gaps that exist for eligibility for services—or limitation on scope of current services and programs—to inform appropriate implementation and application of HRS. The state will develop more complete and specific eligibility criteria and service definitions for each service following submission of the application.

Domain	Proposed service or setting	Service description	Target populations
Nutrition and Wellness	Medically tailored meals and medically supportive foods	Medically tailored meals and medically supportive foods to help individuals achieve their nutrition goals at critical times to help them regain and maintain their health, including healthy food box delivery, fruit and vegetable prescriptions, complementary wellness programs, etc.	Individuals with chronic conditions or individuals who have extensive care coordination needs
Housing and Transitional Care	Medical respite	Short-term and post-hospitalization residential care and housing to support members in healing and recovery from an injury or illness (including behavioral health conditions) and whose condition does not require hospitalization but would be exacerbated by an unstable living environment. Includes support in accessing benefits and permanent housing.	Individuals who are at risk of hospitalization/institutionalization or post-hospitalization/institutionalization and experiencing housing instability
	Housing transition navigation services	This service assists enrollees with obtaining housing, including tenant screening and assessment; developing a housing support plan; advocacy to identify housing options and the necessary resources; advocacy and assistance with eligibility and benefits; and assistance with transportation, language access services, childcare, and other supports as needed.	Individuals not eligible for FCS services who are homeless or at-risk of experiencing homelessness and have a qualifying condition (e.g., chronic condition or SMI)

Housing tenancy and sustaining services	This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured. This includes early mitigation to avoid risk of eviction or lease violations, education regarding lease agreement and responsibilities, coordination with the landlord, assistance with disputes, advocacy and assistance with eligibility and benefits, help navigating and accessing legal support, etc.	Individuals not eligible for FCS services who are homeless or at-risk of experiencing homelessness and have a qualifying condition (e.g., chronic condition or SMI)
Housing deposits	Housing deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to help a person establish a basic household that does not constitute room and board.	Individuals not eligible for FCS services who are homeless or at-risk of experiencing homelessness and have a qualifying condition (e.g., chronic condition or SMI)
Nursing facility transition/diversion to assisted living facilities	Nursing facility transition/diversion services assist individuals to live in the community and/or avoid institutionalization when possible. The goal is to facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for enrollees with an imminent need for nursing facility level of care (LOC).	For nursing facility transition: individuals who have resided 60+ days in a nursing facility and are willing and able to safely reside in an assisted living setting as an alternative to a nursing facility For nursing facility diversion: individuals who meet the criteria for nursing facility LOC who are interested in remaining in the community and willing and able to reside safely in an assisted living facility
Community transition services/nursing facility transition to a home	Community transition services/nursing facility transition to a home helps individuals to live in the community and avoid further institutionalization. Community transition services/nursing facility transition to a home have non-recurring set-up expenses, and non-emergency, non-medical transportation to ensure reasonable accommodations and access to housing options for individuals who are transitioning from a licensed facility to a living arrangement in a private residence.	Individuals who have resided 60+ days in a nursing home or medical respite setting; currently receiving medically necessary nursing facility LOC services; and willing and able to transition home and continue to receive medically necessary nursing facility LOC services
Stabilization centers	Stabilization centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the ED or jail. Stabilization centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.	Adults who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress

Respite and Daily Living Supports	Day habilitation programs	Services provided in an enrollee’s home or an out-of-home, non-facility setting. The programs are designed to provide advocacy and assistance with eligibility and benefits and assist the enrollee in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person’s natural environment.	Individuals who are experiencing homelessness, recently experienced homelessness, or at risk of homelessness or institutionalization
	Caregiver respite services	This service is provided to caregivers of enrollees who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise the enrollee and are non-medical in nature.	Individuals who live in the community and are compromised in their ADL and who require caregiver relief to avoid institutional placement
	Personal care and homemaker services	Services provided for individuals who need assistance with ADL, such as bathing, dressing, toileting, ambulation, or feeding.	Individuals at risk for hospitalization or institutionalization; or individuals with functional impairments and no other adequate support system
	Environmental accessibility and remediation adaptations (home modifications)	Physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual or enable the individual to function with greater independence in the home. Without this, the enrollee could require institutionalization or result in the need for emergency services and hospitalization. Includes asthma remediation services.	Individuals at risk for institutionalization or individuals with poorly controlled asthma

Appendix B
Budget Neutrality Summary - Enrollment and Expenditures

Historical Enrollment - Member Months

	DEMONSTRATION YEARS (DY)						Total
	1 (1/1 - 12/31/2017)	2 (1/1 - 12/31/2018)	3 (1/1 - 12/31/2019)	4 (1/1 - 12/31/2020)	5 (1/1 - 12/31/2021)	6* (1/1 - 12/31/2022)	
Medicaid Per Capita							
Non-Expansion Adults Only	4,471,441	4,403,043	4,329,531	4,443,372	4,667,802	4,856,314	27,171,503

*DY6 are projections.

Projected Enrollment - Member Months

	DEMONSTRATION YEARS (DY)					Total
	7 (1/1 - 12/31/2023)	8 (1/1 - 12/31/2024)	9 (1/1 - 12/31/2025)	10 (1/1 - 12/31/2026)	11 (1/1 - 12/31/2027)	
Medicaid Per Capita						
Non-Expansion Adults Only	4,348,867	4,361,586	4,394,256	4,427,247	4,460,563	21,992,519

Historical Expenditures - Medicaid Transformation Project

Without-Waiver Total Expenditures

		Actuals plus projections through DY5						6* (1/1 - 12/31/2022)	Total
		DEMONSTRATION YEARS (DY)							
		1 (1/1 - 12/31/2017)	2 (1/1 - 12/31/2018)	3 (1/1 - 12/31/2019)	4 (1/1 - 12/31/2020)	5 (1/1 - 12/31/2021)			
Medicaid Per Capita									
Non-Expansion Adults Only	Total	\$4,528,764,874	\$4,606,639,708	\$3,006,339,736	\$3,208,825,524	\$3,505,752,692	\$3,647,334,630		
	PMPM	\$1,012.82	\$1,046.24	\$694.38	\$722.16	\$751.05	\$751.05		
	Mem-Mon	4,471,441	4,403,043	4,329,531	4,443,372	4,667,802	4,856,314		
TOTAL		\$ 4,528,764,874	\$ 4,606,639,708	\$ 3,006,339,736	\$ 3,208,825,524	\$ 3,505,752,692	\$ 3,647,334,630	\$ 22,503,657,163	

With-Waiver Total Expenditures

		Actuals plus projections through DY5							
		DEMONSTRATION YEARS (DY)							Total
		1 (1/1 - 12/31/2017)	2 (1/1 - 12/31/2018)	3 (1/1 - 12/31/2019)	4 (1/1 - 12/31/2020)	5 (1/1 - 12/31/2021)	6* (1/1 - 12/31/2022)		
Medicaid Per Capita									
Non-Expansion Adults Only	Total	\$4,127,735,474	\$4,587,790,292	\$2,568,179,713	\$2,622,977,778	\$2,911,837,802	\$2,832,804,746		
	PMPM	\$923.13	\$1,041.96	\$593.18	\$590.31	\$623.81	\$583.32		
	Mem-Mon	4,471,441	4,403,043	4,329,531	4,443,372	4,667,802	4,856,314		
Medicaid Aggregate - WW only									
DSHP		\$192,631,572	\$181,287,442	\$118,941,926	\$50,466,103	\$52,598,437	\$1		
DSRIP		\$242,100,000	\$232,600,000	\$179,180,434	\$143,510,022	\$63,250,000	\$101,679,588		
MAC and TSOA Not Eligible		\$0	\$1,587	\$1,438	\$3,159	\$600	\$0		
TOTAL		\$4,562,467,046	\$5,001,679,321	\$2,866,303,511	\$2,816,957,062	\$3,027,686,839	\$2,934,484,335	\$ 21,209,578,114	
Actual Cumulative Variance (Positive = Overspending)									
NET VARIANCE - SAVINGS		(\$33,702,172)	(\$395,039,613)	\$140,036,225	\$391,868,462	\$478,065,853	\$712,850,295	\$581,228,754	

<Note: variance adjusted to show savings through DY05. Per STC 106, cannot accumulate savings in DY06.

		DEMONSTRATION YEARS (DY)						Total
		1 (1/1 - 12/31/2017)	2 (1/1 - 12/31/2018)	3 (1/1 - 12/31/2019)	4 (1/1 - 12/31/2020)	5 (1/1 - 12/31/2021)	6*	
Expenditure Authorities								
Medicaid Transformation Project (Hypotheticals)								
Initiative 2: Medicaid Alternative Care and Tailored Supports for Older Adults		\$149,435	\$3,764,589	\$10,106,518	\$17,076,859	\$22,507,413	\$47,453,000	\$101,057,814
Initiative 3: Foundational Community Supports (FCS)		\$0	\$1,282,185	\$7,267,200	\$16,021,557	\$16,241,701	\$22,961,407	\$63,774,050
Initiative 4: Substance Use Disorder Institutions for Mental Diseases (IMD)		\$0	\$459,060	\$2,135,081	\$3,262,506	\$2,836,879	\$16,508,550	\$25,202,076
Initiative 5: Mental Health IMD		\$0	\$0	\$0	\$10,336	\$337,950	\$4,792,708	\$5,140,994
Hep C Rx		\$84,720,557	\$31,135,206	\$23,941,932	\$13,601,930	\$11,749,666	\$11,749,666	\$176,898,957
TOTAL		\$84,869,992	\$36,641,040	\$43,450,731	\$49,973,188	\$53,673,609	\$103,465,331	\$372,073,891

*DY6 are projections.

Projected Expenditures - MTP 2.0

Without-Waiver Total Expenditures

		Projections					Total
		DEMONSTRATION YEARS (DY)					
		7	8	9	10	11	
Medicaid Per Capita							
Non-Expansion Adults Only	Total	\$3,281,396,456	\$3,495,035,244	\$3,739,530,108	\$4,001,197,284	\$4,281,247,459	
Proposed PMPM	PMPM	\$754.54	\$801.32	\$851.00	\$903.77	\$959.80	
	Mem-Mon	4,348,867	4,361,586	4,394,256	4,427,247	4,460,563	
TOTAL		\$ 3,281,396,456	\$ 3,495,035,244	\$ 3,739,530,108	\$ 4,001,197,284	\$ 4,281,247,459	\$ 18,798,406,551

With-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY)					Total
		7	8	9	10	11	
Medicaid Per Capita							
Non-Expansion Adults Only	Total	\$2,781,415,702	\$2,952,688,731	\$3,164,576,507	\$3,391,727,785	\$3,635,246,067	
	PMPM	\$639.57	\$676.98	\$720.16	\$766.10	\$814.97	
	Mem-Mon	4,348,867	4,361,586	4,394,256	4,427,247	4,460,563	
Medicaid Aggregate - WW only							
DSHP		\$86,901,142	\$130,301,924	\$132,738,665	\$127,542,163	\$122,516,106	
TOTAL		\$2,868,316,844	\$3,082,990,655	\$3,297,315,172	\$3,519,269,948	\$3,757,762,173	\$ 16,525,654,792
BASE VARIANCE							
Carry-Forward Savings From Prior Period		\$413,079,612	\$412,044,589	\$442,214,936	\$481,927,335	\$523,485,286	\$2,272,751,759
NET VARIANCE - SAVINGS							\$581,228,754
							\$2,853,980,513

Expenditure Authorities	7	8	9	10	11	
	(1/1 - 12/31/2023)	(1/1 - 12/31/2024)	(1/1 - 12/31/2025)	(1/1 - 12/31/2026)	(1/1 - 12/31/2027)	
MTP 2.0 (Hypotheticals)						
1.1 Continuous Apple Health Enrollment for Children	\$26,951,000	\$26,781,000	\$26,612,000	\$26,443,000	\$26,276,000	\$133,063,000
1.2 Re-entry coverage for continuity of care	\$99,056,685	\$100,896,000	\$102,770,000	\$104,678,000	\$106,622,000	\$514,022,685
1.3 Apple Health Postpartum Coverage Expansion	\$16,293,195	\$16,293,195	\$16,293,195	\$16,293,195	\$16,293,195	\$81,465,975
1.4 SUD and Mental Health IMD: Supports for people receiving substance use disorder and mental health treatment (Formerly MTP Initiatives 4 and 5)	\$22,917,513	\$24,661,768	\$26,543,045	\$28,572,456	\$30,762,043	\$133,456,825
2.1 Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) programs (Formerly MTP Initiative 2)	\$48,983,000	\$52,463,000	\$55,152,000	\$57,454,000	\$59,863,000	\$273,915,000
2.2 Program Innovations for Long Term Services and Supports (LTSS)	\$33,273,000	\$57,906,000	\$61,518,000	\$61,518,000	\$61,518,000	\$275,733,000
2.3 Washington Integrated Care Behavioral Health Integration Assessment (WA-ICA)	\$3,870,000	\$6,120,000	\$6,660,000	\$6,660,000	\$6,660,000	\$29,970,000
3.1 Taking Action for Healthier Communities – (TAHC) Program (Formerly MTP Initiative 1)	\$83,031,142	\$124,181,924	\$126,078,665	\$120,882,163	\$115,856,106	\$570,030,000
3.2 Foundational Community Supports (FCS) (Formerly MTP Initiative 3)	\$34,634,859	\$35,916,607	\$37,246,426	\$38,626,140	\$40,057,644	\$186,481,676
Hep C Rx	\$13,863,425	\$13,900,608	\$13,862,622	\$13,862,622	\$13,862,622	\$69,351,898
TOTAL	\$382,873,819	\$459,120,102	\$472,735,953	\$474,989,576	\$477,770,609	\$2,267,490,059

Budget Neutrality Summary

Current period: January 1, 2017 through December 31, 2022

Without-Waiver Total Expenditures

		Actuals plus projections through DY5					Extension projections	Total
		DEMONSTRATION YEARS (DY)					6	
		1	2	3	4	5		
Medicaid Per Capita								
Non-Expansion Adults Only	Total	\$4,528,764,874	\$4,606,639,708	\$3,006,339,736	\$3,208,825,524	\$3,505,752,692	\$3,647,334,630	
	PMPM	\$1,012.82	\$1,046.24	\$694.38	\$722.16	\$751.05	\$751.05	
	Mem-Mon	4,471,441	4,403,043	4,329,531	4,443,372	4,667,802	4,856,314	
TOTAL		\$ 4,528,764,874	\$ 4,606,639,708	\$ 3,006,339,736	\$ 3,208,825,524	\$ 3,505,752,692	\$ 3,647,334,630	\$ 22,503,657,163

With-Waiver Total Expenditures

		Actuals plus projections through DY5					Extension projections	Total
		DEMONSTRATION YEARS (DY)					6	
		1	2	3	4	5		
Medicaid Per Capita								
Non-Expansion Adults Only	Total	\$4,127,735,474	\$4,587,790,292	\$2,568,179,713	\$2,622,977,778	\$2,911,837,802	\$2,832,804,746	
	PMPM	\$923.13	\$1,041.96	\$593.18	\$590.31	\$623.81	\$583.32	
	Mem-Mon	4,471,441	4,403,043	4,329,531	4,443,372	4,667,802	4,856,314	
Medicaid Aggregate - WW only								
DSHP		\$192,631,572	\$181,287,442	\$118,941,926	\$50,466,103	\$52,598,437	\$1	
DSRIP		\$242,100,000	\$232,600,000	\$179,180,434	\$143,510,022	\$63,250,000	\$101,679,588	
MAC and TSOA Not Eligible		\$0	\$1,587	\$1,438	\$3,159	\$600	\$0.00	
TOTAL		\$4,562,467,046	\$5,001,679,321	\$2,866,303,511	\$2,816,957,062	\$3,027,686,839	\$2,934,484,335	\$ 21,209,578,114

BASE VARIANCE		(\$33,702,172)	(\$395,039,613)	\$140,036,225	\$391,868,462	\$478,065,853	\$712,850,295	\$581,228,754
Excess Spending from Hypotheticals								
1115A Dual Demonstration Savings (state preliminary estimate)								
1115A Dual Demonstration Savings (OACT certified)								
Carry-Forward Savings From Prior Period								
NET VARIANCE								\$581,228,754

<Note: variance adjusted to show savings through DY05. Per STC 106, cannot accumulate savings in DY06.

Cumulative Target Limit

		DEMONSTRATION YEARS (DY)					Extension projections
		1	2	3	4	5	6
Cumulative Target Percentage (CTP)		2.0%	1.5%	1.0%	0.0%	0.0%	0.0%
Cumulative Budget Neutrality Limit (CBNL)		\$4,528,764,874	\$9,135,404,582	\$12,141,744,318	\$15,350,569,841	\$18,856,322,533	\$22,503,657,163
Allowed Cumulative Variance (= CTP X CBNL)		\$90,575,297	\$137,031,069	\$121,417,443	\$0	\$0	\$0
Actual Cumulative Variance (Positive = Overspending)		\$33,702,172	\$428,741,785	\$288,705,560	(\$103,162,901)	(\$581,228,754)	(\$1,294,079,049)
Is a Corrective Action Plan needed?			CAP Needed	CAP Needed			

HYPOTHETICALS TEST 1

Without-Waiver Total Expenditures

Hypothetical 1 Aggregate	DEMONSTRATION YEARS (DY)					Extension projections	Total
	1	2	3	4	5	6	
MAC & TSOA	\$200,000	\$3,800,000	\$0	\$0	\$0	\$47,453,000	
Tailored Supports for Older Adults (TSOA)	\$0	\$0	\$11,000,000	\$20,586,370	\$48,052,000		
Medicaid Alternative Care (MAC)	\$0	\$0	\$300,000	\$500,000	\$1,399,000		
TOTAL	\$200,000	\$3,800,000	\$11,300,000	\$21,086,370	\$49,451,000	\$47,453,000	\$133,290,370

With-Waiver Total Expenditures

Hypothetical 1 Aggregate	DEMONSTRATION YEARS (DY)					Extension projections	Total
	1	2	3	4	5	6	
Tailored Supports for Older Adults (TSOA)	\$145,414	\$3,701,537	\$9,900,598	\$16,685,726	\$21,952,201		
Medicaid Alternative Care (MAC)	\$4,021	\$63,052	\$205,920	\$391,133	\$555,212		
MAC & TSOA						\$47,453,000	
TOTAL	\$149,435	\$3,764,589	\$10,106,518	\$17,076,859	\$22,507,413	\$47,453,000	\$101,057,814

HYPOTHETICALS VARIANCE 1	\$50,565	\$35,411	\$1,193,482	\$4,009,511	\$26,943,587	\$0	\$32,232,556
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HYPOTHETICALS TEST 1 Cumulative Target Limit

	DEMONSTRATION YEARS (DY)					Extension projections	
	1	2	3	4	5	6	
Cumulative Target Percentage (CTP)	2.0%	1.5%	1.0%	0.0%	0.0%	0.0%	
Cumulative Budget Neutrality Limit (CBNL)	\$200,000	\$4,000,000	\$15,300,000	\$36,386,370	\$85,837,370	\$133,290,370	
Allowed Cumulative Variance (= CTP X CBNL)	\$4,000	\$60,000	\$153,000	\$0	\$0	\$0	
Actual Cumulative Variance (Positive = Overspending)	(\$50,565)	(\$85,976)	(\$1,279,458)	(\$5,288,969)	(\$32,232,556)	(\$32,232,556)	
Is a Corrective Action Plan needed?							

HYPOTHETICALS TEST 2

Without-Waiver Total Expenditures

Hypothetical 2 Aggregate	DEMONSTRATION YEARS (DY)					Extension projections	Total
	1	2	3	4	5	6	
HepC Rx	\$131,821,200	\$136,171,300	\$140,664,952	\$145,306,896	\$138,352,357	\$11,749,666	
TOTAL	\$131,821,200	\$136,171,300	\$140,664,952	\$145,306,896	\$138,352,357	\$11,749,666	\$704,066,371

With-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY)					Extension projections	Total
		1	2	3	4	5	6	
Hypothetical 2 Aggregate								
HepC Rx		\$84,720,557	\$31,135,206	\$23,941,932	\$13,601,930	\$11,749,666	\$11,749,666	
TOTAL		\$84,720,557	\$31,135,206	\$23,941,932	\$13,601,930	\$11,749,666	\$11,749,666	\$176,898,957
HYPOTHETICALS VARIANCE 2								
		\$47,100,643	\$105,036,094	\$116,723,020	\$131,704,966	\$126,602,691	\$0	\$527,167,414

HYPOTHETICALS TEST 2 Cumulative Target Limit

		DEMONSTRATION YEARS (DY)					Extension projections	
		1	2	3	4	5	6	
Cumulative Target Percentage (CTP)		2.0%	1.5%	1.0%	0.0%	0.0%	0.0%	
Cumulative Budget Neutrality Limit (CBNL)		\$131,821,200	\$267,992,500	\$408,657,452	\$553,964,348	\$692,316,705	\$704,066,371	
Allowed Cumulative Variance (= CTP X CBNL)		\$2,636,424	\$4,019,888	\$4,086,575	\$0	\$0	\$0	
Actual Cumulative Variance (Positive = Overspending)		(\$47,100,643)	(\$152,136,737)	(\$268,859,757)	(\$400,564,723)	(\$527,167,414)	(\$527,167,414)	
Is a Corrective Action Plan needed?								

HYPOTHETICALS TEST 3

Without-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY)					Extension projections	Total
		1	2	3	4	5	6	
Hypothetical 3 Aggregate								
Foundational Community Supports 1		\$9,425,000	\$9,339,182	\$19,322,095	\$23,846,960	\$25,581,527	\$12,842,818	
Foundational Community Supports 2		\$5,567,000	\$925,411	\$8,024,095	\$15,308,960	\$16,912,527	\$10,118,589	
TOTAL		\$14,992,000	\$10,264,593	\$27,346,190	\$39,155,919	\$42,494,053	\$22,961,407	\$157,214,162

With-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY)					Extension projections	Total
		1	2	3	4	5	6	
Hypothetical 3 Aggregate								
Foundational Community Supports 1			\$550,410	\$3,616,869	\$9,334,757	\$9,733,474	\$12,842,818	
Foundational Community Supports 2			\$731,775	\$3,650,331	\$6,686,800	\$6,508,227	\$10,118,589	
TOTAL			\$1,282,185	\$7,267,200	\$16,021,557	\$16,241,701	\$22,961,407	\$63,774,050
HYPOTHETICALS VARIANCE 3								
		\$14,992,000	\$8,982,408	\$20,078,990	\$23,134,362	\$26,252,352	\$0	\$93,440,112

HYPOTHETICALS TEST 3 Cumulative Target Limit

		DEMONSTRATION YEARS (DY)					Extension projections	Total
		1	2	3	4	5	6	
Cumulative Target Percentage (CTP)		2.0%	1.5%	1.0%	0.0%	0.0%	0.0%	
Cumulative Budget Neutrality Limit (CBNL)		\$14,992,000	\$25,256,593	\$52,602,783	\$91,758,702	\$134,252,755	\$157,214,162	
Allowed Cumulative Variance (= CTP X CBNL)		\$299,840	\$378,849	\$526,028	\$0	\$0	\$0	
Actual Cumulative Variance (Positive = Overspending)		(\$14,992,000)	(\$23,974,408)	(\$44,053,398)	(\$67,187,760)	(\$93,440,112)	(\$93,440,112)	
Is a Corrective Action Plan needed?								

HYPOTHETICALS TEST 4

<u>Without-Waiver Total Expenditures</u>		DEMONSTRATION YEARS (DY)					Extension projections	Total
		1	2	3	4	5	6	
Hypothetical 4 Per Capita								
Medicaid Disabled IMD	Total	\$0	\$31,436	\$797,116	\$440,067	\$284,171	\$1,949,194	
	PMPM	\$0	\$1,084	\$1,142	\$1,149	\$1,189	\$1,229	
	Mem-Mon	0	29	698	383	239	1586	
Medicaid Non-Disabled IMD	Total	\$0	\$35,332	\$633,000	\$410,831	\$309,764	\$907,812	
	PMPM	\$0	\$292	\$300	\$311	\$322	\$334	
	Mem-Mon	0	121	2110	1321	962	2718	
Newly Eligible IMD	Total	\$0	\$253,176	\$3,659,090	\$2,512,500	\$1,870,156	\$6,049,980	
	PMPM	\$0	\$462	\$478	\$500	\$524	\$549	
	Mem-Mon	0	548	7655	5025	3569	11020	
American Indian/Alaska Native IMD	Total	\$0	\$5,548,596	\$18,446,289	\$7,627,122	\$684,057	\$7,608,370	
	PMPM	\$0	\$3,009	\$3,079	\$3,174	\$3,273	\$3,374	
	Mem-Mon	0	1844	5991	2403	209	2255	
TOTAL		\$0	\$5,868,540	\$23,535,495	\$10,990,520	\$3,148,148	\$16,515,356	\$60,058,059

With-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY)					Extension projections	Total
		1	2	3	4	5	6	
Hypothetical 4 Per Capita								
Medicaid Disabled IMD		\$0	\$28,935	\$83,216	\$309,250	\$268,726	\$1,949,274	
Medicaid Non-Disabled IMD		\$0	\$44,520	\$123,562	\$452,002	\$415,363	\$906,717	
Newly Eligible IMD		\$0	\$9,716	\$113,696	\$1,706,600	\$1,711,980	\$6,044,202	
American Indian/Alaska Native IMD		\$0	\$375,889	\$1,814,607	\$794,654	\$440,810	\$7,608,357	
TOTAL		\$0	\$459,060	\$2,135,081	\$3,262,506	\$2,836,879	\$16,508,550	\$25,202,076

HYPOTHETICALS VARIANCE 4

		\$0	\$5,409,480	\$21,400,414	\$7,728,014	\$311,269	\$6,806	\$34,855,983
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HYPOTHETICALS TEST 4 Cumulative Target Limit

		DEMONSTRATION YEARS (DY)					Extension projections	Total
		1	2	3	4	5	6	
Cumulative Target Percentage (CTP)		2.0%	1.5%	1.0%	0.0%	0.0%	0.0%	
Cumulative Budget Neutrality Limit (CBNL)		\$0	\$5,868,540	\$29,404,035	\$40,394,555	\$43,542,703	\$60,058,059	
Allowed Cumulative Variance (= CTP X CBNL)		\$0	\$88,028	\$294,040	\$0	\$0	\$0	
Actual Cumulative Variance (Positive = Overspending)		\$0	(\$5,409,480)	(\$26,809,894)	(\$34,537,908)	(\$34,849,177)	(\$34,855,983)	
Is a Corrective Action Plan needed?								

HYPOTHETICALS TEST 5

Without-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY)					Extension projections	TOTAL
		1	2	3	4	5	6	
Hypothetical 5 Per Capita								
SMI Medicaid Disabled IMD	Total	\$ -	\$ -	\$ -	\$ 6,833	\$ 101,332	\$ 2,278,498	
	PMPM	\$0.00	\$0.00	\$0.00	\$1,138.75	\$1,192.14	\$1,267.24	
	Mem-Mon	0	0	0	6	85	1,798	
SMI Medicaid Non-Disabled IMD	Total	\$ -	\$ -	\$ -	\$ 1,313	\$ 28,702	\$ 264,633	
	PMPM	\$0.00	\$0.00	\$0.00	\$262.51	\$275.98	\$295.02	
	Mem-Mon	0	0	0	5	104	897	
SMI Newly Eligible IMD	Total	\$ -	\$ -	\$ -	\$ 14,118	\$ 210,563	\$ 1,287,725	
	PMPM	\$0.00	\$0.00	\$0.00	\$470.60	\$491.97	\$521.98	
	Mem-Mon	0	0	0	30	428	2,467	
SMI American Indian/Alaskan Native IMD	Total	\$ -	\$ -	\$ -	\$ -	\$ 307,971	\$ 966,531	
	PMPM	\$0.00	\$0.00	\$0.00	\$14,008.47	\$14,665.29	\$15,589.20	
	Mem-Mon	0	0	0	0	21	62	
TOTAL		\$ -	\$ -	\$ -	\$ 22,263	\$ 648,568	\$ 4,797,386	\$ 5,468,217

With-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY)					Extension projections	TOTAL
		1	2	3	4	5	6	
Hypothetical 5 Per Capita								
SMI Medicaid Disabled IMD		\$ -	\$ -	\$ -	\$ 266	\$ 44,637	\$ 2,278,650	
SMI Medicaid Non-Disabled IMD		\$ -	\$ -	\$ -	\$ 266	\$ 44,637	\$ 264,501	
SMI Newly Eligible IMD		\$ -	\$ -	\$ -	\$ 9,804	\$ 238,022	\$ 1,289,106	
SMI American Indian/Alaskan Native IMD		\$ -	\$ -	\$ -	\$ -	\$ 10,654	\$ 960,451	
TOTAL		\$ -	\$ -	\$ -	\$ 10,336	\$ 337,950	\$ 4,792,708	\$ 5,140,994

HYPOTHETICALS VARIANCE 5		\$ -	\$ -	\$ -	\$ 11,927	\$ 310,618	\$ 4,678	\$ 327,223
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HYPOTHETICALS TEST 5 Cumulative Target Limit

	DEMONSTRATION YEARS (DY)					Extension projections
	1	2	3	4	5	6
Cumulative Target Percentage (CTP)	2.0%	1.5%	1.0%	0.0%	0.0%	0.0%
Cumulative Budget Neutrality Limit (CBNL)	\$ -	\$ -	\$ -	\$ 22,263	\$ 670,831	\$ 5,468,217
Allowed Cumulative Variance (= CTP X CBNL)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Actual Cumulative Variance (Positive = Overspending)	\$ -	\$ -	\$ -	\$ 11,927	\$ 322,545	\$ 327,223
Is a Corrective Action Plan needed?						

Budget Neutrality Summary

Renewal period: January 1, 2023 through December 31, 2027.

Without-Waiver Total Expenditures		Projections					Total
		DEMONSTRATION YEARS (DY)					
		7	8	9	10	11	
Medicaid Per Capita	Total						
Non-Expansion Adults Only		\$3,281,396,456	\$3,495,035,244	\$3,739,530,108	\$4,001,197,284	\$4,281,247,459	
Proposed PMPM		\$754.54	\$801.32	\$851.00	\$903.77	\$959.80	
	Mem-Mon	4,348,867	4,361,586	4,394,256	4,427,247	4,460,563	
TOTAL		\$ 3,281,396,456	\$ 3,495,035,244	\$ 3,739,530,108	\$ 4,001,197,284	\$ 4,281,247,459	\$ 18,798,406,551

With-Waiver Total Expenditures		DEMONSTRATION YEARS (DY)					Total
		7	8	9	10	11	
Medicaid Per Capita	Total						
Non-Expansion Adults Only		\$2,781,415,702	\$2,952,688,731	\$3,164,576,507	\$3,391,727,785	\$3,635,246,067	
		\$639.57	\$676.98	\$720.16	\$766.10	\$814.97	
	Mem-Mon	4,348,867	4,361,586	4,394,256	4,427,247	4,460,563	
Medicaid Aggregate - WW only							
Designated State Health Programs (DSHP)		\$86,901,142	\$130,301,924	\$132,738,665	\$127,542,163	\$122,516,106	
TOTAL		\$2,868,316,844	\$3,082,990,655	\$3,297,315,172	\$3,519,269,948	\$3,757,762,173	\$ 16,525,654,792
BASE VARIANCE		\$413,079,612	\$412,044,589	\$442,214,936	\$481,927,335	\$523,485,286	\$2,272,751,759
Excess Spending from Hypotheticals							
1115A Dual Demonstration Savings (state preliminary estimate)							
1115A Dual Demonstration Savings (OACT certified)							
Carry-Forward Savings From Prior Period							\$581,228,754
NET VARIANCE							\$2,853,980,513

Cumulative Target Limit		DEMONSTRATION YEARS (DY)				
		7	8	9	10	11
Cumulative Target Percentage (CTP)		2.0%	1.5%	1.0%	0.0%	0.0%
Cumulative Budget Neutrality Limit (CBNL)		\$3,281,396,456	\$6,776,431,701	\$10,515,961,808	\$14,517,159,092	\$18,798,406,551
Allowed Cumulative Variance (= CTP X CBNL)		\$65,627,929	\$101,646,476	\$105,159,618	\$0	\$0
Actual Cumulative Variance (Positive = Overspending)		(\$413,079,612)	(\$825,124,202)	(\$1,267,339,138)	(\$1,749,266,473)	(\$2,272,751,759)
Is a Corrective Action Plan needed?						

HYPOTHETICALS TEST 1

Without-Waiver Total Expenditures

Hypothetical 1 Aggregate	DEMONSTRATION YEARS (DY)					Total
	7	8	9	10	11	
Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)	\$48,983,000	\$52,463,000	\$55,152,000	\$57,454,000	\$59,863,000	
TOTAL	\$48,983,000	\$52,463,000	\$55,152,000	\$57,454,000	\$59,863,000	\$273,915,000

With-Waiver Total Expenditures

Hypothetical 1 Aggregate	DEMONSTRATION YEARS (DY)					Total
	7	8	9	10	11	
Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)	\$48,983,000	\$52,463,000	\$55,152,000	\$57,454,000	\$59,863,000	
TOTAL	\$48,983,000	\$52,463,000	\$55,152,000	\$57,454,000	\$59,863,000	\$273,915,000

HYPOTHETICALS VARIANCE 1		\$0	\$0	\$0	\$0	\$0	\$0
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HYPOTHETICALS TEST 1 Cumulative Target Limit

	DEMONSTRATION YEARS (DY)					
	7	8	9	10	11	
Cumulative Target Percentage (CTP)	2.0%	1.5%	1.0%	0.0%	0.0%	
Cumulative Budget Neutrality Limit (CBNL)	\$48,983,000	\$101,446,000	\$156,598,000	\$214,052,000	\$273,915,000	
Allowed Cumulative Variance (= CTP X CBNL)	\$979,660	\$1,521,690	\$1,565,980	\$0	\$0	
Actual Cumulative Variance (Positive = Overspending)	\$0	\$0	\$0	\$0	\$0	
Is a Corrective Action Plan needed?						

HYPOTHETICALS TEST 2

Without-Waiver Total Expenditures

Hypothetical 2 Aggregate	DEMONSTRATION YEARS (DY)					Total
	7	8	9	10	11	
HepC Rx	\$13,863,425	\$13,900,608	\$13,862,622	\$13,862,622	\$13,862,622	
TOTAL	\$13,863,425	\$13,900,608	\$13,862,622	\$13,862,622	\$13,862,622	\$69,351,898

HYPOTHETICALS TEST 4 Cumulative Target Limit

		DEMONSTRATION YEARS (DY)					Total
		7	8	9	10	11	
Cumulative Target Percentage (CTP)		2.0%	1.5%	1.0%	0.0%	0.0%	
Cumulative Budget Neutrality Limit (CBNL)		\$17,770,350	\$36,902,799	\$57,505,930	\$79,697,319	\$103,604,301	
Allowed Cumulative Variance (= CTP X CBNL)		\$355,407	\$553,542	\$575,059	\$0	\$0	
Actual Cumulative Variance (Positive = Overspending)		\$0	\$0	\$0	\$0	\$0	
Is a Corrective Action Plan needed?							

HYPOTHETICALS TEST 5

Without-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY)					TOTAL
		7	8	9	10	11	
Hypothetical 5 Per Capita							
SMI Medicaid Disabled IMD	Total	\$ 2,452,365	\$ 2,639,323	\$ 2,840,534	\$ 3,057,084	\$ 3,290,143	
	PMPM	\$1,347.08	\$1,431.95	\$1,522.16	\$1,618.06	\$1,719.99	
	Mem-Mon	1,821	1,843	1,866	1,889	1,913	
SMI Medicaid Non-Disabled IMD	Total	\$ 286,441	\$ 310,200	\$ 335,930	\$ 363,795	\$ 393,970	
	PMPM	\$315.38	\$337.14	\$360.40	\$385.27	\$411.85	
	Mem-Mon	908	920	932	944	957	
SMI Newly Eligible IMD	Total	\$ 1,377,188	\$ 1,472,702	\$ 1,574,840	\$ 1,684,062	\$ 1,800,859	
	PMPM	\$553.82	\$587.60	\$623.45	\$661.48	\$701.83	
	Mem-Mon	2,487	2,506	2,526	2,546	2,566	
SMI American Indian/Alaskan Native IMD	Total	\$ 1,031,169	\$ 1,107,094	\$ 1,188,609	\$ 1,276,126	\$ 1,370,088	
	PMPM	\$16,571.32	\$17,615.32	\$18,725.08	\$19,904.76	\$21,158.76	
	Mem-Mon	62	63	63	64	65	
TOTAL		\$ 5,147,163	\$ 5,529,319	\$ 5,939,914	\$ 6,381,068	\$ 6,855,061	\$ 29,852,524

With-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY)					TOTAL
		7	8	9	10	11	
Hypothetical 5 Per Capita							
SMI Medicaid Disabled IMD		\$ 2,452,365	\$ 2,639,323	\$ 2,840,534	\$ 3,057,084	\$ 3,290,143	
SMI Medicaid Non-Disabled IMD		\$ 286,441	\$ 310,200	\$ 335,930	\$ 363,795	\$ 393,970	
SMI Newly Eligible IMD		\$ 1,377,188	\$ 1,472,702	\$ 1,574,840	\$ 1,684,062	\$ 1,800,859	
SMI American Indian/Alaskan Native IMD		\$ 1,031,169	\$ 1,107,094	\$ 1,188,609	\$ 1,276,126	\$ 1,370,088	
TOTAL		\$ 5,147,163	\$ 5,529,319	\$ 5,939,914	\$ 6,381,068	\$ 6,855,061	\$ 29,852,524

HYPOTHETICALS VARIANCE 5		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
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HYPOTHETICALS TEST 5 Cumulative Target Limit

	DEMONSTRATION YEARS (DY)				
	7	8	9	10	11
Cumulative Target Percentage (CTP)	2.0%	1.5%	1.0%	0.0%	0.0%
Cumulative Budget Neutrality Limit (CBNL)	\$ 5,147,163	\$ 10,676,482	\$ 16,616,396	\$ 22,997,463	\$ 29,852,524
Allowed Cumulative Variance (= CTP X CBNL)	\$ 102,943	\$ 160,147	\$ 166,164	\$ -	\$ -
Actual Cumulative Variance (Positive = Overspending)	\$ -	\$ -	\$ -	\$ -	\$ -
Is a Corrective Action Plan needed?					

WA Budget Neutrality Rebasing Analysis

Without-Waiver (WOW) Total Expenditures		CY2023	CY2024	CY2025	CY2026	CY2027	
		DY07	DY08	DY09	DY10	DY11	TOTAL
Medicaid Per Capita							
Non-Expansion Adults Only (Projections)	Total	\$3,281,396,456	\$3,495,035,244	\$3,739,530,108	\$4,001,197,284	\$4,281,247,459	
Proposed WOW PMPM	PMPM	\$754.54	\$801.32	\$851.00	\$903.77	\$959.80	
	Mem-Mon	4,348,867	4,361,586	4,394,256	4,427,247	4,460,563	
TOTAL WOW		\$3,281,396,456	\$3,495,035,244	\$3,739,530,108	\$4,001,197,284	\$4,281,247,459	\$18,798,406,551

With-Waiver (WW) Total Expenditures		CY2023	CY2024	CY2025	CY2026	CY2027	
		DY07	DY08	DY09	DY10	DY11	TOTAL
Medicaid Per Capita							
Non-Expansion Adults Only (Projections)	Total	\$2,781,415,702	\$2,952,688,731	\$3,164,576,507	\$3,391,727,785	\$3,635,246,067	
	PMPM	\$639.57	\$676.98	\$720.16	\$766.10	\$814.97	
TOTAL WW		\$2,781,415,702	\$2,952,688,731	\$3,164,576,507	\$3,391,727,785	\$3,635,246,067	\$15,925,654,792

WOW Proposed Trend Rate 6.2%

WA Budget Neutrality Trend Rate

<u>Without-Waiver Total Expenditures</u>		Updated data based on reporting through March 2022					
		DEMONSTRATION YEARS (DY)					Total
		1	2	3	4	5	
<u>Medicaid Per Capita</u>							
Non-Expansion Adults Only	Total	\$4,528,764,874	\$4,606,639,708	\$3,006,339,736	\$3,208,825,524	\$3,505,752,692	
	PMPM	\$1,012.82	\$1,046.24	\$694.38	\$722.16	\$751.05	
	Mem-Mon	4,471,441	4,403,043	4,329,531	4,443,372	4,667,802	
TOTAL		\$ 4,528,764,874	\$ 4,606,639,708	\$ 3,006,339,736	\$ 3,208,825,524	\$ 3,505,752,692	\$ 18,856,322,533

<u>With-Waiver Total Expenditures</u>		Updated data based on reporting through March 2022					
		DEMONSTRATION YEARS (DY)					Total
		1	2	3	4	5	
<u>Medicaid Per Capita</u>							
Non-Expansion Adults Only		\$4,127,735,474	\$4,587,790,292	\$2,568,179,713	\$2,622,977,778	\$2,911,837,802	\$ 16,818,521,059

Trend Rate Analysis

<u>With-Waiver Total Expenditures</u>		DEMONSTRATION YEARS (DY)					Total	
		1	2	3	4	5		
LTSS Costs Reported in DY1 and DY2		\$1,776,314,902	\$2,207,073,371					
<u>Medicaid Per Capita (adjusted)</u>								
Non-Expansion Adults Only	Total	\$2,351,420,572	\$2,380,716,921	\$2,568,179,713	\$2,622,977,778	\$2,911,837,802	\$ 12,835,132,786	
	PMPM	\$525.88	\$540.70	\$593.18	\$590.31	\$623.81		
	Trend Rate		2.8%	9.7%	-0.5%	5.7%		
								4.4% <Average trend rate (5 years)
								6.2% <Average trend rate (3 years)

\$629.95 DY04 WOW PMPM (REBASED)

\$669.01 DY05 WOW PMPM (REBASED)

\$710.49 DY06 WOW PMPM (REBASED)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850



State Demonstrations Group

May 20, 2021

MaryAnne Lindeblad
Medicaid Director
Washington State Health Care Authority and Department of Social and Health Services
626 8th Ave SE
PO Box 45502
Olympia, WA 98504

Dear Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Interim Evaluation Report, which is required by the Special Terms and Conditions (STCs), specifically STC #123 “Evaluation Reports” of Washington’s section 1115 demonstration, “Medicaid Transformation Project” (Project No: 11-W-00304/0). This report covers the demonstration period from January 2017 through December 2019. CMS determined that the evaluation report, submitted on December 29, 2020, is in alignment with the approved evaluation design and the requirements set forth in the STCs, and therefore, approves the state’s Interim Evaluation Report.

The approved evaluation design may now be posted to the state’s Medicaid website. CMS will also post the evaluation report on Medicaid.gov.

The interim evaluation report effectively integrates quantitative and qualitative findings, and offers many important insights, taking care to interpret findings appropriately in the context of the strength of the analytic approaches used. There were notable successes in the Delivery System Reform Incentive Payment (DSRIP) program at improving the integration of physical and behavioral health as evidenced by the improvement in follow-up after emergency department visits and hospitalizations for substance use disorder. Beneficiaries with comorbid conditions also showed improvement in a variety of quality measures. The Medicaid Alternative Care and Tailored Supports for Older Adults programs appear to have succeeded at delaying the need for traditional long term services and supports, and survey results showed positive beneficiary experience. While rates of employment increased among participants in the Foundational Community Supports program¹, rates of homelessness did not appear to improve relative to the comparison group at the time of this interim

¹ The Foundational Community Supports program seeks to address social determinants of health through tenancy-sustaining supports and employment services for state Medicaid beneficiaries with complex needs.

evaluation. We note that preliminary findings on the Substance Use Disorder component of the demonstration suggest positive effects, and we look forward to the fuller analysis with the additional data that will be available with the final evaluation report, expected June 2023.

We look forward to our continued partnership on the Washington Medicaid Transformation Project section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly
-S

Digitally signed by
Danielle Daly -S
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Danielle Daly
Director
Division of Demonstration
Monitoring and Evaluation

**Angela D.
Garner -S**

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Angela D. Garner
Director
Division of System Reform
Demonstrations

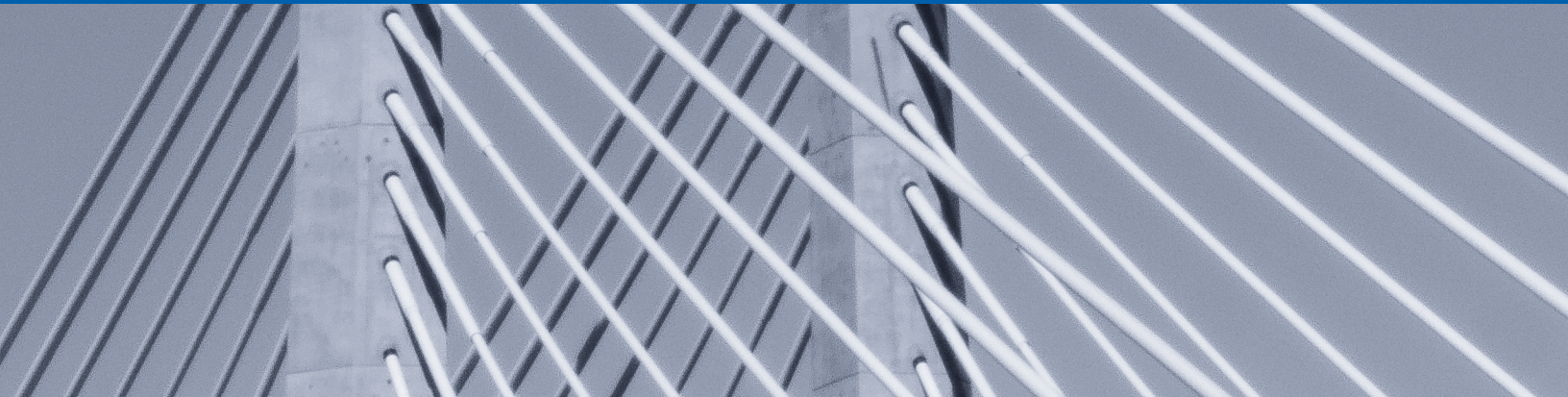
cc: Nikki Lemmon, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

Medicaid Transformation Project Evaluation

INTERIM REPORT

December 13, 2020

CENTER FOR HEALTH SYSTEMS EFFECTIVENESS



Prepared for:

Washington State Health Care Authority



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About Us

The Center for Health Systems Effectiveness at Oregon Health & Science University is a research organization that uses economic approaches and big data to answer pressing questions about health care delivery. Our mission is to provide the analyses, evidence, and economic expertise to build a more sustainable health care system.

CHSE's publications do not necessarily reflect the opinions of its clients and funders.

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Acknowledgments

We thank Katie Bittinger, Karen Jensen, David Mancuso, and other staff at the Washington State Health Care Authority and the Washington State Department of Social and Health Services for their generosity with information about Washington State's Medicaid Transformation Project, assistance with obtaining data for the evaluation, and time to answer questions and provide feedback. We also thank Vijet Muley and Sara Edelstein at the Center for Health Systems Effectiveness for assistance with quantitative analysis for this report, and Jonah Kushner for foundational contributions to the MTP evaluation and assistance with project management related to the interim report.

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Medicaid Transformation Project Evaluation

Since 2017, the State of Washington has been engaged in an ambitious effort to transform its health care delivery and payment system for the state's Apple Health members. The Medicaid Transformation Project (MTP) is a five-year agreement between Washington and the Centers for Medicare and Medicaid Services under a Section 1115 Medicaid demonstration waiver. MTP aims to improve quality of care and test innovative approaches through several focused initiatives.

MTP Consists of Five Initiatives

Initiative 1: Delivery System Reform Incentive Payment (DSRIP) Program. Establishes statewide goals for payment reform and delivery system integration, and directs nine regional Accountable Communities of Health (ACHs) to collaborate with health and social services organization partners on a series of locally-led health improvement projects.

Initiative 2: Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA). Establishes new service options for older adults to remain in their homes and avoid the need for more intensive services.

Initiative 3: Foundational Community Supports (FCS). Establishes a statewide network of organizations connecting vulnerable adults with supportive housing and supported employment.

Initiative 4: Substance Use Disorder (SUD) Amendment. Expands options for federally funded treatment of substance use disorder in mental health and SUD facilities.

Initiative 5: Mental Health Amendment. In November 2020, Washington State received approval from CMS to amend its waiver through the addition of a fifth MTP initiative related to mental health treatment. Implementation had not yet begun at the time of this report.

The State of Washington engaged the Center for Health Systems Effectiveness at Oregon Health & Science University to conduct a comprehensive evaluation of MTP. This Interim Evaluation Report is the second in a series of three reports that will assess MTP's implementation and impacts.

The measurement period for this report spans early 2017 through December 2019, and predates the COVID-19 outbreak in Washington State. Future reports will examine whether and how the pandemic affected progress on MTP.

KEY FINDINGS

Our evaluation of MTP to date found the following:

We found substantial improvements in statewide measures related to substance use disorder and chronic conditions. Changes in other domains were modest or unchanged during this period.

Racial and ethnic disparities were evident. Groups including Black and American Indian/Alaska Native beneficiaries experienced less access to or a lower quality of care on the majority of measures compared to Medicaid beneficiaries as a whole.

Early results of ACH Health Improvement Projects were mixed. We observed a variety of improvements in measures for projects to integrate behavioral and physical health care and to address the opioid crisis. There were fewer detectable improvements in analyses of other projects. Most HIPs were in an early stage of implementation with ACHs focused on developing partnerships, workforce, and infrastructure to support new interventions.

Washington State has achieved progress toward MTP goals related to value-based payment (VBP) and integrated managed care (IMC). The state achieved targets for VBP participation by MCOs through 2018 and expanded participation in VBP arrangements by primary care practices. While all regions of the state have also transitioned to IMC, this may have created unexpected challenges for other MTP efforts such as the state's Substance Use Disorder waiver priorities.

Workforce shortages were a top challenge in implementing MTP initiatives. ACHs devoted substantial effort to workforce development. Community health workers (CHWs) played an important role in regional progress toward MTP goals, but retention challenges were evident.

Stakeholders desired a statewide health information technology (HIT) and health information exchange (HIE) strategy to promote standardization and interoperability. MTP required substantial effort from partnering organizations to adopt new HIT/HIE tools, and there were concerns about the distribution of costs and effort.

Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) may have reduced statewide utilization of traditional Medicaid long-term services and supports. Enrollment ramped up slowly, but satisfaction in the programs was high. MAC participants had fewer adverse outcomes following enrollment. One quarter of TSOA participants enrolled in Medicaid within 6 months of participation, but few used traditional Medicaid-paid long-term services and supports.

Early results from Foundational Community Supports (FCS) are promising. The FCS Supported Employment program demonstrated progress increasing employment. The impact of FCS Supportive Housing is less clear, which may be related to shortages in affordable housing. Health care access and utilization rates improved for some groups.

Access to and quality of substance use disorder treatment improved in the year following implementation of Washington's SUD waiver, and there is evidence of increased capacity for SUD treatment across the state. Despite this progress, there were implementation challenges for SUD treatment and mental health providers, some of which were unintended consequences of MTP's integrated managed care transition.

Recommendations

Specific recommendations for Washington State and the Health Care Authority arising from this interim evaluation include:

- 1 Address health disparities.** Washington's Medicaid system performance through 2019 revealed persistent racial and ethnic disparities in access and quality of care. HCA should further investigate structural factors that may be driving differences. The state's managed care contracts may also present options to reduce health care disparities.
- 2 Strengthen engagement of non-clinical partners in MTP.** Behavioral health and community-based partners have faced challenges engaging in MTP. Achieving the state's goal of progress on social factors such as homelessness may require strengthening collaboration between Tribes, ACHs, MCOs, providers and community-based organizations. The state should also explore how to increase housing options for FCS Supportive Housing participants.
- 3 Support the recruitment and retention of key workers necessary for MTP success.** Additional efforts may be particularly needed in rural areas where difficulty recruiting for community health workers has limited ACH progress on health improvement activities, and where in-home caregiver demand is projected to increase in future years.
- 4 Provide clear guidance regarding Washington State's vision for community information exchange (CIE),** including the desired financing mechanisms to support CIE platforms. Promote standardization and interoperability of HIT/HIE platforms across regions and sectors, focusing on lowering barriers to participation among behavioral health and SUD treatment providers.
- 5 Continue to monitor progress on ACH health improvement projects.** ACHs' early activities focused on developing infrastructure and workforce necessary to implement new interventions. A longer period of observation and consideration of ACHs' roles in COVID-19 response and recovery will yield more robust conclusions about the impact of ACH projects.
- 6 Explore options to ensure benefit packages are clearly understood across TSOA, MAC, and traditional long-term services and supports so individuals can make the choice that best meets their needs.** Stronger incentives may be needed to promote enrollment in MAC versus traditional Medicaid in-home services.
- 7 Build on early positive results from the FCS Supported Employment program.** The program may play an important role in employment recovery after the COVID-19 pandemic. Further investigation may help to identify the service needs for FCS participants who enroll in both Supported Employment and Supportive Housing services.
- 8 Continue to assess the entire system of substance use prevention, treatment, and recovery,** and ensure that the SUD waiver does not create incentives for unnecessary residential stays.
- 9 Monitor challenges identified in Managed Care Organization (MCO) payments made to behavioral health and SUD treatment providers,** including timeliness of payments and appropriateness of prior authorization requirements. Assess whether these challenges resolve following implementation of IMC and execution of new MCO contracts in 2021, or whether these challenges persist and warrant future changes to IMC.

About MTP

Washington State's Medicaid Transformation Project (MTP) is a \$1.27 billion effort spanning 2017-2021 to transform health care delivery and payment for the state's Apple Health members.

MTP is a five-year agreement between Washington State and the Centers for Medicare & Medicaid Services under a Section 1115 Medicaid demonstration waiver. Under this waiver, the State of Washington aims to improve the quality of care delivered to people enrolled in Medicaid, while testing innovative approaches to improve and transform Washington's health and wellness systems.

MTP consists of **four initiatives**:

- **Initiative 1: Delivery System Reform Incentive Payment (DSRIP) Program.** Establishes statewide goals for payment reform and delivery system integration, and directs nine regional Accountable Communities of Health (ACHs) to collaborate with health and social services organization partners on a series of locally-led health improvement projects.
- **Initiative 2: Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA).** Establishes new service options for older adults to remain in their homes and avoid the need for more intensive services.
- **Initiative 3: Foundational Community Supports (FCS).** Establishes a statewide network of organizations connecting vulnerable adults with supportive housing and supported employment.
- **Initiative 4: Substance Use Disorder (SUD) Amendment.** Expands options for federally funded treatment of substance use disorder in mental health and SUD facilities.
- **Initiative 5: Mental Health Amendment.** In November 2020, Washington State received approval from CMS to amend its waiver through the addition of a fifth MTP initiative related to mental health treatment. Implementation had not yet begun at the time of this report.

A detailed description of MTP and its initiatives can be found in the Baseline Evaluation Report delivered May 2019.

About the MTP Evaluation

In order to assess changes that may occur as a result of MTP, the State of Washington engaged the Center for Health Systems Effectiveness at Oregon Health & Science University as an Independent External Evaluator (IEE) to conduct a comprehensive evaluation of MTP.

The overarching purpose of this evaluation is to assess whether MTP, as envisioned and implemented, achieved its stated goals to transform the delivery of Washington State's health systems and improved care for people enrolled in Apple Health.

The MTP evaluation includes **eight specific aims**, including:

- 1 Provide an assessment of overall Medicaid system performance (related to access, quality and efficiency of care) under the Delivery System Reform Incentive Payments (DSRIP) program;
- 2 Provide an assessment of progress toward meeting Medicaid value-based payment (VBP) adoption targets;
- 3 Provide an assessment of the impact of MTP on the development of the workforce capacity needed to support health system transformation;
- 4 Provide an assessment of the impact of MTP on provider adoption and use of appropriate health information technology;
- 5 Provide an assessment of the impact of MTP initiatives and projects at the state and ACH regional level;
- 6 Provide an assessment of the impact of Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults on the need for and use of long-term services and supports;
- 7 Provide an assessment of the impact of Foundational Community Supports on health outcomes, utilization and cost; and
- 8 Provide an assessment of the impact of the Medicaid Substance Use Disorder (SUD) waiver amendment.

Our evaluation of these aims occurs throughout a series of reports. The reporting schedule of results is presented in Exhibit A.

Exhibit A: Evaluation Aims and Reporting Schedule

Evaluation Aim	Evaluation Results Reporting Schedule					
	Baseline Report	Interim Report	SUD Mid-Point Assessment	Rapid Cycle Reports	Final Report	Final SUD Report
AIM 1: Medicaid System Performance Under DSRIP	X	X		X	X	
AIM 2: Value-Based Payment	X			X	X	
AIM 3: Workforce Capacity	X			X	X	
AIM 4: Health Information Technology	X			X	X	
AIM 5: ACH Health Improvement Projects		X			X	
AIM 6: MAC and TSOA		X			X	
AIM 7: Foundational Community Supports		X			X	
AIM 8: SUD Waiver Amendment		X	X		X	X

About This Report

This report (the “Interim Evaluation Report”) is the second in a series of **three evaluation reports** that will assess MTP’s impacts, explore the factors underlying these impacts, and communicate lessons learned from MTP.

- 1 Baseline Evaluation Report.** A prior Baseline Report (Kushner and McConnell, 2020) described Washington State’s Medicaid system readiness for transformation as of 2019, when health improvement projects under Initiative 1 were first being implemented. The Baseline Report focused on Aims 1-4 and presented contextual information and preliminary findings related to the other aims.
- 2 Interim Evaluation Report.** This Interim Evaluation Report describes the performance of Washington State’s Medicaid system through December 2019, spanning the first three years of activities under the MTP initiative. This report presents findings from Aims 1 and 5 pertaining to MTP Initiative 1 (DSRIP), and Aims 6-8 pertaining to MTP Initiatives 2-4.
- 3 Final Evaluation Report.** A forthcoming Final Evaluation Report in 2022 will describe the performance of Washington State’s Medicaid system through December 2020, spanning the first four years of the MTP demonstration.

The MTP evaluation relies on a wide variety of quantitative and qualitative data to achieve its aims. Key **data sources** collected and analyzed for the Interim Evaluation Report included:

- Administrative data including program enrollment and claims data provided information on health care access, quality, and utilization.
- Key informant interviews provided qualitative, contextual information on how ACHs and providers were implementing changes in care.
- Case summaries of ACH efforts, including regional health improvement projects provided another source of information about implementation efforts at the ACH and clinical level.
- Surveys of MAC and TSOA program participants documented their experiences of new programs and services.

HOW TO READ THIS REPORT

When reading this report, readers are encouraged to interpret results within the context of each MTP initiative’s intended and actual implementation efforts through late 2019.

The interim report reflects a relatively early time period in the MTP demonstration. As such, many of the findings in the interim report relate to early successes and challenges in implementation.

The COVID-19 outbreak began in Washington State in early 2020, causing widespread disruption to the state’s health care delivery system. However, the COVID-19 outbreak had little to no effect on Washington’s delivery system during the time period described in this report (through December 2019), as this period predates the first known case of the virus in the United States. Later reports will address whether and how COVID-19 impacted progress on MTP.

Roadmap to the Interim Report

Section 1: We present an interim evaluation of MTP Initiative 1. In Chapter 1 we describe the performance of Washington State's Medicaid system in 2018 and 2019, the second and third year of MTP, based on administrative data from the State of Washington. We provide an overview of Washington's nine Accountable Communities of Health (ACH) in Chapter 2, and present an interim evaluation of eight ACH Health Improvement Projects (HIPs) in Chapters 3-10. **See p. 12**

Section 2: We present an interim evaluation of MTP Initiative 2, Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA). In Chapter 11 we present findings related to enrollment and participant satisfaction in these two programs. In Chapter 12 we assess MAC and TSOA participants' health care outcomes compared with participants in traditional Medicaid long-term services and supports. **See p. 120**

Section 3: We present results of an interim evaluation of MTP Initiative 3, Foundational Community Supports (FCS). In Chapter 13, we describe the implementation of FCS and examine enrollment trends in the program's first year. Using administrative data from Washington State, we compare social and health outcomes of FCS participants before and after enrollment to a matched comparison group of Medicaid beneficiaries. **See p. 139**

Section 4: We present results of an interim evaluation of MTP Initiative 4, Washington State's Substance Use Disorder (SUD) amendment to its 1115 Medicaid waiver. In Chapter 14, we describe implementation progress during the first year following the amendment. We present changes in outcomes for Medicaid beneficiaries through July 2019, the first year following the amendment. **See p. 153**

Section 5: We describe key conclusions and recommendations from the Interim Evaluation. In Chapter 15, we discuss overarching successes achieved to date across the demonstration, describe remaining challenges and opportunities for further action. We present recommendations to the State of Washington for the remaining years of the MTP demonstration. This section also contains technical appendices with additional descriptions of methods and data. **See p. 162**

MTP Initiative 1

This section presents an evaluation of the Medicaid Transformation Project Initiative 1 – Transformation Through Accountable Communities of Health. Section One includes:

- **Chapter 1**, an evaluation of statewide Medicaid system performance through 2019;
- **Chapter 2**, an overview of the state’s Accountable Communities of Health (ACHs), their approaches to health improvement projects (HIPs), and our approach to evaluating HIP progress to date;
- **Chapter 3**, evaluation of Project 2A: Bi-Directional Integration of Physical and Behavioral Health Through Care Transformation;
- **Chapter 4**, evaluation of Project 2B: Community-Based Care Coordination;
- **Chapter 5**, evaluation of Project 2C: Transitional Care;
- **Chapter 6**, evaluation of Project 2D: Diversion Interventions;
- **Chapter 7**, evaluation of Project 3A: Addressing the Opioid Use Public Health Crisis;
- **Chapter 8**, evaluation of Project 3B: Reproductive and Maternal/Child Health;
- **Chapter 9**, evaluation of Project 3C: Access to Oral Health Services; and
- **Chapter 10**, evaluation of Project 3D: Chronic Disease Prevention and Control.

KEY FINDINGS

- *We found substantial improvements in statewide measures related to substance use disorder and chronic conditions; changes across other performance domains were modest or unchanged.*
- *Black and American Indian/Alaska Native beneficiaries experienced less access to, or a lower quality of, care on the majority of measures than Medicaid beneficiaries of other races. Asian and Hispanic beneficiaries also experienced lower quality of care on some measures than the state’s Medicaid beneficiaries as a whole.*
- *We observed a variety of improvements for projects 2A and 3A. There were fewer detectable improvements in analyses of other HIPs. Most HIPs were in an early stage of implementation.*
- *The transition to integrated managed care may have created unexpected challenges for other MTP efforts such as the state’s Substance Use Disorder waiver priorities (also see Chapter 15).*
- *Workforce shortages were cited as a top challenge in implementing MTP initiatives. ACHs devoted substantial effort to workforce development. Community health workers played an important role in regional progress toward MTP goals, but retention challenges were evident.*
- *Stakeholders desired a statewide health information technology (HIT) strategy to promote standardization and interoperability. MTP required substantial effort from partnering organizations to adopt new HIT tools, and there were concerns about the distribution of costs and effort.*

Recommendations

The following recommendations relate to the evaluation results for MTP Initiative 1:

- 1 Address Health Disparities.** The state should further investigate structural factors that may be driving differences among specific groups. The state's managed care contracts may also present untapped options to reduce health care disparities.
- 2 Strengthen Engagement of non-Clinical Partners in MTP.** Behavioral health, human services, and other community-based partners faced particular challenges engaging in MTP. Achieving the state's goal of making progress on social factors such as homelessness, arrest rate, or unemployment may require further strengthening collaboration between the state, Tribes, ACHs, MCOs, Foundational Community Supports providers and community-based organizations. The state should also explore how to increase housing options for FCS Supportive Housing participants.
- 3 Continue to monitor progress on ACH Health Improvement Projects.** ACHs' early activities focused on developing the infrastructure and workforce necessary to implement new interventions or programs. A more extended period of observation and consideration of ACHs' roles in COVID-19 response and recovery will yield more robust conclusions about the impact of ACH projects.
- 4 Support the recruitment and retention of key workers necessary for MTP success.** Additional efforts may be needed in rural areas where, for example, difficulty recruiting community health worker positions may have restricted ACH progress. In-home caregiver demand is also projected to increase in future years.
- 5 The state should provide clear guidance regarding Washington State's vision for Community Information Exchange (CIE),** including the desired financing mechanisms to support CIE platforms. Promote standardization and interoperability of HIT/HIE platforms across regions and sectors, focusing on lowering barriers to participation among behavioral health and SUD treatment providers.

Statewide Medicaid Performance Under DSRIP

Overview

In this chapter, we describe Washington State's progress toward statewide MTP milestones and performance of its Medicaid system in 2018 and 2019, representing the second year of MTP (2018) and the first year (2019) with performance incentives. We measure statewide performance on 44 metrics categorized into 10 domains.

Background

The State of Washington has engaged in substantial efforts in recent years to transform the state's Medicaid program through greater emphasis on integrating care, paying for value rather than service volume, and sharing accountability for performance with the state's providers and Medicaid managed care organizations (MCOs).

In 2015, Washington State began to establish regional Accountable Communities of Health (ACHs) using a State Innovation Model (SIM) grant from the Center for Medicare and Medicaid Services (CMS) (Washington State Health Care Authority, n.d.b). ACHs are regional entities meant to convene organizations concerned with health - including health care providers and hospitals, public health districts, and social service organizations - and align their efforts toward common goals. Core functions of ACHs include identifying health needs within their regions and implementing health improvement projects to meet those needs. The SIM grant and other resources supported planning and startup of ACHs by local health care improvement organizations across the state. Under SIM, a designated "backbone" organization supported each ACH's development and performed administrative functions like payroll.

MTP Approach to Change

As part of its 1115 Medicaid demonstration waiver for 2017-2021, Washington State sought approval from CMS to participate in the Delivery System Reform Incentive Payment (DSRIP) program. DSRIP is an initiative that makes federal funds available to states to transform their health care delivery systems, tying provider payments to a performance measurement framework (Gates et al., 2014). MTP Initiative 1 introduced a new statewide performance and accountability framework for Washington, with multiple levels of performance incentives and accountability for health improvement during the demonstration.

Statewide Accountability

Washington State is accountable to CMS for demonstrating progress at the statewide level toward:

- 1 Integrating physical and behavioral health care,
- 2 Increasing adoption of value-based payments, and
- 3 Achieving improvement on 10 quality measures (see Exhibit 1.1).

Beginning in 2019 (DY3), an increasing proportion of the state's DSRIP funding is at risk in the event that performance milestones are not met. Exhibit 1.1 displays these statewide performance metrics.

Exhibit 1.1: Statewide Accountability Quality Metrics

Metric Name
All-cause ED visits per 1,000 member months
Antidepressant medication management
Asthma-related metric <ul style="list-style-type: none">• In 2019: Medication management for people with asthma• In 2020-2021: Asthma medication ratio
Comprehensive diabetes care: blood pressure control
Comprehensive diabetes care: hemoglobin A1c poor control (>9%)
Controlling high blood pressure (<140/90)
Mental health treatment penetration (broad)
Plan all-cause readmission rate (30 days)
Substance use disorder (SUD) treatment penetration
Well-child visits in the 3rd, 4th, 5th, and 6th years of life

Source: Delivery System Reform Incentive Program (DSRIP) Measurement Guide (October 2020)

MTP Initiative 1 also provides incentives to Indian health care providers (IHCP) to identify and report on health improvement projects to improve the health of the populations they serve. These projects are not within the scope of the MTP evaluation.

Regional Accountability

Additional measures and incentives for certain stakeholders are nested within this larger framework of statewide accountability, including:

- Accountable Communities of Health are accountable for promoting adoption of value-based payments as well as for performance on a subset of project-related measures, with DSRIP funds at risk beginning in 2019; and

- Managed care organizations (MCOs) are incentivized to achieve targets for adoption of value-based payments that increase over the course of the demonstration.

Implementation of Initiative 1

Washington State engaged in a series of reforms to achieve the goals and performance improvement targets of the demonstration, including:

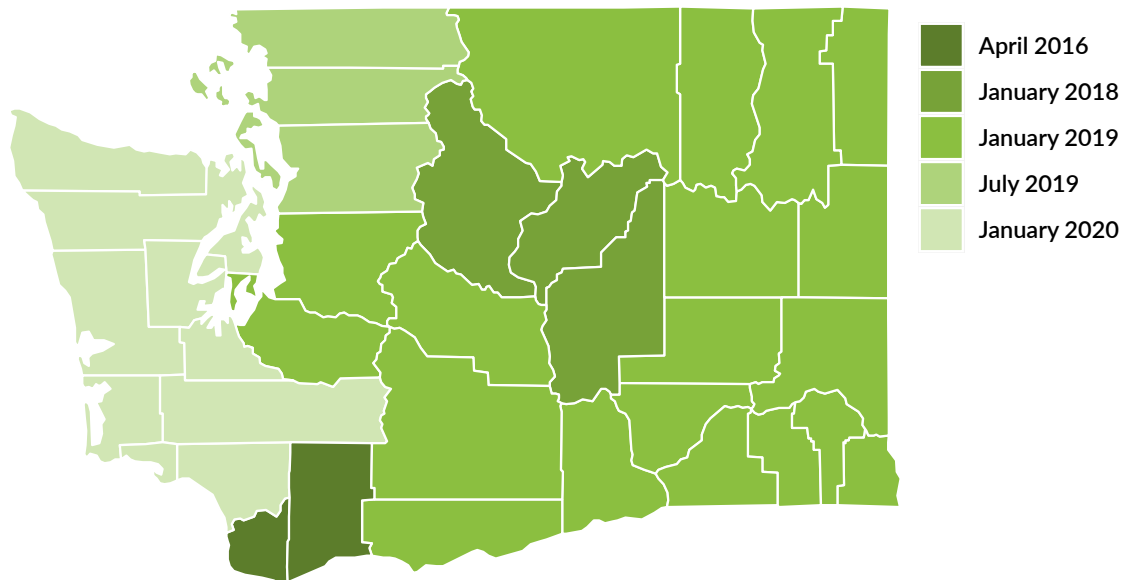
- Directing the state’s managed care organizations to financially integrate physical and behavioral health care (i.e., IMC);
- Establishing targets and a Value-Based Payment Roadmap to increase adoption of value-based payment arrangements between managed care organizations and providers;
- Expanding the Accountable Communities of Health model statewide and developing an MTP Project Toolkit to guide efforts of nine ACHs to promote health and transform care delivery in their regions.

At the time of this report, Washington State had demonstrated substantial progress toward implementation of each of these reforms as described below.

Integration of Physical and Behavioral Health Care

To achieve the MTP goal of integrating physical and behavioral health care, Washington required its five managed care organizations to financially integrate (“carve in”) behavioral health services, with those transitions happening in waves that corresponded roughly to ACH regions. This financial integration occurred in five waves as shown in Exhibit 1.2:

Exhibit 1.2: Integrated Managed Care Regions by Implementation Date



A study by Washington State’s Research and Data Analysis Division assessed changes in the first year of IMC for group 1 (which transitioned to IMC in April 2016), compared to the rest of the state. This evaluation found IMC to be associated with improvements in mental health access, reductions in psychiatric inpatient readmissions, and improvements in diabetes screening rates for people with

serious mental illness (Bittinger, Court and Mancuso, 2019). Among people with co-occurring mental illness and substance use disorder, IMC was associated with improvements in measures of social determinants of health, including reductions in arrests and homelessness.

While all regions completed the transition to IMC by 2020, there is evidence that this transition may have impeded other MTP initiatives in unexpected ways. In Chapters 2-10, we note that ACHs encountered difficulty engaging some partnering providers in their MTP initiatives because these providers were focused on organizational changes necessary under IMC. This was particularly true for behavioral health and substance use disorder treatment providers, as we describe further in Chapter 15.

Adoption of Value-Based Payments

As reported in the Baseline Evaluation Report (Kushner and McConnell, 2020), between 2017 and 2019 Washington State also made progress toward MTP goals related to value-based payment, with evidence of widespread participation in new VBP arrangements among primary care practices, and achievement of the state's targets for VBP participation by managed care organizations. The Health Care Authority's Paying for Value survey of MCOs and providers (Washington State Health Care Authority, 2019d) found that MCOs were leading the way in VBP adoption in Washington, with 57% of 2018 Medicaid managed care payments made through arrangements that included shared gains and/or risks (classified as Category 3A or higher using the Health Care Payment Learning and Action Network's APM Framework), compared with 20 percent of commercial payments and 8 percent of Medicare Advantage payments.

Improvements in Performance and Quality

ACHs are key partners in the state's efforts to improve performance and quality and achieve its targets for accountability. To guide ACHs in supporting the state attainment of performance targets, a Project Toolkit developed at the outset of MTP defined eight health improvement project areas, each with links to ACH performance incentives and required milestones (Washington State Health Care Authority, 2019a).

As reported in the Baseline Evaluation Report, ACHs have pursued a wide range of activities within these eight project areas during the first three years of the demonstration; yet early evidence suggests that while ACHs were well positioned to address social and community-level determinants of health within their regions, the design of the MTP Project Toolkit narrowed their focus to primarily clinical partnerships and interventions during the planning stages of MTP. In Chapters 2-10 of this report, we present an update to these findings and the first round of results of our evaluation of each health improvement project.

A Shifting Landscape During COVID-19

In early 2020, the COVID-19 pandemic reached the United States, with the first confirmed outbreaks occurring in Washington State. The pandemic and the steps taken to respond to it caused widespread disruptions to the health care delivery system. In response to these disruptions, Washington Health Care Authority requested and received authorization from the Centers for Medicare and Medicaid Services to modify elements of MTP performance and accountability.

At the statewide level, Washington's accountability to CMS to achieve performance targets on the 10 statewide quality measures in 2020 was modified to pay-for-reporting only, and eliminated risk in

the event that the state did not achieve statewide quality targets for 2020 (Washington State Health Care Authority, 2020). Responding to changes in CMS' national VBP strategy during the COVID-19 pandemic, HCA also implemented changes to its Long-Term Value-Based Purchasing Roadmap. VBP targets for MCOs in 2021 were frozen at the 2020 target level of 85 percent rather than increasing to 90 percent.

ACHs were actively engaged in COVID-19 response and recovery at the regional level throughout 2020, while also navigating challenges related to the pandemic that disrupted implementation of regional health improvement projects. In recognition of these challenges, the Washington Health Care Authority made changes to ACHs' incentive payments in July 2020 to offer greater flexibility in meeting performance targets during the pandemic (see Chapter Two).

At the time of this report, the State of Washington was engaged in additional negotiations with CMS regarding a potential modification to its Section 1115 Medicaid Demonstration Waiver to add a sixth demonstration year and extend MTP initiatives through 2022. Among the priorities for this potential sixth year, the state articulated a formal role for ACHs in continuing COVID-19 response and recovery. No determination had yet been made.

These changes in Washington's performance accountability requirements and VBP targets occurred after the measurement period for this Interim Evaluation Report, but future reports will include examination of how Washington's Medicaid system has performed and changed during these periods.

Statewide Evaluation Approach

We analyzed 44 metrics to assess the performance of Washington State's Medicaid system through December 2019 (see Appendix A for details on these measures). These analyses serve as an assessment of the overall effects of population health efforts focused on broad themes, including, for example, behavioral health, maternal health, or oral health improvement, and do not assess the effectiveness of specific interventions or programs occurring in Washington State during this period.

The National Committee for Quality Assurance (NCQA) served as the steward of 22 of our 44 evaluation metrics. In addition to these NCQA metrics, we included measures with a variety of other stewards, including the Bree Collaborative in Washington State, the state's Department of Social and Health Services, and the Dental Quality Alliance. The 44 measures represent a blend of statewide accountability metrics and metrics which were used in pay-for-performance incentives as part of the Health Improvement Project work.

For ease of interpretation, we categorize these evaluation metrics into 10 domains. Exhibit 1.3 presents the domains and metrics that appeared in the Baseline Evaluation Report and any changes in specification of these measures that occurred prior to this Interim Evaluation Report.

We analyzed change in each metric from a baseline period (2018) to 2019. We used statistical models to adjust for observable factors, including changes in patient demographics and health status that may also drive changes in metrics. Unless otherwise noted, the study period spans calendar year 2018 and 2019 (reproductive and maternal health care measures reflect the period July 2017 - June 2018 and July 2018 - June 2019 due to a different production schedule of these measures).

Additional analyses of Initiative 1 Health Improvement Projects are presented in Chapters 2-10.

Exhibit 1.3: Performance Metrics Used in the MTP Evaluation

Domain	MTP Evaluation Metrics	Changes from Baseline Report
SOCIAL DETERMINANTS OF HEALTH	<ul style="list-style-type: none"> • Homelessness^{P4P} • Employment • Arrest Rate^{P4P} 	<ul style="list-style-type: none"> • No change
ACCESS TO PRIMARY AND PREVENTIVE CARE	<ul style="list-style-type: none"> • Children and Adolescents' Access to Primary Care^{P4P} • Adults' Access to Primary Care 	<ul style="list-style-type: none"> • No change
REPRODUCTIVE AND MATERNAL HEALTH CARE	<ul style="list-style-type: none"> • Timely Prenatal Care^{NCQA,P4P} • Effective Contraception^{P4P} • Long-Acting Reversible Contraceptives • Effective Contraception Within 60 Days of Delivery^{P4P} 	<ul style="list-style-type: none"> • Measures in this domain are reported for the period July 2018 - June 2019 due to availability of data at time of publication
PREVENTION AND WELLNESS	<ul style="list-style-type: none"> • Well-Child Visits in the First 15 Months ^{NCQA,P4P} • Well-Child Visits Age 3 to 6 ^{NCQA,P4P} • Immunizations for Children ^{NCQA,P4P} • Body Mass Index Assessment for Adults^{NCQA} • Chlamydia Screening for Women^{P4P} • Cervical Cancer Screening ^{NCQA} • Breast Cancer Screening ^{NCQA} • Colorectal Cancer Screening 	<ul style="list-style-type: none"> • Immunizations for Children metric for 2019 was not yet available at the time of publication
MENTAL HEALTH CARE	<ul style="list-style-type: none"> • Mental Health Treatment Penetration^{P4P} • Antidepressant Medication for Adults (12 Weeks)^{NCQA,P4P} • Antidepressant Medication for Adults (6 Months)^{NCQA,P4P} • Antipsychotic Medication for People with Schizophrenia^{NCQA} • Diabetes Screening for People with Schizophrenia/ Bipolar Disorder • 30-Day Follow-Up After ED Visit for Mental Illness^{NCQA,P4P} • 30-Day Follow-Up After Hospitalization for Mental Illness^{NCQA,P4P} • 30-Day Hospital Readmission for a Psychiatric Condition 	<ul style="list-style-type: none"> • No change
ORAL HEALTH CARE	<ul style="list-style-type: none"> • Preventive or Restorative Dental Services^{P4P} • Topical Fluoride at a Medical Visit^{P4P} • Periodontal Exam for Adults^{P4P} 	<ul style="list-style-type: none"> • No change
CARE FOR PEOPLE WITH CHRONIC CONDITIONS	<ul style="list-style-type: none"> • Controller Medication for Asthma^{NCQA,P4P} • Eye Exam for People with Diabetes^{NCQA,P4P} • Hemoglobin A1c Testing for People with Diabetes^{NCQA,P4P} • Nephropathy Screening for People with Diabetes^{NCQA,P4P} • Statin Medication for Cardiovascular Disease^{NCQA,P4P} 	<ul style="list-style-type: none"> • No change

Exhibit 1.3 (continued): Performance Metrics Used in Interim Evaluation

Domain	Baseline Evaluation Metrics	Change in Interim Metrics
EMERGENCY DEPARTMENT, HOSPITAL, AND INSTITUTIONAL CARE USE	<ul style="list-style-type: none"> Emergency (ED) Department Visit Rate^{P4P} Acute Hospital Use Among Adults^{P4P} Hospital Readmission Within 30 Days^{P4P} Ratio of Home and Community-Based Care Use to Nursing Facility Use 	<ul style="list-style-type: none"> Acute Hospital Use is updated to reflect new specification in the DSRIP Measurement Guide
SUBSTANCE USE DISORDER CARE	<ul style="list-style-type: none"> Substance Use Disorder (SUD) Treatment Penetration^{P4P} Alcohol or Other Drug (AOD) Treatment: Initiation^{NCQA} Alcohol or Other Drug (AOD) Treatment: Engagement^{NCQA} 30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence^{P4P} 	<ul style="list-style-type: none"> No change
OPIOID PRESCRIBING AND OPIOID USE DISORDER TREATMENT	<ul style="list-style-type: none"> People with an Opioid Prescription \geq 50mg MED^{P4P} People with an Opioid Prescription \geq 90mg MED^{P4P} People with an Opioid Prescription Who Were Prescribed a Sedative^{P4P} Opioid Use Disorder Treatment Penetration^{P4P} 	<ul style="list-style-type: none"> No change

^{P4P}: Pay-for-performance metric for at least one ACH Health Improvement Project. ^{NCQA}: National 2018 Medicaid HMO rate available from National Center for Quality Assurance (National Center for Quality Assurance, n.d.).

See DSRIP Measurement Guide for a list of all changes in measure specifications for 2019. Available at <https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-metrics>

Populations

The data for this evaluation include outcomes for approximately 2.5 million Medicaid members enrolled over a three year period ending December 2019. In this chapter, we present results for all Medicaid members in Washington, as well as for specific sub-groups described in Exhibit 1.4.

Exhibit 1.4: Subgroups of Medicaid Members

HEALTH CONDITION	Chronic condition	People diagnosed with at least one chronic physical health condition, such as asthma or diabetes, from a list of chronic conditions
	Serious mental illness (SMI)	People diagnosed with schizophrenia, bipolar I, major depressive disorder, or other schizophrenia spectrum or psychotic disorder
GEOGRAPHY OF RESIDENCE	Rural	People who resided in regions with a population center of less than 49,000 people
	High poverty	People who resided in ZIP codes where the median income was in the bottom fifth of Washington State's income distribution
RACE/ETHNICITY	American Indian/Alaska Native Asian Black Hawaiian or Pacific Islander Hispanic White	Race/ethnicity group from Medicaid enrollment records

How to Read the Results

This section describes how to interpret the tables and maps in the following sections. We use a sample of results from the Baseline Evaluation Report to illustrate.

The first table in each section presents the statewide average for each metric in 2018, the change in the rate for each metric from 2017 to 2018, and the US average for each metric, if available.

The middle column shows the change in the rate for each metric from 2017 to 2018. Shades of **blue** indicate the metric improved and shades of **orange** indicate the metric worsened. For example, Timely Prenatal Care increased by 0.7 percent from 2017 to 2018. A higher rate is better for this metric, so the change is shaded blue.

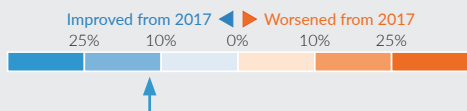
This column shows the national average for Medicaid managed care organizations in 2017, if available. Data were obtained from the National Center for Quality Assurance.

Statewide Rates, 2017-2018 Change, and US Comparison

Statewide rate in 2018, statewide change from 2017 to 2018, and US average in 2017

		2018 Statewide	2017-2018 Change	2017 US Average
Timely Prenatal Care	[1]	86.6 %	1.1 %	NA
Effective Contraception	[1]	28.5 %	-0.6 %	NA
Long-Acting Reversible Contraceptives	[0]	16.1 %	0.9 %	NA
Effective Contraception within 60 Days of Delivery	[1]	40.7 %	-0.1 %	NA

↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)



A key at the bottom of table explains the table shading.

A down arrow next to a metric means a lower rate is better.

Numbers in brackets show the number of ACH Health Improvement Projects for which the metric is a pay-for-performance metric. For example, Effective Contraception Within 60 Days of Delivery is a P4P metric for one project.

The three remaining tables in each section present rates for subgroups of Medicaid members in 2018. The example below shows rates for three race/ethnicity groups. Shades of **blue** indicate that the rate for the subgroup was better than the state average, and shades of **orange** indicate the rate was worse for the subgroup than the state average. For example, the rate for Timely Prenatal Care (a metric where a higher rate is better) was higher among Hispanic Medicaid members than the statewide average.

Measures by Race and Ethnicity

Hawaiian or Pacific Islander (HI/PI), Hispanic, and White members

		HI/PI	Hispanic	White
Timely Prenatal Care	[1]	79.8 %	88.8 %	86.9 %
Effective Contraception	[1]	24.1 %	29.2 %	29.5 %
Long-Acting Reversible Contraceptives	[0]	13.2 %	21.9 %	14.5 %
Effective Contraception within 60 Days of Delivery	[1]	33.0 %	48.1 %	40.6 %

↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)



A key at the bottom of table explains the table shading. The shading scheme is the same for the last three tables and the map in each section, and *different* from the shading scheme in the first table.

Results

Domain 1: Social Determinants of Health

This domain includes the following measures:

- **Homelessness:** Percentage of members who were homeless at least one month in the year, as reported by the Washington State Department of Social and Health Services, Economic Services Administration.
- **Employment:** Percentage of members age 18 to 64 with any earnings in the year, as reported by the Washington State Employment Security Department.
- **Arrest Rate:** Percentage of members age 18 to 64 years of age who were arrested at least once in the year, as reported by the Washington State Patrol.

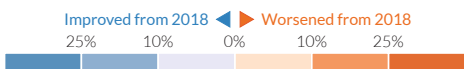
KEY FINDINGS

- Homelessness and the arrest rate were essentially unchanged from 2018 to 2019. Employment declined by 4.6 percent.
- Homelessness and the arrest rate were higher and Employment was lower among people with chronic conditions and serious mental illness. More than 10 percent of people with serious mental illness experienced homelessness.
- Homelessness was highest among American Indian/Alaska Native and Black Medicaid members.

Statewide Rates, 2018-2019 Change, and US Comparison

Statewide rate in 2019, statewide change from 2018 to 2019, and US average in 2018

		2019 Statewide	2018-2019 Change	2018 US Average
Homelessness	[3] ↓	3.4 %	0.2 %	NA
Employment (Age 18 to 64)	[0]	45.1 %	-4.6 %	NA
Arrest Rate (Age 18 to 64)	[1] ↓	3.9 %	0.0 %	NA



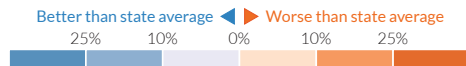
↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Domain 1: Social Determinants of Health (continued)

Measures by Health Condition and Geographic Area, 2019

Members with chronic illness, members with serious mental illness (SMI), members living in rural areas, and members living in high-poverty areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High Poverty
Homelessness	[3] ↓	7.3 %	10.6 %	2.5 %	4.1 %
Employment (Age 18 to 64)	[0]	39.8 %	33.6 %	46.0 %	47.7 %
Arrest Rate (Age 18 to 64)	[1] ↓	8.5 %	12.0 %	3.5 %	4.7 %



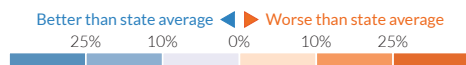
↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Measures by Race and Ethnicity, 2019

American Indian or Alaska Native (AI/AN), Asian, Black, Hawaiian or Pacific Islander (HI/PI), Hispanic and White members

		AI/AN	Asian	Black
		Homelessness	6.1 %	0.9 %
Employment (Age 18 to 64)		38.2 %	44.6 %	52.0 %
Arrest Rate (Age 18 to 64)		8.0 %	1.3 %	6.0 %

		HI/PI	Hispanic	White
		Homelessness	[3] ↓	2.1 %
Employment (Age 18 to 64)	[0]	50.0 %	58.5 %	41.3 %
Arrest Rate (Age 18 to 64)	[1] ↓	2.2 %	2.5 %	4.8 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Domain 2: Access to Primary and Preventive Services

This domain includes the following measures:

- **Children and Adolescents' Access to Primary Care:** Percentage of Medicaid members age one to 19 who had at least one ambulatory or preventive care visit.
- **Adults' Access to Primary Care:** Percentage of Medicaid members age 20 and older who had at least one ambulatory or preventive care visit.

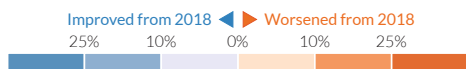
KEY FINDINGS

- Metrics in this domain were mostly unchanged from 2018 to 2019.
- Adults' access to primary care was substantially higher among people with chronic conditions and people with serious mental illness than among Medicaid members overall.
- Rural areas and high-poverty areas had access rates that were comparable to the statewide average.
- Access measures were notably lower for the Native Hawaiian/Pacific Islander subgroup than for other Medicaid members.

Statewide Rates, 2018-2019 Change, and US Comparison

Statewide rate in 2019, statewide change from 2018 to 2019, and US average in 2018

		2019 Statewide	2018-2019 Change	2018 US Average
Children and Adolescents' Access to Primary Care	[2]	90.8 %	0.5 %	NA
Adults' Access to Primary Care	[0]	78.4 %	0.5 %	NA

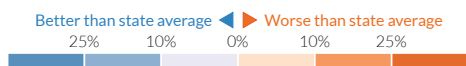


↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Measures by Health Condition and Geographic Area, 2019

Members with chronic illness, members with serious mental illness (SMI), members living in rural areas, and members living in high-poverty areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High Poverty
Children and Adolescents' Access to Primary Care	[2]	97.9 %	98.6 %	92.1 %	91.9 %
Adults' Access to Primary Care	[0]	89.4 %	94.6 %	79.4 %	78.7 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Domain 2: Access to Primary and Preventive Services (continued)

Measures by Race and Ethnicity, 2019

American Indian or Alaska Native (AI/AN), Asian, Black, Hawaiian or Pacific Islander (HI/PI), Hispanic and White members

		AI/AN	Asian	Black
Children and Adolescents' Access to Primary Care		91.6 %	91.3 %	89.8 %
Adults' Access to Primary Care		78.6 %	77.1 %	77.7 %
		HI/PI	Hispanic	White
Children and Adolescents' Access to Primary Care	[2]	84.4 %	93.1 %	90.0 %
Adults' Access to Primary Care	[0]	73.2 %	80.6 %	78.7 %



Domain 3: Reproductive and Maternal Health Care

This section presents changes in measures of reproductive and maternal health care. These measures differ from measures in the rest of this chapter and are reported on a state fiscal year basis. Results below compare changes in a pre-period of July 2017 - June 2018 to a post period of July 2018 - June 2019.

This domain includes the following measures:

- **Timely Prenatal Care:** Percentage of deliveries with a prenatal care visit in the first trimester, on the Medicaid enrollment start date, or within 42 days of enrollment.
- **Effective Contraception:** Percentage of female Medicaid members age 15 to 44 who received a most-effective or moderately effective method of contraception.
- **Long-Acting Reversible Contraceptives:** Percentage of female Medicaid members age 15 to 44 who received a long-acting reversible method of contraception, defined as contraceptive implants, intrauterine devices, or intrauterine systems.
- **Effective Contraception Within 60 Days of Delivery:** Percentage of female Medicaid members age 15 to 44 with a live birth who received a most-effective or moderately effective method of contraception within 60 days of delivery.

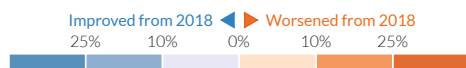
KEY FINDINGS

- Metrics in this domain were essentially relatively stable between the pre and post periods.
- People with chronic conditions and people with serious mental illness had better measures of contraceptive quality relative to the state as a whole.
- Asian, Black, and Hawaiian/Pacific Islander Medicaid members had worse measures for contraceptive quality relative to the state as a whole.

Statewide Rates, Pre-post Change, and US Comparison

Statewide rate from July 2018-June 2019, statewide change from 2017-2018 to 2018-2019, and US average in 2018

		2018-19 Statewide	Pre-post Change	2018 US Average
Timely Prenatal Care	[1]	86.6 %	1.1 %	NA
Effective Contraception	[1]	28.5 %	-0.6 %	NA
Long-Acting Reversible Contraceptives	[0]	16.1 %	0.9 %	NA
Effective Contraception within 60 Days of Delivery	[1]	40.7 %	-0.1 %	NA



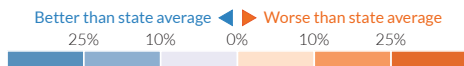
↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Domain 3: Reproductive and Maternal Health Care (continued)

Measures by Health Condition and Geographic Area, July 2018 - June 2019

Members with chronic illness, members with serious mental illness (SMI), members living in rural areas, and members living in high-poverty areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High Poverty
Timely Prenatal Care	[1]	85.4 %	85.3 %	87.6 %	86.4 %
Effective Contraception	[1]	31.5 %	34.6 %	30.0 %	29.3 %
Long-Acting Reversible Contraceptives	[0]	16.2 %	18.1 %	16.9 %	19.2 %
Effective Contraception within 60 Days of Delivery	[1]	43.1 %	45.0 %	44.8 %	45.8 %

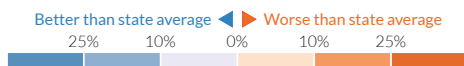


↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Measures by Race and Ethnicity, July 2018 - June 2019

American Indian or Alaska Native (AI/AN), Asian, Black, Hawaiian or Pacific Islander (HI/PI), Hispanic and White members

		AI/AN	Asian	Black
		Timely Prenatal Care		79.2 %
Effective Contraception		26.7 %	24.0 %	25.9 %
Long-Acting Reversible Contraceptives		13.8 %	12.8 %	14.2 %
Effective Contraception within 60 Days of Delivery		37.3 %	30.1 %	35.4 %
		HI/PI	Hispanic	White
		Timely Prenatal Care	[1]	79.8 %
Effective Contraception	[1]	24.1 %	29.2 %	29.5 %
Long-Acting Reversible Contraceptives	[0]	13.2 %	21.9 %	14.5 %
Effective Contraception within 60 Days of Delivery	[1]	33.0 %	48.1 %	40.6 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Domain 4: Prevention and Wellness

This domain includes the following measures:

- **Well-Child Visits in the First 15 Months:** Percentage of children who reached an age of 15 months in the year and who had six or more well-child visits during their first 15 months of life. *This measure is presented for the period July 2018-June 2019 due to data availability.*
- **Well-Child Visits Age 3 to 6:** Percentage of children age 3-6 who had one or more well-child visits during the year.
- **Immunizations for Children:** Percentage of children age 2 who received all vaccinations in the combination 10-vaccination set by their second birthday.
- **Body Mass Index Assessment for Adults:** Percentage of Medicaid members age 18 to 74 who had an outpatient visit and whose body mass index was documented within the last two years.
- **Chlamydia Screening for Women:** Percentage of women age 16 to 24 identified as sexually active who received at least one chlamydia test during the measurement year.
- **Cervical Cancer Screening:** Percentage of women age 21 to 64 who were screened for cervical cancer.
- **Breast Cancer Screening:** Percentage of women age 50 to 74 who had a mammogram to screen for breast cancer.
- **Colorectal Cancer Screening:** Percentage of Medicaid members age 50 to 74 who were screened for colorectal cancer.

KEY FINDINGS

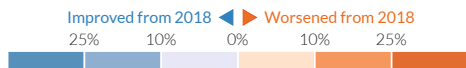
- *Most metrics in this domain were relatively stable between 2018 and 2019. Body Mass Index assessment exhibited the largest change (3.4 percent).*
- *American Indian/Alaska Native Medicaid members experienced substantially worse outcomes on six of seven metrics.*
- *Metrics were generally better among people with chronic conditions and serious mental illness and slightly worse among rural residents.*

Domain 4: Prevention and Wellness (continued)

Statewide Rates¹, 2018-2019 Change², and US Comparison

Statewide rate in 2019, statewide change from 2018 to 2019, and US average in 2018

		2019 ¹ Statewide	2018-2019 ² Change	2018 US Average
Immunizations for Children	[1]	NA	NA	NA
Well-Child Visits in the First 15 Months	[1]	70.0 %	2.1 %	NA
Well-Child Visits Age 3 to 6	[1]	66.7 %	1.5 %	NA
Body Mass Index Assessment for Adults	[0]	36.3 %	3.4 %	NA
Chlamydia Screening for Women	[1]	51.0 %	-0.4 %	58.1 %
Cervical Cancer Screening	[0]	50.8 %	-0.1 %	NA
Breast Cancer Screening	[0]	50.5 %	0.0 %	58.4 %
Colorectal Cancer Screening	[0]	41.9 %	0.8 %	NA



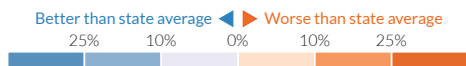
↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Notes: 1) Well-Child Visits in the First 15 Months metric is calculated for the period July 2018-June 2019 due to data availability. 2) Well-Child Visits in the First 15 months metric is calculated to display change from the period July 2017-June 2018 to the period July 2018-June 2019.

Measures by Health Condition and Geographic Area, 2019

Members with chronic illness, members with serious mental illness (SMI), members living in rural areas, and members living in high-poverty areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High Poverty
Immunizations for Children		NA	NA	NA	NA
Well-Child Visits in the First 15 Months	[1]	73.6 %	NA	67.7 %	70.5 %
Well-Child Visits Age 3 to 6	[1]	73.9 %	71.1 %	68.0 %	68.3 %
Body Mass Index Assessment for Adults	[0]	44.8 %	52.2 %	30.7 %	36.8 %
Chlamydia Screening for Women	[1]	52.9 %	54.6 %	48.4 %	54.2 %
Cervical Cancer Screening	[0]	53.2 %	53.4 %	49.7 %	51.2 %
Breast Cancer Screening	[0]	54.9 %	54.1 %	48.2 %	49.9 %
Colorectal Cancer Screening	[0]	48.5 %	52.4 %	38.8 %	41.7 %



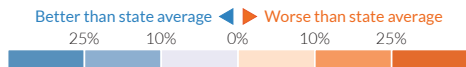
↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Domain 4: Prevention and Wellness (continued)

Measures by Race and Ethnicity, 2018-2019¹

American Indian or Alaska Native (AI/AN), Asian, Black, Hawaiian or Pacific Islander (HI/PI), Hispanic and White members

		AI/AN	Asian	Black
Immunizations for Children		NA	NA	NA
Well-Child Visits in the First 15 Months		55.2 %	81.1 %	69.3 %
Well-Child Visits Age 3 to 6		57.8 %	72.4 %	63.3 %
Body Mass Index Assessment for Adults		27.3 %	38.3 %	41.8 %
Chlamydia Screening for Women		51.6 %	48.5 %	58.7 %
Cervical Cancer Screening		42.6 %	55.8 %	54.3 %
Breast Cancer Screening		35.1 %	65.8 %	46.7 %
Colorectal Cancer Screening		31.8 %	52.2 %	40.6 %
		HI/PI	Hispanic	White
Immunizations for Children		NA	NA	NA
Well-Child Visits in the First 15 Months	[1]	65.9 %	74.6 %	65.9 %
Well-Child Visits Age 3 to 6	[1]	59.8 %	71.1 %	64.6 %
Body Mass Index Assessment for Adults	[0]	39.6 %	34.6 %	36.4 %
Chlamydia Screening for Women	[1]	51.9 %	53.6 %	48.6 %
Cervical Cancer Screening	[0]	49.8 %	58.5 %	49.1 %
Breast Cancer Screening	[0]	51.5 %	61.3 %	48.3 %
Colorectal Cancer Screening	[0]	41.7 %	46.9 %	40.9 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Notes: 1) Well-Child Visits in the First 15 months metric is calculated to display change from the period July 2017-June 2018 to the period July 2018-June 2019.

Domain 5: Mental Health Care

This domain includes the following measures:

- **Mental Health Treatment Penetration:** Percentage of Medicaid members age 6 and older with a mental health service need who received at least one mental health service.
- **Antidepressant Medication for Adults (12 Weeks):** Percentage of Medicaid members age 18 and older with depression who remained on antidepressant medication for 12 weeks.
- **Antidepressant Medication for Adults (6 Months):** Percentage of Medicaid members age 18 and older with depression who remained on antidepressant medication for six months.
- **Antipsychotic Medication for People with Schizophrenia:** Percentage of Medicaid members age 19 to 64 with schizophrenia who received and remained on an antipsychotic medication.
- **Diabetes Screening for People with Schizophrenia/Bipolar Disorder:** Percentage of Medicaid members age 18 to 64 with schizophrenia or bipolar disorder who received antipsychotic medication and had a diabetes test.
- **30-Day Follow-Up After ED Visit for Mental Illness:** Percentage of emergency department visits with a diagnosis of mental illness where the patient received a follow-up outpatient service within 30 days.
- **30-Day Follow-Up After Hospitalization for Mental Illness:** Percentage of discharges after hospitalization for mental illness where the patient received a follow-up outpatient service within 30 days.
- **30-Day Hospital Readmission for a Psychiatric Condition:** Percentage of inpatient psychiatric stays by adults that were followed by a readmission within 30 days.

KEY FINDINGS

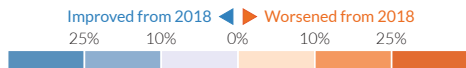
- *The change in mental health metrics was mixed between 2018 and 2019, with four improving moderately, and four worsening more substantially. Follow-up after emergency department or hospitalization for mental health decreased by more than six percentage points. Antidepressant medication quality measures improved by more than two percent.*
- *People with serious mental illness and rural residents had measures that were slightly better than the statewide average for most metrics.*
- *Measures were highest among white enrollees, with disparities apparent across other racial and ethnic groups. American Indian/Alaska Native and Black Medicaid experienced worse outcomes than the state average on most metrics.*

Domain 5: Mental Health Care (continued)

Statewide Rates, 2018-2019 Change, and US Comparison

Statewide rate in 2019, statewide change from 2018 to 2019, and US average in 2018

		2019 Statewide	2018-2019 Change	2018 US Average
Mental Health Treatment Penetration	[3]	54.9 %	0.3 %	NA
Antidepressant Medication for Adults (12 Weeks)	[1]	53.4 %	2.6 %	53.5 %
Antidepressant Medication for Adults (6 Months)	[1]	38.0 %	2.7 %	37.9 %
Antipsychotic Medication for People with Schizophrenia	[0]	63.0 %	-1.6 %	59.8 %
Diabetes Screening for People with Schizophrenia/Bipolar Disorder	[0]	79.9 %	0.4 %	NA
30-Day Follow-Up After ED Visit for Mental Illness	[3]	67.6 %	-7.0 %	54.8 %
30-Day Follow-Up After Hospitalization for Mental Illness	[3]	67.7 %	-6.6 %	56.8 %
30-Day Hospital Readmission for a Psychiatric Condition	[0] ↓	14.2 %	1.4 %	NA

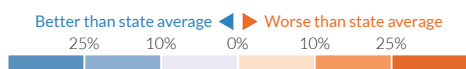


↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Measures by Health Condition and Geographic Area, 2019

Members with chronic illness, members with serious mental illness (SMI), members living in rural areas, and members living in high-poverty areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High Poverty
Mental Health Treatment Penetration	[3]	54.6 %	73.2 %	54.9 %	56.0 %
Antidepressant Medication for Adults (12 Weeks)	[1]	52.8 %	55.1 %	53.6 %	50.9 %
Antidepressant Medication for Adults (6 Months)	[1]	37.9 %	41.4 %	38.0 %	35.4 %
Antipsychotic Medication for People with Schizophrenia	[0]	61.7 %	61.5 %	61.2 %	59.5 %
Diabetes Screening for People with Schizophrenia/Bipolar Disorder	[0]	83.4 %	85.1 %	80.5 %	79.4 %
30-Day Follow-Up After ED Visit for Mental Illness	[3]	68.3 %	70.5 %	73.9 %	68.6 %
30-Day Follow-Up After Hospitalization for Mental Illness	[3]	69.0 %	70.5 %	69.9 %	66.8 %
30-Day Hospital Readmission for a Psychiatric Condition	[0] ↓	14.3 %	14.7 %	13.2 %	15.1 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

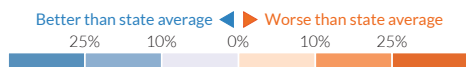
Domain 5: Mental Health Care (continued)

Measures by Race and Ethnicity, 2018-2019

American Indian or Alaska Native (AI/AN), Asian, Black, Hawaiian or Pacific Islander (HI/PI), Hispanic and White members

	AI/AN	Asian	Black
Mental Health Treatment Penetration	54.4 %	47.8 %	53.2 %
Antidepressant Medication for Adults (12 Weeks)	47.2 %	52.2 %	43.9 %
Antidepressant Medication for Adults (6 Months)	31.3 %	36.6 %	28.5 %
Antipsychotic Medication for People with Schizophrenia	51.3 %	73.4 %	53.7 %
Diabetes Screening for People with Schizophrenia/Bipolar Disorder	83.5 %	75.4 %	77.3 %
30-Day Follow-Up After ED Visit for Mental Illness	59.1 %	69.2 %	63.9 %
30-Day Follow-Up After Hospitalization for Mental Illness	62.3 %	73.4 %	63.1 %
30-Day Hospital Readmission for a Psychiatric Condition	NA	NA	NA

	HI/PI	Hispanic	White
Mental Health Treatment Penetration [3]	48.0 %	55.0 %	55.7 %
Antidepressant Medication for Adults (12 Weeks) [1]	45.8 %	46.1 %	56.2 %
Antidepressant Medication for Adults (6 Months) [1]	28.8 %	30.6 %	40.9 %
Antipsychotic Medication for People with Schizophrenia [0]	63.8 %	56.3 %	65.6 %
Diabetes Screening for People with Schizophrenia/Bipolar Disorder [0]	73.1 %	77.2 %	80.7 %
30-Day Follow-Up After ED Visit for Mental Illness [3]	66.7 %	67.4 %	68.9 %
30-Day Follow-Up After Hospitalization for Mental Illness [3]	70.0 %	62.9 %	69.9 %
30-Day Hospital Readmission for a Psychiatric Condition [0] ↓	NA	NA	NA



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Note: 30-Day Hospital Readmission for a Psychiatric Condition is suppressed due to small sample sizes.

Domain 6: Oral Health Care

This domain reflects quality of oral health care. It includes three metrics:

- **Preventive or Restorative Dental Services:** Percentage of Medicaid members who received preventive or restorative dental services.
- **Topical Fluoride at a Medical Visit:** Percentage of children age 5 and younger who received topical fluoride from a non-dental medical provider during a medical visit.
- **Periodontal Exam for Adults:** Percentage of Medicaid members age 30 and over with a history of periodontitis who received an oral or periodontal evaluation.

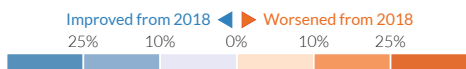
KEY FINDINGS

- *People with serious mental illness and people with chronic conditions had substantially lower rates of preventive or restorative dental services, slightly lower rates of periodontal exams, and slightly higher rates of topical fluoride use.*
- *Enrollees in rural areas and high-poverty areas had substantially lower rates of topical fluoride at a medical visit.*
- *American Indian/Alaska Native Medicaid and Black Medicaid members experienced worse outcomes than the state as a whole.*

Statewide Rates, 2018-2019 Change, and US Comparison

Statewide rate in 2019, statewide change from 2018 to 2019, and US average in 2018

		2019 Statewide	2018-2019 Change	2018 US Average
Preventive or Restorative Dental Services	[1]	48.1 %	0.9 %	NA
Topical Fluoride at a Medical Visit	[1]	4.5 %	0.1 %	NA
Periodontal Exam for Adults	[2]	51.0 %	0.3 %	NA



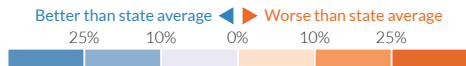
↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Domain 6: Oral Health Care (continued)

Measures by Health Condition and Geographic Area, 2019

Members with chronic illness, members with serious mental illness (SMI), members living in rural areas, and members living in high-poverty areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High Poverty
Preventive or Restorative Dental Services	[1]	41.0 %	38.2 %	50.1 %	51.2 %
Topical Fluoride at a Medical Visit	[1]	6.4 %	NA	2.3 %	4.0 %
Periodontal Exam for Adults	[2]	50.6 %	49.9 %	49.2 %	50.3 %



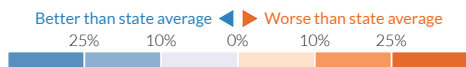
↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Measures by Race and Ethnicity, 2019

American Indian or Alaska Native (AI/AN), Asian, Black, Hawaiian or Pacific Islander (HI/PI), Hispanic and White members

		AI/AN	Asian	Black
Preventive or Restorative Dental Services		45.7 %	49.0 %	45.8 %
Topical Fluoride at a Medical Visit		3.9 %	4.6 %	4.4 %
Periodontal Exam for Adults		42.5 %	61.8 %	46.1 %

		HI/PI	Hispanic	White
Preventive or Restorative Dental Services	[1]	43.5 %	61.9 %	41.7 %
Topical Fluoride at a Medical Visit	[1]	5.3 %	3.6 %	5.2 %
Periodontal Exam for Adults	[2]	51.0 %	52.6 %	49.7 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Domain 7: Care for People with Chronic Conditions

This domain includes the following measures:

- **Controller Medication for Asthma:** Percentage of Medicaid members age 5 to 64 with persistent asthma who had a ratio of controller medication to total asthma medications of 0.5 or greater.
- **Eye Exam for People with Diabetes:** Percentage of Medicaid members age 18 to 75 with diabetes who had an eye exam by an eye care professional.
- **Hemoglobin A1c Testing for People with Diabetes:** Percentage of Medicaid members age 18 to 75 with diabetes who had a hemoglobin A1c test.
- **Nephropathy Screening for People with Diabetes:** Percentage of Medicaid members age 18 to 75 with diabetes who had a nephropathy screening or evidence of nephropathy.
- **Statin Medication for Cardiovascular Disease:** Percentage of men age 21 to 75 and women age 40 to 75 with atherosclerotic cardiovascular disease who received a high- or moderate-intensity statin medication during the measurement year.

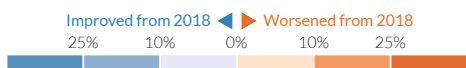
KEY FINDINGS

- For the state as a whole, metrics improved very modestly between 2018 and 2019.
- On three to five metrics where national data were available, Washington State performed worse than the national average.
- American Indian/Alaska Native and Black Medicaid members generally had worse quality on measures of the quality of care for people with chronic conditions.

Statewide Rates, 2018-2019 Change, and US Comparison

Statewide rate in 2019, statewide change from 2018 to 2019, and US average in 2018

		2019 Statewide	2018-2019 Change	2018 US Average
Controller Medication for Asthma	[2]	53.0 %	0.5 %	37.8 %
Eye Exam for People with Diabetes	[2]	45.9 %	0.1 %	NA
Hemoglobin A1c Testing for People with Diabetes	[2]	83.4 %	0.7 %	NA
Nephropathy Screening for People with Diabetes	[2]	84.8 %	0.1 %	NA
Statin Medication for Cardiovascular Disease	[1]	83.5 %	0.3 %	76.3 %



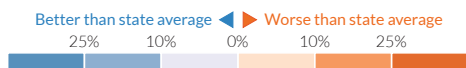
↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Domain 7: Care for People with Chronic Conditions (continued)

Measures by Health Condition and Geographic Area, 2019

Members with chronic illness, members with serious mental illness (SMI), members living in rural areas, and members living in high-poverty areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High Poverty
Controller Medication for Asthma	[2]	51.3 %	50.6 %	50.1 %	51.0 %
Eye Exam for People with Diabetes	[2]	46.9 %	46.3 %	45.7 %	45.9 %
Hemoglobin A1c Testing for People with Diabetes	[2]	83.0 %	81.0 %	85.6 %	82.9 %
Nephropathy Screening for People with Diabetes	[2]	85.4 %	87.4 %	85.4 %	85.2 %
Statin Medication for Cardiovascular Disease	[1]	83.4 %	80.7 %	82.1 %	83.9 %

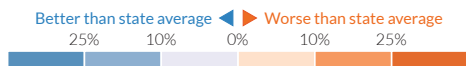


↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Measures by Race and Ethnicity, 2018-2019

American Indian or Alaska Native (AI/AN), Asian, Black, Hawaiian or Pacific Islander (HI/PI), Hispanic and White members

		AI/AN	Asian	Black
		Controller Medication for Asthma	43.0 %	62.0 %
Eye Exam for People with Diabetes		41.9 %	55.5 %	41.0 %
Hemoglobin A1c Testing for People with Diabetes		78.9 %	89.9 %	78.8 %
Nephropathy Screening for People with Diabetes		84.7 %	88.1 %	83.3 %
Statin Medication for Cardiovascular Disease		73.7 %	91.4 %	79.6 %
		HI/PI	Hispanic	White
		Controller Medication for Asthma	[2]	52.6 %
Eye Exam for People with Diabetes	[2]	44.8 %	48.2 %	45.1 %
Hemoglobin A1c Testing for People with Diabetes	[2]	84.5 %	84.4 %	83.3 %
Nephropathy Screening for People with Diabetes	[2]	86.0 %	84.7 %	84.6 %
Statin Medication for Cardiovascular Disease	[1]	89.3 %	86.8 %	83.2 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Domain 8: Emergency Department, Hospital and Institutional Care Use

This domain includes the following measures:

- **Emergency Department (ED) Visit Rate:** Number of ED visits, including visits related to mental health and substance use disorder, per 1,000 member months.
- **Acute Hospital Use Among Adults:** Number of acute inpatient discharges among Medicaid members age 18 or older per 1,000 members during the measurement year.
- **Hospital Readmission Within 30 Days:** Percentage of hospital stays among Medicaid members age 18 and over with unplanned readmission to the hospital within 30 days.
- **Ratio of Home and Community-Based Care Use to Nursing Facility Use:** Months of home and community-based services received by Medicaid members age 18 and over as a percentage of total months of long-term care received.

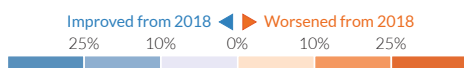
KEY FINDINGS

- For the state as a whole, metrics changed relatively little from 2018 to 2019. The emergency department visit rate and acute hospital use increased slightly.
- People with chronic conditions and people with serious mental illness experienced substantially worse outcomes on ED and hospital use metrics relative to the state average, likely reflecting their need for higher levels of care.
- American Indian/Alaska Native and Black Medicaid members experienced substantially worse outcomes on ED and hospital use metrics relative to the state average.

Statewide Rates, 2018-2019 Change, and US Comparison

Statewide rate in 2019, statewide change from 2018 to 2019, and US average in 2018

		2019 Statewide	2018-2019 Change	2018 US Average
Emergency Department Visit Rate	[8] ↓	50.3	0.6	NA
Acute Hospital Use among Adults	[5] ↓	59.2	0.5	NA
Hospital Readmission within 30 Days	[3] ↓	13.4 %	0.7 %	NA
Ratio of Home and Community-Based Care Use to Nursing Facility Use	[0]	93.3 %	0.6 %	NA



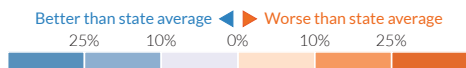
↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Domain 8: Emergency Department, Hospital and Institutional Care Use

Measures by Health Condition and Geographic Area, 2019

Members with chronic illness, members with serious mental illness (SMI), members living in rural areas, and members living in high-poverty areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High Poverty
Emergency Department Visit Rate	[8] ↓	108.7	190.5	48.2	62.0
Acute Hospital Use among Adults	[5] ↓	118.3	221.7	53.6	63.8
Hospital Readmission within 30 Days	[3] ↓	13.8 %	18.2 %	11.1 %	13.8 %
Ratio of Home and Community-Based Care Use to Nursing Facility Use	[0]	93.0 %	92.1 %	93.5 %	93.1 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Measures by Race and Ethnicity, 2018-2019

American Indian or Alaska Native (AI/AN), Asian, Black, Hawaiian or Pacific Islander (HI/PI), Hispanic and White members

		AI/AN	Asian	Black
		Emergency Department Visit Rate	68.8	21.7
Acute Hospital Use among Adults		59.4	29.6	64.6
Hospital Readmission within 30 Days		14.6 %	10.4 %	15.1 %
Ratio of Home and Community-Based Care Use to Nursing Facility Use		90.3 %	95.3 %	93.5 %
		HI/PI	Hispanic	White
		Emergency Department Visit Rate	[8] ↓	41.1
Acute Hospital Use among Adults	[5] ↓	53.3	42.2	67.2
Hospital Readmission within 30 Days	[3] ↓	12.6 %	11.1 %	13.7 %
Ratio of Home and Community-Based Care Use to Nursing Facility Use	[0]	93.5 %	94.1 %	93.2 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Domain 9: Substance Use Disorder Care

This domain includes the following measures:

- **Substance Use Disorder (SUD) Treatment Penetration:** Percentage of Medicaid members age 12 and over with an SUD treatment need who received at least one qualifying SUD treatment.
- **Alcohol or Other Drug (AOD) Treatment (Initiation):** Percentage of Medicaid members age 13 and over with a new episode of AOD dependence who received treatment within 14 days of diagnosis.
- **Alcohol or Other Drug (AOD) Treatment (Engagement):** Percentage of members who initiated treatment and had two or more additional AOD services within 34 days of the initial visit.
- **30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence:** Percentage of emergency department visits among Medicaid members age 13 and over with a diagnosis of alcohol or other drug dependence (AOD) who had a follow-up outpatient visit for AOD within 30 days of ED visit.

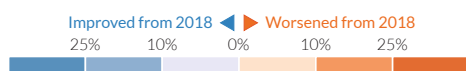
KEY FINDINGS

- For the state as a whole, performance on all metrics improved between 2018 and 2019.
- Outcomes for residents of rural areas and residents of high-poverty areas were generally worse. However, differences between urban and rural areas were slight.
- Quality of substance use treatment measures were lower for Asian, Black, Hawaiian/Pacific Islander, and Hispanic Medicaid members relative to the state average.

Statewide Rates, 2018-2019 Change, and US Comparison

Statewide rate in 2019, statewide change from 2018 to 2019, and US average in 2018

		2019 Statewide	2018-2019 Change	2018 US Average
Substance Use Disorder Treatment Penetration	[3]	37.3 %	2.9 %	NA
Alcohol or Other Drug Treatment: Initiation	[0]	38.8 %	2.0 %	42.8 %
Alcohol or Other Drug Treatment: Treatment	[0]	15.5 %	0.7 %	14.0 %
30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	[3]	30.2 %	5.2 %	19.2 %



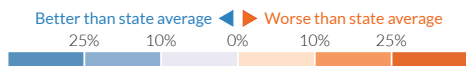
↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Domain 9: Substance Use Disorder Care (continued)

Measures by Health Condition and Geographic Area, 2019

Members with chronic illness, members with serious mental illness (SMI), members living in rural areas, and members living in high-poverty areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High Poverty
Substance Use Disorder Treatment Penetration	[3]	36.1 %	36.1 %	35.2 %	36.7 %
Alcohol or Other Drug Treatment: Initiation	[0]	39.5 %	43.8 %	38.5 %	38.6 %
Alcohol or Other Drug Treatment: Treatment	[0]	14.6 %	13.2 %	15.4 %	15.3 %
30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	[3]	30.5 %	32.8 %	30.6 %	31.8 %



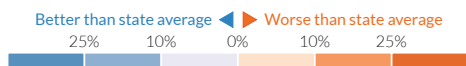
↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Measures by Race and Ethnicity, 2018-2019

American Indian or Alaska Native (AI/AN), Asian, Black, Hawaiian or Pacific Islander (HI/PI), Hispanic and White members

		AI/AN	Asian	Black
		Substance Use Disorder Treatment Penetration	45.1 %	29.1 %
Alcohol or Other Drug Treatment: Initiation		41.8 %	35.1 %	34.3 %
Alcohol or Other Drug Treatment: Treatment		19.2 %	11.6 %	10.7 %
30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence		27.6 %	24.0 %	20.5 %

		HI/PI	Hispanic	White
		Substance Use Disorder Treatment Penetration	[3]	30.2 %
Alcohol or Other Drug Treatment: Initiation	[0]	34.7 %	33.6 %	40.2 %
Alcohol or Other Drug Treatment: Treatment	[0]	12.1 %	13.3 %	16.4 %
30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	[3]	12.1 %	28.8 %	33.2 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Domain 10: Opioid Prescribing and Opioid Use Disorder Treatment

This domain reflects opioid use and opioid use disorder (OUD) treatment for Medicaid members with a treatment need. The domain includes four metrics:

- **People with an Opioid Prescription \geq 50mg MED:** Percentage of Medicaid members prescribed chronic opioid therapy with dosage greater than or equal to 50mg morphine-equivalent dose.
- **People with an Opioid Prescription \geq 90mg MED:** Percentage of Medicaid members prescribed chronic opioid therapy with dosage greater than or equal to 90mg morphine-equivalent dose.
- **People with an Opioid Prescription Who Were Prescribed a Sedative:** Percentage of Medicaid members prescribed chronic opioids who were also prescribed a chronic sedative.
- **Opioid Use Disorder Treatment Penetration:** Percentage of Medicaid members age 18 and over with an opioid use disorder treatment need who received medication-assisted treatment or medication-only treatment for OUD.

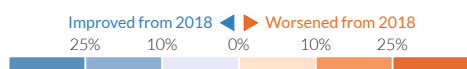
KEY FINDINGS

- Opioid measures moved in a positive direction, with decreases in prescriptions and large increases in treatment for those who needed it.
- Opioid prescriptions were slightly higher among people with chronic conditions and serious mental illness and treatment rates slightly lower.
- High-poverty areas experienced better quality measures, receiving lower rates of prescriptions and marginally higher treatment rates.
- Outcomes on three of four metrics were substantially worse for Black Medicaid enrollees.

Statewide Rates, 2018-2019 Change, and US Comparison

Statewide rate in 2019, statewide change from 2018 to 2019, and US average in 2018

		2019 Statewide	2018-2019 Change	2018 US Average
People with an Opioid Prescription \geq 50mg MED	[1] ↓	31.7 %	-1.3 %	NA
People with an Opioid Prescription \geq 90mg MED	[1] ↓	12.3 %	-1.8 %	NA
People with an Opioid Prescription who were Prescribed a Sedative	[1] ↓	17.3 %	-2.1 %	NA
Opioid Use Disorder Treatment for People with Treatment Need	[3]	58.0 %	7.0 %	NA



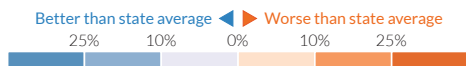
↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Domain 10: Opioid Prescribing and Opioid Use Disorder Treatment (continued)

Measures by Health Condition and Geographic Area, 2019

Members with chronic illness, members with serious mental illness (SMI), members living in rural areas, and members living in high-poverty areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High Poverty
People with an Opioid Prescription >= 50mg MED	[1] ↓	32.3 %	33.5 %	31.5 %	27.8 %
People with an Opioid Prescription >= 90mg MED	[1] ↓	12.3 %	12.7 %	12.5 %	9.5 %
People with an Opioid Prescription who were Prescribed a Sedative	[1] ↓	17.8 %	24.4 %	17.1 %	16.7 %
Opioid Use Disorder Treatment for People with Treatment Need	[3]	56.7 %	51.4 %	57.2 %	58.6 %

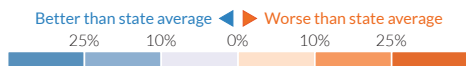


↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Measures by Race and Ethnicity, 2018-2019

American Indian or Alaska Native (AI/AN), Asian, Black, Hawaiian or Pacific Islander (HI/PI), Hispanic and White members

		AI/AN	Asian	Black
		People with an Opioid Prescription >= 50mg MED	28.4 %	23.6 %
People with an Opioid Prescription >= 90mg MED		10.0 %	10.9 %	14.3 %
People with an Opioid Prescription who were Prescribed a Sedative		14.4 %	14.5 %	13.7 %
Opioid Use Disorder Treatment for People with Treatment Need		59.4 %	51.8 %	46.3 %
		HI/PI	Hispanic	White
		People with an Opioid Prescription >= 50mg MED	[1] ↓	25.8 %
People with an Opioid Prescription >= 90mg MED	[1] ↓	13.4 %	7.8 %	12.5 %
People with an Opioid Prescription who were Prescribed a Sedative	[1] ↓	12.4 %	14.8 %	18.1 %
Opioid Use Disorder Treatment for People with Treatment Need	[3]	47.7 %	55.0 %	59.8 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Discussion and Limitations

In this chapter, we evaluated changes in 44 metrics across 10 domains. In general, changes across most metrics were modest. Metrics for substance use and opioid use were exceptions; these moved in the desired direction between 2018 and 2019. Improvements in the behavioral health domain were confined largely to substance use treatment; changes in mental health measures were largely mixed.

The data in this report also point to persistent racial and ethnic disparities, with the most striking differences among Black, American Indian and Alaska Native populations relative to state averages for all Medicaid members. Across 44 measures, Black Medicaid enrollees experienced lower quality in 38 of these measures; American Indian and Native Alaskan Medicaid enrollees experienced lower quality in 31 of these measures. Asian Medicaid enrollees had lower quality for 15 measures, and Hispanic enrollees had lower quality for 12 of the 44 measures.

The results presented here include several limitations. We rely on administrative data, which are limited in their ability to provide a comprehensive assessment of the experience and quality of health care and overall quality of life. The production schedule and availability of measures required us to examine maternal health measures for a different time period (July 2017 to June 2019) than for other domains (January 2018 to December 2019). In addition, while assessing changes between 2018 and 2019, we cannot directly attribute improvements to the MTP, given the wide variety of reforms and changes taking place in the health care system at this time. Similarly, although some measures showed relatively little change, we are unable to say whether those measures may have been worse in the absence of MTP.

Overview of ACH Health Improvement Projects

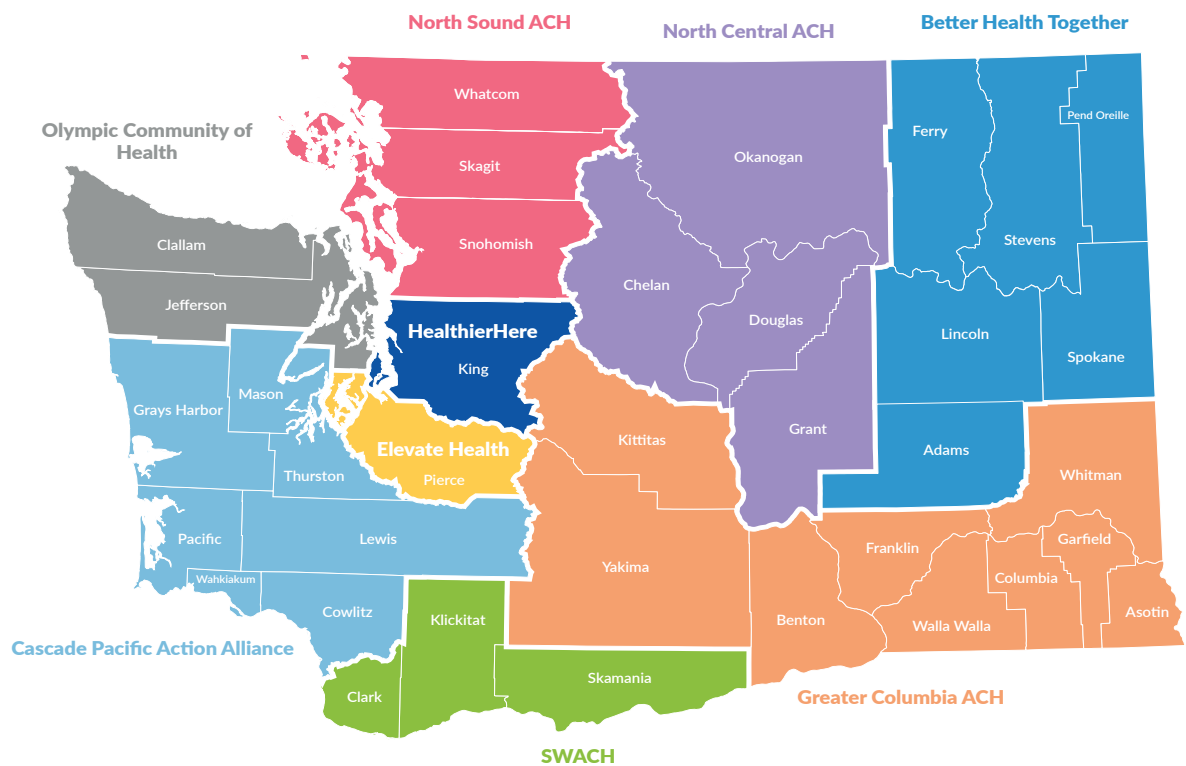
In this chapter, we provide an overview of the eight health improvement projects implemented by ACHs as part of MTP Initiative 1. We describe the MTP approach to system transformation through these projects and present key findings related to how ACHs and their partners interpreted and implemented these steps.

Chapters 3-10 provide in-depth results of our evaluation of each of the eight health improvement projects.

MTP Approach to Change

Under MTP Initiative 1, Washington State created nine regional Accountable Communities of Health to convene local stakeholders, identify collaboration opportunities, and coordinate health transformation efforts within each region (see Exhibit 2.1).

Exhibit 2.1: Washington State's Accountable Communities of Health



ACHs were tasked with pursuing projects in their regions that advanced the statewide goals of MTP in the following three areas:

- **Domain 1: Health Systems and Community Capacity Building**, including promoting the adoption of value-based payments, supporting the development of the health care workforce, and expanding health information technology (HIT) and health information exchange (HIE) infrastructure.
- **Domain 2: Care Delivery Redesign**, including supporting bidirectional integration of behavioral and physical health care; promoting community-based care coordination; improving transitions from intensive or institutional care settings; and implementing emergency department diversion strategies to connect medically underserved groups with primary care and social services.
- **Domain 3: Prevention and Health Promotion**, including supporting interventions to address opioid misuse; ensuring access to reproductive care; increasing access to oral health services, and enhancing health system approaches to chronic disease management.

The MTP Project Toolkit and Health Improvement Projects

Washington State created a Project Toolkit to provide direction and guidance to ACHs in the design and implementation of their activities (Washington State Health Care Authority, 2019c).

The Project Toolkit defined the following **eight health improvement projects**, two of which required participation from all ACHs, and six of which were voluntary:

- **Project 2A: Bi-Directional Integration of Physical and Behavioral Health Through Care Transformation** *[required of all ACHs]*
- **Project 2B: Community-Based Care Coordination**
- **Project 2C: Transitional Care**
- **Project 2D: Diversion Interventions**
- **Project 3A: Addressing the Opioid Use Public Health Crisis** *[required of all ACHs]*
- **Project 3B: Reproductive and Maternal/Child Health**
- **Project 3C: Access to Oral Health Services**
- **Project 3D: Chronic Disease Prevention and Control**

Within each of these project areas, the Project Toolkit outlined a project objective, specific target populations, and approved evidence-based approaches from which the ACH could select.

The Project Toolkit specified **three stages** for all projects. Each project followed the same timeline, with specific milestones for each project during that stage:

- **2017 and 2018 were planning years**, typically involving completion of an assessment, selection of specific evidence-based approaches from the toolkit, identification of partner organizations, and completion of an implementation plan.
- **2019 was an implementation year**, involving the development of new infrastructure, policies and procedures, the engagement and training of partners, and development of plans for continuous quality improvement.

- **2020 and 2021 are “scale and sustain” years**, involving expansion of piloted models, provision of ongoing support and quality improvement activities with partners, and planning for financial sustainability of interventions beyond the demonstration period.

ACHs were required to meet specific reporting and performance milestones at each phase in order to earn incentive payments in a given project area. The level of incentive payments varied across project areas (Washington State Health Care Authority, 2020).

Progress Toward MTP Health Improvement Projects

The Project Toolkit required ACHs to carry out at least two health improvement projects from Domain 2 (Care Delivery Redesign) and two projects from Domain 3 (Prevention and Health Promotion) using evidence-based approaches from HCA's Project Toolkit. At the outset of MTP, ACHs completed regional health needs inventories to guide their project selection processes and selected between four and eight projects. Exhibit 2.2 presents the projects selected by each ACH.

Exhibit 2.2: Projects Selected by ACHs

Accountable Community of Health	Health Improvement Projects							
	Project 2A: Bi-Directional Integration of Physical and Behavioral Health Care (Required)	Project 2B: Community-Based Care Coordination	Project 2C: Transitional Care	Project 2D: Diversion Interventions	Project 3A: Addressing the Opioid Use Public Health Crisis (Required)	Project 3B: Reproductive and Maternal or Child Health	Project 3C: Access to Oral Health Services	Project 3D: Chronic Disease Prevention and Control
Better Health Together	X	X			X			X
Cascade Pacific Action Alliance	X	X	X		X	X		X
Elevate Health	X	X			X			X
Greater Columbia ACH	X		X		X			X
HealthierHere	X		X		X			X
North Central ACH	X	X	X	X	X			X
North Sound ACH	X	X	X	X	X	X	X	X
Olympic Community of Health	X			X	X	X	X	X
SWACH	X	X			X			X

Key informant interviews and reviews of ACH documents during this period suggest that ACHs utilized findings from their community health needs assessments and held forums and workgroups with community partners to elicit priority areas. ACH leaders and board members also considered project feasibility (e.g., required infrastructure costs and the extent to which there was community energy and effort already underway) in their selection.

In late 2017 during ACH planning and prioritization of projects, HCA announced that funding available for MTP Initiative 1 (including ACH Health Improvement Projects) in that year would be lower than previously stated due to unforeseen budget shortfalls. Some ACHs decided to reduce their selected projects and looked for ways that community interests and priorities could still be addressed with fewer projects.

ACHs also considered performance incentive metrics and how they aligned across the eight project areas. However, as these quotes from our interviews illustrate, not all ACHs understood how to calculate and plan for greater incentive payments:

The state provided this menu of eight projects. There was back-and-forth for a while, and nobody knew: was there more financial benefit for the community if we chose all eight? If we chose six? If we chose four? What are the implications if we chose more? What about the capacity of the organization? [There was] a lot of shifting, uncertainty of calculation. (ACH 5, Participant 15)

Other ACHs that took six or eight [projects] get more money than us. That's why I'm bummed that we did [our project selection] that way. [...] We played it safe, and then we played it too safe. [...] I think it's a miss on our part. (ACH 1, Participant 19)

Some ACHs indicated that their initial concerns about overcommitting to too many projects were later replaced by regrets that they had not formally selected more projects. These ACHs ultimately committed resources and supported efforts in areas that were not part of their formal project selection. One ACH noted that project selection within MTP had served primarily to prioritize project areas that would otherwise not receive local attention. As a result, the ACH did not formally select the oral health initiative. Nonetheless, the ACH participated meaningfully in local oral health initiatives that occurred outside the scope of MTP.

ACH Identification of Target Populations

ACHs were required by HCA to identify target populations in each of their chosen project areas. Some ACHs determined target populations for their health improvement projects at the regional level. Other ACHs allowed partner organizations to define target populations as part of their contract negotiations with the ACH. Variation in the approach to defining their target populations meant that within a specific project area, there were often meaningful differences in the relative sizes of the populations of people intended to benefit from projects across participating ACH regions.

Partner Outreach and Contracting

Following project selection, ACHs executed contracts with a variety of organizations to carry out work on health improvement projects. These partners included health care providers, community-based providers of social, educational, and employment services, local government entities, and Tribal nations. Exhibit 2.3 presents examples of ACH collaborations.

ACHs employed a Request for Proposal (RFP) process to identify and select contracted partners. Community partners that participated in an ACH's project prioritization and planning efforts were invited to apply during the RFP stage. Other partner outreach efforts included ACHs hosting information sessions for interested partners and attending community stakeholder coalitions and meetings. ACHs that covered larger geographic regions also leveraged more localized county groups to engage partners.

Exhibit 2.3: Examples of ACH Collaborations

Collaboration Type	Example
HEALTH CARE PROVIDERS	<ul style="list-style-type: none"> • Behavioral health care provider • Hospital • Primary care provider • Residential substance use disorder treatment provider
COMMUNITY-BASED SOCIAL, EDUCATIONAL, AND EMPLOYMENT SERVICES PROVIDERS	<ul style="list-style-type: none"> • 211 network (referral to social services) • The Arc • Assisted living facility • Catholic Charities • Church • Homelessness services provider • YWCA
LOCAL GOVERNMENT ENTITIES	<ul style="list-style-type: none"> • Area Agency on Aging • City fire department • City housing authority • County health department • County human services department • County sheriff • Educational service district • Emergency medical services
TRIBAL NATIONS	<ul style="list-style-type: none"> • Confederated Tribes of the Colville Reservation • Cowlitz Indian Tribe • Port Gamble Sklallam Tribe • Quinault Indian Nation • Tulalip Tribes of Washington

Source: ACH partnering provider rosters submitted to Washington State Health Care Authority.

ACHs considered partner readiness and the number of Medicaid beneficiaries served when prioritizing contracted partners. Some chose to contract with clinical partners before other types of partners, such as education or social service providers, since many of the incentive measures were perceived to be more easily influenced through clinical interventions. These ACHs developed contracts with community-based organizations at a later date. ACH contract terms varied in length, with some spanning multiple years and others requiring partners to update their contracts annually.

Planning and Launching Interventions

ACHs were directed by HCA to require partnering providers to complete a change plan (a reporting tool that described how projects would be implemented and monitored). Change plans specified

the activities, milestones, and outcomes associated with projects, allowing ACHs and their partners to monitor progress. ACHs also conducted regular site visits with contracted partners to observe project progress and identify partner training and support needs.

The uniformity of requirements across projects varied among ACHs. ACHs typically did not approach partners on a project-by-project basis. While the Project Toolkit presented eight distinct projects, ACHs reported that community partners did not conceptualize care and service delivery this way. For example, a community partner could implement a shared care plan that not only supported Project 2A (Bidirectional Integration of Physical and Behavioral Health Care), but also could support projects related to care coordination, transitional care, diversion interventions, and chronic disease prevention and control.

ACHs varied in the level of direction they gave partners regarding the design of interventions in a given project area. While some ACHs prioritized a specific intervention that they sought to spread across their region, other ACHs gave partners flexibility to develop their own interventions or select from a list of options. For example, one ACH elicited community partner input and then chose the Collaborative Care model intervention from the list of bidirectional integration strategies in the MTP toolkit. This ACH then provided technical assistance and resources to contracted partners to support adoption and implementation of the model.

Another ACH shared all of the potential Project Toolkit strategies for a given project area with its partners, letting partners choose which strategies to adopt and whether to tailor or modify the strategies. This was motivated by a recognition that differences in partners' size or scope meant there was no suitable one-size-fits-all strategy for their region:

We're more interested in them working on their own aims and milestones and then tracking those. With the variance in our region and with the volume [differences] we're trying to meet providers where they're at. (ACH 3, Participant #126)

COVID-19 Disruptions

The COVID-19 pandemic outbreak that began in Washington in January 2020 caused widespread disruptions to the state's health care delivery system. These disruptions occurred during a key point in the MTP demonstration, as 2020 marked the year when 50% of ACHs' Health Improvement Project incentive payments were slated to be determined by their achievement of project-related performance measures.

Due to these disruptions, the Washington Health Care Authority made changes to ACHs' incentive payments in July 2020 to offer greater flexibility in meeting performance targets during the pandemic. The state received approval from CMS to calculate ACHs' performance three ways, using whichever approach resulted in the highest achievement for the ACH in 2020 relative to the baseline year of 2018:

- 1 ACH performance in calendar year 2019
- 2 Statewide average in calendar year 2019
- 3 ACH performance in calendar year 2020

These changes occurred as this report was being developed. It is unclear whether or how these shifts in performance incentive design may have affected ACHs project-related efforts in 2020. This report's focus is on changes and outcomes that occurred in 2019, prior to the onset of COVID-19. Future evaluation reports will include information regarding changes ACHs made in their health improvement project activities due to COVID-19 and the related changes in performance requirements.

Evaluating the MTP Health Improvement Projects

In Chapters 3-10, we present interim evaluation results for each of the eight health improvement projects. Here, we describe our approach to evaluating each project through December 2019. We consider 2019 as the first implementation year because it is defined as the first year of implementation in the Project Toolkit and represents the first year that ACHs began contracting with partnering providers for HIP implementation activities.

To evaluate the impact of the eight health improvement projects on health care utilization and outcomes, we examined relevant health measures in regions that participated in a project. We used **two analytic approaches** to reflect different levels of project adoption across regions:

- **Pre-post.** Three projects (2A, 3A, and 3D) were implemented by all nine ACHs. In the absence of a suitable comparison group, we compared outcomes in the periods leading up to the intervention year (2017 and 2018) to outcomes in the first intervention year (2019).
- **Difference-in-differences.** Five projects were implemented by some, but not all ACHs. In these cases, we conducted a difference-in-differences analysis. In this approach, we measured the change in outcomes among participating ACHs between 2017-2018 and 2019 and subtracted the change in outcomes among non-participating ACHs. This approach was designed to isolate the change that could be attributed to a project from other statewide changes that may have affected project-related performance in both participating and non-participating ACHs.

In both cases, we combined these analyses with key informant interviews and document review to identify relevant contextual factors and guide the interpretation of results.

The analyses presented here are intended to provide a broad assessment of the effect of ACH participation in each HIP. The approaches undertaken by individual ACHs varied within HIPs. We did not evaluate the merits of specific evidence-based practices or approaches that ACHs may have undertaken. Rather than measuring the success of specific tools or practices ACHs employed, our analyses should be seen as an assessment of the overall effects of population health projects focused on broad themes, including, for example, behavioral health, maternal health, or oral health improvement.

Analysis of Target Populations by Project

To evaluate the impact of health improvement projects across ACH regions, we first identified target populations that were intended beneficiaries of these projects. When defining target populations, we identified two common populations across each health improvement project. We analyzed both populations by ACH region across each HIP.

This strategy was based, in part, on the fact that it was not possible to systematically identify all Medicaid enrollees who received interventions or were cared for by participating partners in an ACH region. Our approach was population-based and reflected an attempt to identify, through health care

claims data, enrollees who could have benefited from each HIP. In some cases, our target populations were likely to be an imprecise indicator of the groups who were the focus of ACHs efforts. However, our use of a common population allowed for an assessment of changes across ACHs, providing an indication of the extent to which ACH participation in a HIP may have impacted population health.

We identified target populations based on a review of the toolkits for each HIP, input from ACHs, and the data available to the study team. In some cases such as Project 2A (Bi-Directional Integration of Physical and Behavioral Health Care) there was general uniformity in the populations that ACHs targeted, with most focusing on people with behavioral health conditions or a combination of behavioral health conditions and chronic physical health conditions. In other cases such as Project 2B (Community-Based Care Coordination) there was considerable heterogeneity in target populations across ACHs. Furthermore, some ACHs identified more than one target population within a single HIP, reflecting the overlapping nature of the evidence-based models defined in the Project Toolkit.

We defined two target populations: a “broad” population and a “narrow” population (see Exhibit 2.4). The broad population was typically larger (e.g., any individual with a behavioral health condition for Project 2A or people with selected chronic conditions for Project 3D) whereas the narrow population was typically relatively smaller and more focused (e.g., people with behavioral health conditions and chronic physical conditions for Project 2A, or people with type 2 diabetes for Project 3D), although this framework applies more loosely to some projects (for example, Project 2C).

Exhibit 2.4: Target Populations for the Evaluation of Health Improvement Projects

Project	Target Population 1 (Broad)	Target Population 2 (Narrow)	Type of Analysis
Project 2A Bi-Directional Integration of Physical and Behavioral Health Care	People with any behavioral health condition	Behavioral health and physical health comorbidity	Pre-post
2B: Community-Based Care Coordination	People with behavioral health and physical health comorbidity	High-risk pregnant women	Difference-in-Difference
Project 2C: Transitional Care	People discharged from hospital and any chronic condition	People experiencing homelessness	Difference-in-Difference
Project 2D: Diversion Interventions	People with 3 or more ED visits in year prior to intervention	People with 5 or more ED visits in year prior to intervention	Difference-in-Difference
Project 3A: Addressing the Opioid Use Public Health Crisis	Adults 19-64 (for preventive measures only)	People diagnosed with opioid use disorder	Pre-post
Project 3B: Reproductive and Maternal/Child Health	Women of reproductive age	Pregnant women	Difference-in-Difference
Project 3C: Access to Oral Health Services	All beneficiaries	Pregnant women	Difference-in-Difference
Project 3D: Chronic Disease Prevention and Control	People with diabetes, asthma, COPD, cardiovascular conditions	People diagnosed with type 2 diabetes	Pre-post

Outcomes of Interest

We selected specific measures for each HIP analysis from the larger list of measures for MTP Initiative 1 (see Chapter 1). We selected outcome measures including health care access and utilization that were relevant and aligned with the intent of each project area.

In the final report, we will also analyze additional measures, including changes in spending (see Exhibit 2.5).

Exhibit 2.5: Additional Evaluation Measures Planned in the Final Evaluation Report

Metric Name
Opioid Related Deaths per 100,000 Covered Lives
Timeliness of Prenatal Care
Spending: Primary Care Spending Per Member, Per Month
Spending: Other Outpatient Spending Per Member, Per Month
Spending: Inpatient Spending Per Member, Per Month
Spending: Long-Term Services and Supports (LTSS) Spending Per Member, Per Month
Spending: Pharmacy Spending Per Member, Per Month
Spending: Behavioral Health Care Spending Per Member, Per Month
Spending: Non-Behavioral Health Care Spending Per Member, Per Month
Spending: Substance Use Disorder Spending Per Member, Per Month
Total Spending Per Member, Per Month (excluding pharmacy)
Total Spending Per Member, Per Month

The [following chapters](#) of this report present our analysis of each of the eight health improvement projects, along with contextual information gathered from key informant interviews and document review:

- **Chapter 3** presents results of Health Improvement Project 2A (see p. 54)
- **Chapter 4** presents results of Health Improvement Project 2B (see p. 64)
- **Chapter 5** presents results of Health Improvement Project 2C (see p. 74)
- **Chapter 6** presents results of Health Improvement Project 2D (see p. 83)
- **Chapter 7** presents results of Health Improvement Project 3A (see p. 90)
- **Chapter 8** presents results of Health Improvement Project 3B (see p. 98)
- **Chapter 9** presents results of Health Improvement Project 3C (see p. 106)
- **Chapter 10** presents results of Health Improvement Project 3D (see p. 113)

Health Improvement Project 2A

This chapter presents results of the interim evaluation of MTP Initiative 1 Health Improvement Project 2A, “Bi-Directional Integration of Primary Care and Behavioral Health Services.”

We first provide background and an overview of how the MTP approach was intended to transform care in this area. We present a description of this project’s implementation through 2019, including observations from key informant interviews and reviews of program documents collected during this period. We then present results of an analysis of health care claims to compare whether and how health outcomes changed for key populations under this initiative.

Background

Integrated care models are intended to remove barriers to care, reduce the complexity of navigating health systems, and provide support and alignment for providers of different specialties. One model for integrating primary and behavioral health care, the Collaborative Care Model, has been shown through extensive research (including more than 80 randomized trials) to be associated with improvements in the overall quality of care and patient outcomes (Unutzer, et al., 2002; Gilbody, et al., 2006; Hunkeler, et al., 2006; O’Connor, et al., 2009; Archer, et al., 2012; Thota, et al., 2012; Woltmann, et al., 2012; Siu, et al., 2016; Miller, et al., 2013). Models that focus on the integration of physical health care into the mental health care setting (sometimes referred to as “reverse integration”) have demonstrated similar findings (Druss, et al., 2001; Druss, et al., 2010; Druss, et al., 2016).

Improvements from integrated care models include, but are not limited to, reductions in depressive symptoms, greater remission and recovery, reductions in suicidal ideation, and improvements in overall quality of life. Integrated care has also been described as occurring across a spectrum with **six levels of integration**:

- 1 Minimal collaboration:** patients referred to provider at another site; minimal communication;
- 2 Basic collaboration from a distance:** providers at separate sites periodically communicate;
- 3 Basic collaboration onsite:** providers share the same facility but maintain separate treatment plans for patients;
- 4 Close collaboration onsite:** providers share records and some system integration;
- 5 Close collaboration approaching an integrated practice:** providers share space and actively seek systems solutions together; and
- 6 Full integration:** providers develop and implement treatment plans in a seamless biopsychosocial web (SAMHSA-HRSA Center for Integrated Health Solutions, 2020).

MTP Approach to Change

The Project Toolkit presents ACHs with **three options**: two approaches for integrating behavioral health care into primary care and one approach for integrating primary care into behavioral health:

- 1** The **Collaborative Care Model** was developed at the University of Washington approximately 20 years ago. This team-based model includes a behavioral health care manager and a psychiatric consultant to support primary care. The model can be either practice-based or telehealth-based, so it can be used in rural and urban areas. The model has been extended to treat a wide range of behavioral health conditions, including depression, substance use disorders, bipolar disorder, PTSD, and other conditions. It includes five principles: patient-centered team care; population-based care; measurement-based treatment to target; evidence-based care; and accountable care.
- 2** ACHs may choose to support the **Bree Collaborative**, established by Washington's legislature, to identify ways to improve health care in the state. This integrated behavioral health care standard includes eight common elements: an integrated care team; patient access to behavioral health as a routine part of care; accessibility and sharing of patient information; patient access to psychiatric services; operational systems and workflows to support population-based care; evidence-based treatments; patient involvement in care; and the use of data for quality improvement.
- 3** A **Milbank Report** (Collins, et al., 2010) provides guidance for ACHs to support work to integrate primary care into behavioral health settings. For example, the Milbank report promotes the use of care managers to facilitate collaboration across settings and to use registries to track and monitor physical health outcomes (which may be overlooked in mental health settings). Integrating primary care into mental health centers should include screening for chronic diseases and conditions, such as obesity, diabetes, heart disease, and others, as well as regular review of patients who are not improving.

ACHs Participating in Project 2A

Within MTP Initiative 1, Project 2A ("Bi-Directional Integration of Physical and Behavioral Health Care") is a mandatory project for all ACHs. ACHs must implement a project that includes at least one approach to integrating behavioral health into primary care settings and at least one approach from integrating primary care into the behavioral health setting (SAMHSA-HRSA Center for Integrated Health Solutions, 2020).

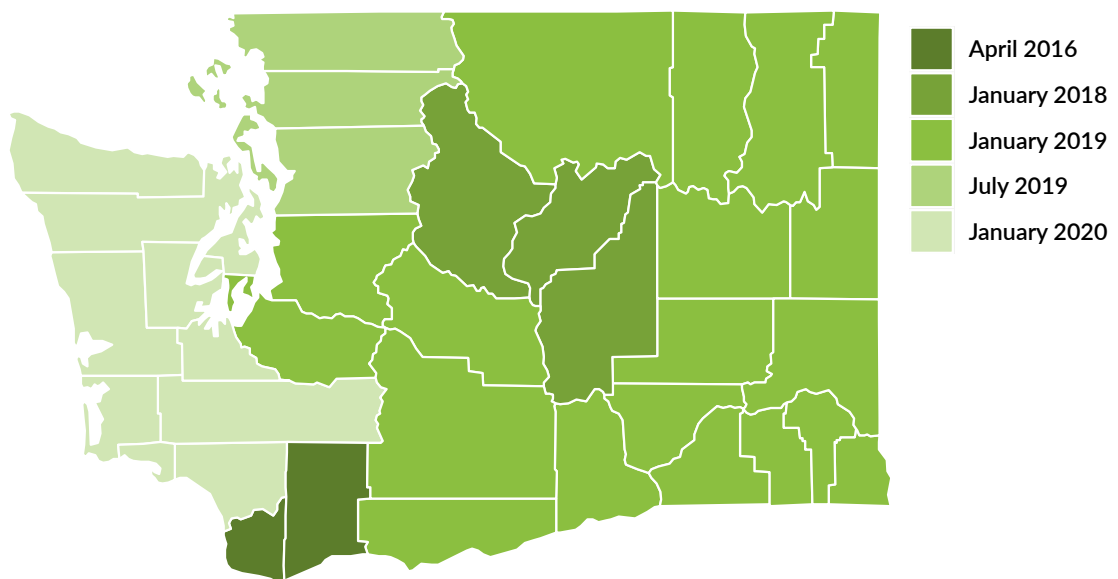
ACHs were required to compile a partnering provider list, assess the level of integrated care model adoption among those partners, identify a target population, and facilitate health systems capacity building by embedding value-based payment, workforce development, and population health management strategies into its 2A projects.

Project 2A Implementation

Key informant interviews and reviews of program documents through 2020 indicate that integration of primary care and behavioral health services was occurring at the financial and administrative level as well as within clinics.

Washington's requirement for MCOs to financially integrate physical and behavioral health services (integrated managed care, or IMC, described in Chapter 1) provides important context for understanding ACH progress on Project 2A. While ACHs were required to help partners integrate services in the delivery system through Project 2A, Washington's five MCOs were also required to financially integrate ("carve in") behavioral health services. The IMC transition occurred in five waves, shown in Exhibit 3.1 below.

Exhibit 3.1: Implementation of Integrated Managed Care, by Region and Date



The IMC transitions corresponded roughly, but not perfectly, to ACH regions. For example, in the Southwest Washington Accountable Community of Health (SWACH) region, two counties (Clark and Skamania) moved to IMC in 2016, but Klickitat County (also in SWACH) transitioned in 2019. Regions that transitioned in waves 1-4 received financial incentives to encourage earlier IMC adoption. ACHs in wave 5 had the additional responsibility of ensuring that county commissioners, Tribal governments, managed care organizations, clinical and behavioral health provider organizations, and other critical partners convened to support the regional transition to integrated managed care.

Integration of Care Delivery

ACHs interpreted Project 2A guidance from the Project Toolkit in various ways, with some adopting narrow goals for clinical quality improvement and others embarking on approaches that combined 2A efforts with other project areas.

Key informant interviews and publicly available documents indicated that **ACHs implemented the following strategies** to support partners with bidirectional integration in 2019:

- Provided direct or contracted support and guidance on adopting the Collaborative Care Model;
- Facilitated peer learning opportunities for partner organizations to share best practices with others;
- Provided direct or contracted support and guidance on implementing new care processes such as routinized screening (e.g., depression screening in clinical settings, blood pressure screening in behavioral health settings);
- Provided funding for population health management tools that support integrated care (e.g., patient caseload tracker used by care managers in collaborative care);
- Provided contracted support to behavioral health agencies to learn to effectively use their electronic health records (EHRs) for information sharing, reporting, and billing;
- Wave 5 ACHs convened partners and helped facilitate the transition to integrated managed care by convening provider readiness workgroups and participating in early warning systems to track, manage, and monitor potential issues.

By December 2019, the period through which we report interim evaluation results, MTP required ACHs to have engaged partnering providers in contractual agreements to implement new activities related to Project 2A. Our evaluation revealed key factors that facilitated and impeded progress in this area.

Factors That Facilitated Project 2A Implementation

Two factors may have facilitated Project 2A implementation.

- **2A was a mandatory project and a priority for ACHs and their contracted partners.** The majority of partners that ACHs contracted with participated in Project 2A. ACHs provided partners with tools, resources, and coaching and technical assistance services to implement their 2A projects.
- **A number of initiatives coincided with MTP** (e.g., encouragement from other payers; patient centered medical home requirements) that also garnered partner attention and spurred motivation to adopt bidirectional integrated care strategies. Many clinical partners across the state had implemented some form of bidirectional integration prior to MTP. For example, over 150 practices participated in the Healthier Washington Practice Transformation Hub. This initiative provided Washington practices with the training, coaching, technical assistance, and tools for integrating physical and behavioral health services and improving population health. These efforts may have supported readiness among participating partners to implement their 2A projects.

Factors that Impeded Project 2A Implementation

Three factors possibly hindered the implementation of Project 2A.

- **Bidirectional integrated care required hiring new workers**, and some regions experienced hiring challenges. ACH regions, especially those that serve rural areas, reported that their partners struggled to recruit psychiatrists, licensed clinical social workers, and other behavioral health specialists.

- **Behavioral health agencies experienced a unique set of challenges when beginning bidirectional integration.** These challenges included allocating physical space and exam rooms for clinical care and the costs associated with purchasing clinical equipment. Behavioral health organizations often had less experience with activities necessary for integration, including practice transformation, reporting on clinical quality measures, conducting population health management activities, and adapting their EHRs to assist in monitoring and recording physical health measures.
- **ACH regions in waves four and five of IMC were simultaneously transitioning to IMC in 2019.** Behavioral health partners were in the midst of negotiating new contracts with MCOs, acquiring technical infrastructure, including new EHR systems and reporting systems to meet MCO reporting and billing regulations, and responding to MCOs' new licensure, credentialing, and billing requirements. While most Medicaid beneficiaries remained with the same health plan, some required additional support from partner organizations during this time to change their health plans for care continuity.

Evaluation Approach

Project 2A was a requirement for all ACHs. In the absence of a strong comparison group, we assessed changes among enrollees in all ACH regions from a pre-intervention period of calendar year 2017 and 2018 to a post-intervention period of 2019.

Our regressions adjusted for regional differences in Medicaid enrollees' age, gender, race/ethnicity, urban vs. rural residence, and CDPS risk. See Appendix B for methodological details.

Target Populations

Our analysis focused on **two populations** that were described by ACHs as intended beneficiaries of this project area:

- 1 People with any behavioral health condition (including mental health or substance use disorders),
- 2 People with behavioral health conditions and comorbid physical health chronic conditions.

Our focus on people with any behavioral health condition reflected the approaches taken by a variety of ACHs and the potential for integrating physical and behavioral health care to improve access to both behavioral and physical health services.

Our selection of people with comorbid behavioral and physical health conditions as a second target population reflects the potential for this group to benefit from Project 2A, as integration may provide a single site of care for overall health needs.

We defined behavioral health conditions by the psychiatric and substance use indicators in the CDPS risk adjusters. We defined chronic conditions broadly, using markers from the CMS Chronic Conditions Data Warehouse (Centers for Medicare and Medicaid Services, 2020a). Chronic conditions included acquired hypothyroidism; acute myocardial infarction; Alzheimer's disease; anemia; asthma; atrial fibrillation; benign prostatic hyperplasia; cataracts; chronic kidney disease; chronic obstructive pulmonary disease; diabetes; glaucoma; heart failure; hip or pelvic fracture; hyperlipidemia; hypertension; ischemic heart disease; osteoporosis; rheumatoid arthritis; stroke; and a variety of cancers (breast, colorectal, prostate, lung, and endometrial).

Interim Evaluation Results

Results of our evaluation of Project 2A are presented below and reflect changes from a baseline period (2017 and 2018) to the first year of implementation (2019). We first present outcomes for our broadly defined target population for this project area: people with any behavioral health condition. We then present outcomes for our narrowly defined target population, people with comorbid behavioral and physical health conditions.

How are these results impacted by COVID-19?

The COVID-19 outbreak began in Washington State in early 2020, causing widespread disruption to health services delivery across the state. This report presents data through December 2019, prior to the outbreak. It is therefore unlikely that COVID-19 had any effect on measures presented in this report, though future reporting periods may be affected.

Analysis 1: People with Any Behavioral Health Condition

Exhibit 3.2 displays changes for each metric across the state for people with any behavioral health condition. *See page 21 of this report for a guide to reading results.*

A variety of quality measures trended in the desired direction over our period of observation. There were substantial improvements (more than four percent) in measures of follow-up after an emergency department visit for alcohol and drug disorders. We also observed notable changes (two percent or more) in treatment penetration for substance use disorder and antidepressant medication management. Modest but significant improvements occurred in initiation and engagement of alcohol and substance use treatment and some diabetes quality measures, including hemoglobin A1c testing and eye exams. Hospital utilization and emergency department visits also decreased significantly in this population.

We observed decreases in the percentage of people who were employed (3.8 percent) and reductions in Follow-Up After Hospitalization for Mental Health Conditions and Follow-Up After Hospitalization or Emergency Department Visits for Mental Health Conditions.

The improvements in follow-up after hospitalizations and emergency department visits for alcohol and drug disorders, coupled with reductions in follow-up after hospitalizations and emergency department visits for mental health conditions, suggest that hospital systems may have developed systems for managing substance use disorders – reflecting, perhaps, a response to the opioid epidemic – but that these changes have not extended to care for patients with mental health conditions. To the extent that improvements have occurred for people with mental health conditions, they appear to be restricted to the arena of the primary care clinic.

Exhibit 3.2: Change in Outcomes for People with Any Behavioral Health Condition

All-ACH rate in 2017-18, all-ACH rate in 2019, and adjusted pre-post change

	2017-18 All ACHs	2019 All ACHs	Pre-Post Adjusted Change
Homelessness ↓	7.6	8.1	0.4***
Employment (Age 18 to 64)	45.0	41.1	-3.8***
Arrest Rate (Age 18 to 64) ↓	10.5	10.4	-0.1
Children and Adolescents' Access to Primary Care	97.6	97.7	0.1*
Adults' Access to Primary Care	88.4	88.0	0.0
Chlamydia Screening for Women	53.8	53.4	-0.2
Cervical Cancer Screening	52.6	52.2	-0.1
Breast Cancer Screening	52.3	52.2	0.0
Colorectal Cancer Screening	46.7	46.5	0.0
Mental Health Treatment Penetration	62.8	62.3	0.0
Antidepressant Medication for Adults (12 Weeks)	50.9	53.4	2.7***
Antidepressant Medication for Adults (6 Months)	35.4	38.0	2.8***
Antipsychotic Medication for People with Schizophrenia	64.6	63.0	-1.0
Diabetes Screening for People with Schizophrenia/Bipolar Disorder	79.5	79.9	0.1
7-Day Follow-Up After ED Visit for Mental Illness	64.1	55.6	-8.5***
30-Day Follow-Up After ED Visit for Mental Illness	74.5	67.8	-6.8***
7-Day Follow-Up After Hospitalization for Mental Illness	59.5	48.6	-10.6***
30-Day Follow-Up After Hospitalization for Mental Illness	75.4	68.7	-6.8***
30-Day Hospital Readmission for a Psychiatric Condition ↓	6.3	7.1	1.0
Controller Medication for Asthma	50.2	50.9	1.2
Eye Exam for People with Diabetes	44.6	45.3	0.8*
Hemoglobin A1c Testing for People with Diabetes	81.4	82.2	1.1***
Nephropathy Screening for People with Diabetes	85.5	85.3	-0.1
Emergency Department Visit Rate ↓	91.7	90.0	-1.3**
Acute Hospital Use among Adults ↓	104.0	100.8	-2.9**
Hospital Readmission within 30 Days ↓	6.5	6.8	0.1
Ratio of Home and Community-Based Care Use to Nursing Facility Use	92.1	93.1	1.1***
Substance Use Disorder Treatment Penetration	36.9	39.8	2.7***
Alcohol or Other Drug Treatment: Initiation	37.2	39.2	1.9***
Alcohol or Other Drug Treatment: Treatment	15.1	15.8	0.7***
30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	24.6	29.8	5.0***
7-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	15.3	19.9	4.6***

Shaded cells indicate a statistically significant change from 2018 to 2019. Blue-shaded cells indicate an improvement. Orange-shaded cells indicate declining performance. Results marked * are significant at the p<.05 level. Results marked ** are significant at the p<.01 level. Results marked *** are significant at the p<.001 level.

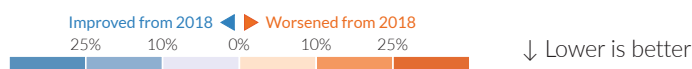


Table 4 in the Data Appendix displays the change in outcomes across all nine ACHs for people with any behavioral health condition. Generally, trends across ACHs followed the statewide trends, with some variations. For example, people in the Greater Columbia ACH experienced improvements across a range of areas, including significant decreases in Hospital and Emergency Department Use and a number of measures related to substance use treatment. In contrast, we did not observe significant improvements in any measures in SWACH. There was some variability in Mental Health Treatment Penetration, with increases in this measure in the Better Health Together and Elevate Health ACHs, and decreases in Cascade Pacific Action Alliance and HealthierHere.

It is important to note that some variation across ACH regions in measures of follow-up after emergency department visits may be driven by underlying differences in ED utilization patterns across these regions, rather than changes in follow-up service. These measures calculate the percentage of ED visits that are followed by a visit with an ambulatory (non-ED) health care provider. These measures might thus be lower in regions with higher ED utilization simply because of the higher number of ED visits in these areas. As we assess smaller populations (e.g., subgroups with comorbid conditions, or ACH-specific analyses), these measures may be subject to large changes in magnitude that are an artifact of the small sample size.

Analysis 2: People with Comorbid Conditions

Exhibit 3.3 displays statewide changes for each metric for people with comorbid behavioral health and chronic physical health conditions. In many cases, the patterns observed for the first target population (people with a behavioral health condition) apply to this group as well. For example, measures of follow-up after emergency department visits for alcohol or drug disorders improved, while measures of follow-up after hospitalization or emergency department visit for mental health conditions worsened. This population of people with comorbid physical and mental health conditions also experienced improvements in a variety of quality measures, including cervical cancer screening, colorectal cancer screening, measures of diabetes care quality, and antidepressant medication management.

Table 4 in the Data Appendix displays the change in outcomes across all nine ACHs for people with comorbid behavioral health and chronic physical health conditions. Hospital use in this population declined significantly in the HealthierHere ACH. Other measures tended to follow statewide trends. Mental health treatment penetration and substance use treatment penetration were slightly higher in Better Health Together and Elevate Health. As noted above, some variation across regions in measures of follow up after emergency department visits may be driven by underlying variation in ED utilization patterns (i.e., more acutely ill members) across these regions rather than differences in follow-up efforts.

Exhibit 3.3: Change in Outcomes for People with Comorbid Behavioral and Physical Chronic Conditions

All-ACH rate in 2017-18, all-ACH rate in 2019, and adjusted pre-post change

	2017-18 All ACHs	2019 All ACHs	Pre-Post Adjusted Change
Homelessness ↓	9.2	9.3	0.3**
Employment (Age 18 to 64)	37.2	31.3	-4.6***
Arrest Rate (Age 18 to 64) ↓	10.8	9.9	-0.6***
Children and Adolescents' Access to Primary Care	99.1	99.2	0.1
Adults' Access to Primary Care	93.0	93.2	0.1
Chlamydia Screening for Women	53.8	52.2	-0.4
Cervical Cancer Screening	53.4	53.8	1.1***
Breast Cancer Screening	54.0	54.6	0.4
Colorectal Cancer Screening	50.8	52.5	1.2**
Mental Health Treatment Penetration	58.6	57.7	0.2
Antidepressant Medication for Adults (12 Weeks)	50.5	52.4	1.5**
Antidepressant Medication for Adults (6 Months)	35.7	38.2	2.1***
Antipsychotic Medication for People with Schizophrenia	63.8	64.5	0.3
Diabetes Screening for People with Schizophrenia/Bipolar Disorder	85.9	87.0	0.4
7-Day Follow-Up After ED Visit for Mental Illness	63.9	56.4	-8.0***
30-Day Follow-Up After ED Visit for Mental Illness	74.2	68.6	-6.4***
7-Day Follow-Up After Hospitalization for Mental Illness	58.7	47.5	-10.2***
30-Day Follow-Up After Hospitalization for Mental Illness	75.2	68.6	-6.6***
30-Day Hospital Readmission for a Psychiatric Condition ↓	7.2	8.6	1.3
Controller Medication for Asthma	49.6	50.4	1.6
Eye Exam for People with Diabetes	45.3	47.1	1.2**
Hemoglobin A1c Testing for People with Diabetes	81.1	82.4	1.2***
Nephropathy Screening for People with Diabetes	86.0	86.3	-0.1
Emergency Department Visit Rate ↓	149.2	148.5	0.5
Acute Hospital Use among Adults ↓	174.9	173.0	-6.2**
Hospital Readmission within 30 Days ↓	7.4	8.2	0.1
Ratio of Home and Community-Based Care Use to Nursing Facility Use	92.0	93.2	1.3***
Substance Use Disorder Treatment Penetration	32.6	35.0	3.1***
Alcohol or Other Drug Treatment: Initiation	39.4	39.5	-0.3
Alcohol or Other Drug Treatment: Treatment	13.6	13.4	0.3
30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	26.2	29.8	3.5***
7-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	16.5	19.6	3.3***

Shaded cells indicate a statistically significant change. Blue-shaded cells indicate an improvement. Orange-shaded cells indicate declining performance. Results marked * are significant at the p<.05 level. Results marked ** are significant at the p<.01 level. Results marked *** are significant at the p<.001 level.



Conclusions

In 2019, all nine ACHs implemented health improvement projects that promoted integrated care (e.g., Bi-Directional Integration of Physical and Behavioral Health Care). During this period, the state was also implementing financial integration through IMC. To build partner capacity, ACHs provided direct or contracted technical assistance and support, facilitated opportunities for peer learning, and invested in health information and exchange to enhance EHR systems. Behavioral health agencies experienced a unique set of challenges, particularly in regions where IMC and bidirectional integration occurred simultaneously, but 2A projects were prioritized and launched. Project 2A maintains the largest number of partners of all nine health improvement projects.

Our findings suggest positive movement in a variety of measures – particularly those that address substance use treatment. Although we observed improvements in follow-up from emergency department visits and hospitalizations for Alcohol and drug disorders, there were decreases in follow-up for patients with emergency department visits and hospital admissions for mental health. These findings suggest that efforts to improve mental health care may have been limited to the primary care setting.

A variety of measures did not improve or showed only modest improvements. There are several potential explanations for these findings. First, as with most of the health improvement projects, change was initiated in 2019. We might not expect to see substantive impacts across large population groups within that first implementation year.

Second, our analysis focused on the Medicaid population broadly. Some ACHs and partner organizations may have made substantial changes to improve outcomes for specific patient groups. These changes may be washed out in our analysis.

The final MTP evaluation report will span years 2017 through 2020, presenting opportunities to examine outcomes later in implementation. Interviews with key stakeholders indicated that the financial component of integration – integrated managed care – created new workloads related to contracting, billing codes, and changes in EHRs. These efforts – many of which were occurring throughout 2019 – may have delayed clinical changes during our observation period.

Health Improvement Project 2B

This chapter presents results of the interim evaluation of MTP Initiative 1 Health Improvement Project 2B, “Community-Based Care Coordination.”

We first provide background and an overview of how the MTP approach was intended to transform care in this area. We present a description of this project’s implementation through 2019, including observations from key informant interviews and reviews of program documents collected during this period. We then present results of an analysis of health care claims to compare whether and how health outcomes changed for target populations under this initiative.

Background

Community-based care coordination models identify people with complex health and social needs and connect them to appropriate health and social services in the community. These programs exist to address the gap in care that can arise when health systems identify clients’ unmet social needs but lack tools to address these needs. Health systems may be disconnected from community-based organizations operating programs to meet social needs, or may lack workflows for providers to ensure patients are able to access resources. Health systems may also lack data to be able to identify the prevalence or type of unmet social needs across the population of patients they serve. This lack of population-level social needs data can hamper health care organizations’ efforts to support community-based programs to address their patients’ needs.

Models of community-based care coordination such as the Pathways Community HUB model feature a central entity (often called a “hub”) that provides infrastructure and coordinates care among health and social service organizations in a community (Community Care Coordination Learning Network and the Pathways Community HUB Certification Program, 2016). **Elements of this model** may include:

- Screenings to identify people with complex health needs in the community;
- Comprehensive assessment of people’ health and social service needs;
- Referral pathways that connect clients with appropriate programs (e.g., a housing pathway connecting a client who has an unstable housing situation with a local housing authority);
- Provision of services based on the assigned pathways; and
- Monitoring clients’ status within pathways to track receipt of services or other outcomes.

These activities are often performed by community health workers (CHWs) or other care coordinators employed by the hub. Early evidence of the Pathways Community HUB model showed promise in reducing low birth weights (Redding, et al., 2015), though there have been few large-scale evaluations of these approaches to date.

MTP Approach to Change

Within MTP Initiative 1, Project 2B is an optional health improvement project for ACHs. The Medicaid Transformation Project Toolkit identified the Pathways Community HUB model as the required approach for ACHs participating in Project 2B.

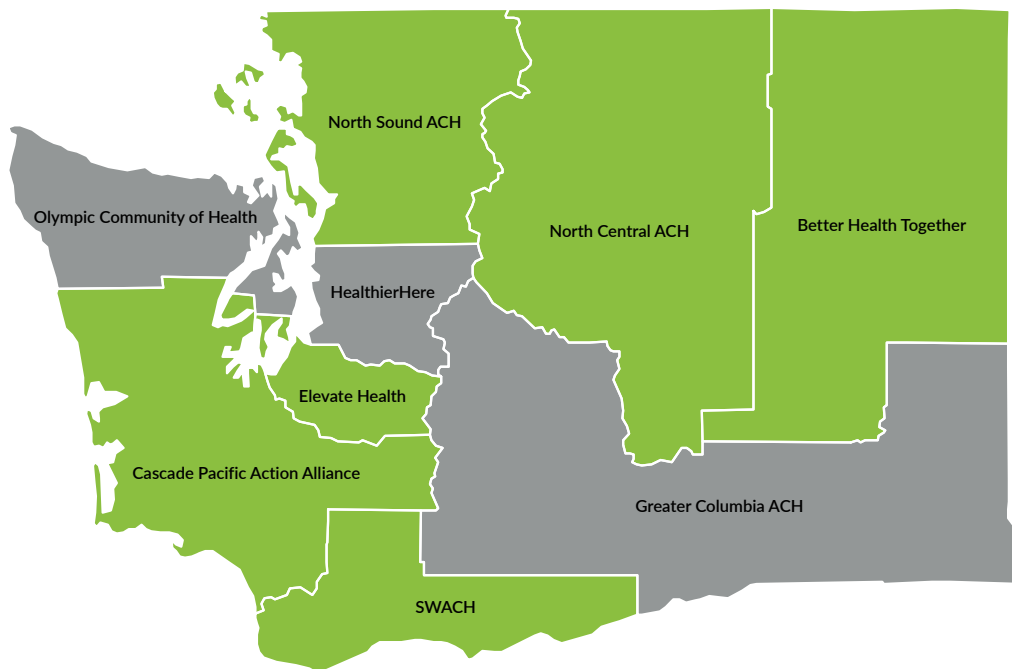
The Project Toolkit described a series of planning and implementation steps that are required for ACHs participating in 2B. Required planning activities included ACH identification and contractual engagement of an organization to serve as the Pathways Community HUB for their region, and recruitment of additional community partners such as patient centered medical homes that were willing to participate in screening, navigation and information exchange with the hubs as care coordination agencies (CCAs).

The Project Toolkit outlined 2B implementation activities for ACHs that included hiring and training of HUB staff (including CHWs), selection and implementation of specific referral pathways (or service need categories) via the Pathways Community HUB Certification program, and development of the data infrastructure for care coordination and monitoring of services provided through the program.

ACHs Participating in Project 2B

Within MTP Initiative 1, participation in Project 2B is voluntary, and six ACHs selected it for implementation while three did not (see Exhibit 4.1).

Exhibit 4.1: ACHs Participating in Project 2B, Community-Based Care Coordination



In addition to this formal participation in Project 2B, the three ACHs not formally participating in Project 2B (Greater Columbia ACH, HealthierHere, and Olympic Community Health) opted to contract with partners to implement care coordination strategies in other areas. These efforts often included elements similar to Project 2B, such as creation of care teams or provision of care coordination for other MTP projects such as 2C: Transitional Care.

Progress Toward Implementing Project 2B

Creating Hubs and Clinical-Community Linkages

As ACHs implemented Project 2B, key informant interviews and publicly available documents from 2019 indicated:

- **All ACHs adopted the same highly structured Pathways Community HUB model.**
- **Five of the six ACHs opted to serve as the Pathways Community HUB in their region.** Only one ACH contracted out this role to a community partner.
- **ACHs selected varying target populations for the Pathways Community HUB.** Two ACHs selected narrowly defined target populations (e.g., those transitioning from jail who had three or more emergency department visits within the past 12 months). The remaining four ACHs selected more broadly defined target populations focused, for example, on higher-risk patients such as those not eligible for enrollment in Health Homes or those with one or more risk factors (e.g., housing insecurity, recent jail admission).
- **The number of community partners that ACHs contracted with as CCAs varied.** ACHs implemented the Pathways Community HUB in partnership with CCAs that were responsible for service provision and coordination. The number of unique CCAs contracted with each ACH ranged from three to 12.

Launching Community HUBS

ACHs launched their Pathways Community HUBs at varying points in time ranging from early 2017 to late 2019. By mid-2019, all six ACHs had contracted with CCAs to provide care coordination services and implemented the Pathways Community HUB model's health information technology tool (Care Coordination Systems, or CCS) to support tracking enrollment, identifying and assigning care pathways, and monitoring progress. During the project implementation period, ACHs also trained community health workers who were a key workforce supporting the Pathways model.

In 2019, all ACHs began operation of their Pathways Community HUBs for at least one of their pathways. ACHs varied in how narrowly or broadly they defined the target population for Project 2B. This resulted in variation in the numbers of people in an ACH region who were eligible to participate in the Pathways Community HUB and receive care coordination services. ACHs selecting broadly defined target populations appear to have had higher enrollment and numbers of people with completed pathways, compared with ACHs that targeted a more narrowly defined group of people.

In October 2019, the Washington Health Care Authority announced that it would prioritize a separate care coordination program – Health Homes – as the community-based care coordination approach for Medicaid beneficiaries in future years. At the time of this report, some ACHs had discontinued their Pathways Community HUB efforts.

Factors That Facilitated Project 2B Implementation

Three factors may have facilitated Project 2B implementation.

- **Prior experience with the Pathways Community HUB model, and preexisting relationships to support the model, may have facilitated some ACHs' implementation of Project 2B.** ACHs also reported that having an established regional CHW workforce prior to MTP helped those ACHs make progress implementing their HUBs.
- **ACHs varied in the extent to which care coordination services were available across their entire geographic region.** Four out of six ACHs contracted with CCAs to serve all of their region's counties. This enhanced access, when paired with a more broadly defined target population, likely led to higher enrollment in these regions.
- **The Pathways Community HUB model supported the use of the CCS information exchange platform,** which allowed the organization acting as the Pathways Community HUB lead agency to closely monitor enrollment and care pathways, and share information with partners.

Factors That Impeded Project 2B Implementation

Three factors may have impeded Project 2B implementation.

- **A common challenge with the Pathways Community HUB model was retaining CHWs,** a workforce experiencing high turnover that was attributed to limited career advancement, lack of standards, low pay, and sometimes trauma-centered work. CHWs were part of the foundation of the Pathways Community HUB model, and challenges retaining this workforce may have created challenges for ACHs maintaining Project 2B.
- **Project 2B coverage was limited by the availability of CCAs with whom ACHs could contract.** Rural ACHs expressed challenges with regional coverage of the Pathways Community HUB through CCAs and service availability, which limited their ability to reach or enroll clients in all areas. This was in contrast to regions that achieved greater geographic coverage through a larger network of CCAs and rural regions.
- **The Pathways Community HUB model was not reimbursed by managed care organizations (MCOs);** while not an impediment to implementation, this had implications for the programs' sustainability after MTP. ACHs were unable to establish contracts with MCOs to pay for closed pathways, with some citing the Pathways Community HUB as duplicative with the state's already established Health Homes program. ACHs aimed to avoid duplication with Health Homes, and several ACHs referenced Health Homes in their target populations in order to support those who did not qualify for Health Homes but who still had complex health service needs. One ACH who contracted out the Pathways Community HUB lead role did so with a regional Health Home. In addition, in October 2019, the HCA indicated its intent that ACHs were responsible for exploring options for payers to reimburse for Pathways Community HUB services, and for considering plans for sustainability of the model beyond the MTP demonstration period (Washington State Health Care Authority, 2019c).

Evaluation Approach

Health Improvement Project 2B was an optional project for ACHs, allowing us to compare health outcomes of Medicaid enrollees in regions that did and did not participate in this project. We used a difference-in-differences approach for our quantitative analysis of Project 2B, measuring changes in outcomes in the pre-intervention period (2017 and 2018) to the post-intervention period (2019) and separately compared each of the six ACHs participating in this project to the three ACHs that did not participate in it.

We adjusted for regional differences in Medicaid enrollees' age, gender, race/ethnicity, urban and rural residence, and Chronic Illness and Disability Payment System (CDPS) risk score, that could otherwise explain observed differences across regions. See Appendix B for a complete description of methodology. Our model tests for changes among the ACHs who selected this particular HIP. Activities in other non-participating ACH regions such as the introduction of a similar program, or other interventions that drive changes in our target populations, may bias our results toward the null.

Target Populations and Context

The variation in target populations identified by ACHs for their Project 2B efforts made evaluating this project particularly challenging. Our analysis focused on **two target populations** as potential beneficiaries of ACHs' Project 2B efforts:

- 1 People with co-morbid behavioral health and chronic physical health conditions.
- 2 High-risk pregnant women.

Our first study population included people with a psychiatric or substance abuse CDPS measure and physical health comorbidity (defined by the Chronic Conditions Data Warehouse) within the last 24 months. We selected this target population because it broadly reflected the target populations of participating ACHs. We note two exceptions: North Central ACH's target population consisted of people with three or more ED visits in the past 12 months. SWACH's target population also included a focus on chronic pain.

The second study population focused on pregnant women with behavioral health or substance use disorder diagnoses. Using indicators provided by Washington State's Department of Social and Health Services, we selected all enrollees who were pregnant and delivered in the second, third or fourth quarter, or who were pregnant in the second or third quarter and remained pregnant until the end of the measurement period. We further limited this population to enrollees with a psychiatric or substance abuse CDPS measure in the last 24 months.

We considered this target population because it included an important subpopulation of people with behavioral health conditions who might especially benefit from care coordination. However, we note that this study population is not well aligned with the Project 2B efforts of Better Health Together, whose Pathways program focused on people transitioning from jail, or the target population of SWACH, which focused on people experiencing homelessness.

Interim Evaluation Results

Results of our evaluation of Health Improvement Project 2B, "Community-Based Care Coordination," are presented below and reflect changes from a baseline period (2017 and 2018) through a post-period, 2019. We first present outcomes for people with comorbid behavioral and physical health conditions. We then present outcomes for high-risk pregnant women. *See page 21 of this report for a guide to reading results.*

How are these results impacted by COVID-19?

The COVID-19 outbreak began in Washington State in early 2020, causing widespread disruption to health services delivery across the state. This report presents analyses of claims data through December 2019, prior to the outbreak. It is therefore unlikely that COVID-19 had any effect on measures presented in this report, though future reporting periods may be affected.

Analysis 1: People with Comorbid Conditions

Exhibit 4.2 (next page) presents results of our analysis for people with behavioral health conditions and comorbid physical health chronic conditions. There were relative improvements in mental health treatment penetration and follow-up after ED visits for alcohol or drug dependence (7 and 30 days). Several measures worsened in participating ACHs relative to non-participating ACHs. These measures included diabetes screening for people with schizophrenia or bipolar disorder using antipsychotic medication, the arrest rate, and the homelessness rate. Difference-in-differences estimates for other measures were not statistically significant.

The estimates of two measures (follow-up after emergency department visit for alcohol or drug dependence within 7 or 30 days) should be regarded with some caution. Some variation across ACH regions in these measures may have been driven by underlying differences in ED utilization patterns across these regions, rather than changes in follow-up service. These measures calculate the percentage of ED visits that are followed by a visit with a health care provider (outside of an ED). These measures might thus be lower in regions with higher ED utilization simply because of a higher number of ED visits in these areas. As we assessed smaller populations (e.g., subgroups with comorbid conditions, or ACH-specific analyses), these measures may have been subject to large changes in magnitude that were an artifact of the small sample size.

We next present results for people with comorbid behavioral and physical health conditions in each of the six ACHs participating in Project 2B (see Data Appendix, Table 5). Follow-up after ED visit for alcohol or drug dependence (both 7 and 30 days) increased in the Better Health Together ACH, but decreased in SWACH. Difference-in-differences estimates for mental health treatment penetration (broad version) improved moderately in three of the six ACHs participating in this project (Better Health Together, North Sound, and Elevate Health). Estimates for substance use disorder treatment penetration improved in two ACHs (Better Health Together and Elevate Health) but worsened in one (Cascade Pacific Action Alliance).

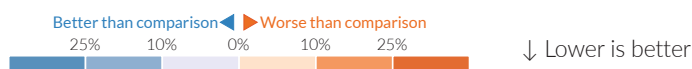
Three measures changed significantly for one ACH but not overall. These measures include relative improvements in the initiation and engagement of alcohol and other drug dependence treatment

Exhibit 4.2: Change in Outcomes for People with Comorbid Behavioral and Physical Chronic Conditions

Pre-post rates for participating ACHs, pre-post rates for comparison ACHs, and adjusted difference-in-differences estimates

	Participating ACHs		Comparison ACHs		Difference in Differences
	Pre	Post	Pre	Post	
Homelessness ↓	8.6	8.9	10.1	9.9	0.5*
Employment (Age 18 to 64)	36.9	31.0	37.7	31.7	0.3
Arrest Rate (Age 18 to 64) ↓	10.5	9.7	11.4	10.1	0.5*
Children and Adolescents' Access to Primary Care	99.1	99.3	99.2	99.0	0.4
Adults' Access to Primary Care	93.1	93.4	92.7	92.9	-0.1
Mental Health Treatment Penetration	57.6	57.3	60.2	58.4	0.9**
Antidepressant Medication for Adults (12 Weeks)	50.9	52.5	49.9	52.2	-0.8
Antidepressant Medication for Adults (6 Months)	36.3	38.3	34.8	38.2	-1.6
Antipsychotic Medication for People with Schizophrenia	64.7	64.2	62.5	64.9	-2.7
Diabetes Screening for People with Schizophrenia/Bipolar Disorder	86.4	86.3	85.2	88.1	-2.3*
7-Day Follow-Up After ED Visit for Mental Illness	65.0	58.2	62.2	53.7	1.3
30-Day Follow-Up After ED Visit for Mental Illness	75.1	69.9	72.6	66.6	0.7
7-Day Follow-Up After Hospitalization for Mental Illness	59.8	49.3	57.3	44.8	2.4
30-Day Follow-Up After Hospitalization for Mental Illness	76.4	69.7	73.4	67.0	0.1
30-Day Hospital Readmission for a Psychiatric Condition ↓	7.3	8.7	7.1	8.5	-0.6
Controller Medication for Asthma	50.1	50.5	48.7	50.3	-0.6
Eye Exam for People with Diabetes	46.3	47.8	43.9	46.0	0.4
Hemoglobin A1c Testing for People with Diabetes	81.6	82.8	80.5	81.8	0.2
Nephropathy Screening for People with Diabetes	86.1	86.8	85.8	85.4	0.7
Emergency Department Visit Rate ↓	141.1	139.6	161.8	161.9	-1.2
Acute Hospital Use among Adults ↓	179.0	180.6	168.6	161.6	7.8
Hospital Readmission within 30 Days ↓	7.3	7.9	7.7	8.6	-0.8
Ratio of Home and Community-Based Care Use to Nursing Facility Use	92.8	93.7	90.8	92.5	-0.9
Substance Use Disorder Treatment Penetration	32.3	35.2	32.9	34.8	0.7
Alcohol or Other Drug Treatment: Initiation	39.8	40.0	38.6	38.7	-0.2
Alcohol or Other Drug Treatment: Treatment	14.6	14.3	12.2	12.1	-0.1
30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	26.5	32.3	25.8	26.9	6.3***
7-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	17.4	22.2	15.5	16.5	5.4***

Shaded cells indicate a statistically significant difference between ACHs that did and did not participate in the ACH Health Improvement Project. Blue-shaded cells indicate that participating ACHs improved more than comparison ACHs. Orange-shaded cells indicate participating ACHs performed worse than comparison ACHs. Results marked * are significant at the p<.05 level. Results marked ** are significant at the p<.01 level. Results marked *** are significant at the p<.001 level.



measure (Better Health Together), a small improvement in the child and adolescent access to primary care measure (North Sound ACH) and a small decline in the adult access to preventive/ambulatory health services measure (North Central ACH).

As noted above, the estimates of two measures (follow-up after emergency department visit for alcohol or drug dependence, 7 and 30 days) should be regarded with some caution. The nature of these measures is such that they may shift due to underlying changes in ED utilization patterns across regions. In stratifying by ACH and focusing on a specific target population, we have also reduced our sample size, creating the potential for changes in a relatively small group of people to produce large swings in these measures.

Analysis 2: High-Risk Pregnant Women

Exhibit 4.3 (next page) displays results for our second target population, high-risk pregnant women. None of the measures exhibited statistically significant differences across ACHs. Emergency department utilization demonstrated a relatively large decrease, although this was not significant at the 5 percent level.

We next present results for high-risk pregnant women in each of the six ACHs participating in Project 2B (see Data Appendix, Table 5). There was inconsistent performance across ACHs. For example, Better Health Together demonstrated significant increases in comprehensive diabetes care (Medical Attention for Nephropathy), follow-up after ED visit for alcohol or drug dependence within 7 Days, follow-up after hospitalization for mental illness within 7 Days and all-cause 30-day psychiatric readmission. Cascade Pacific Action Alliance exhibited decreases in ED visits and diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medication.

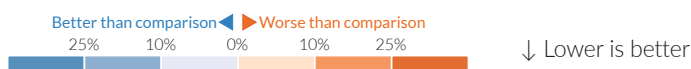
Estimates of three of these measures (all-cause 30-day readmission after psychiatric admission and follow-up after emergency department visit for alcohol or drug dependence, 7 and 30 days) should be regarded with some caution. These measures are fairly narrowly defined; as we reduce our sample size by focusing on pregnant women and stratifying by ACH, the measures become more sensitive. Changes among a relatively small group of enrollees can produce large changes in the measure.

Exhibit 4.3: Change in Outcomes for High-Risk Pregnant Women

Pre-post rates for participating ACHs, pre-post rates for comparison ACHs, and adjusted difference-in-differences estimates

	Participating ACHs		Comparison ACHs		Difference in Differences
	Pre	Post	Pre	Post	
Homelessness ↓	8.4	8.6	8.9	9.9	-0.9
Employment (Age 18 to 64)	51.1	49.6	49.4	46.7	1.7
Arrest Rate (Age 18 to 64) ↓	9.2	8.5	10.1	9.7	-0.4
Children and Adolescents' Access to Primary Care	99.6	99.4	100.0	99.7	0.3
Adults' Access to Primary Care	97.8	97.7	97.6	97.6	-0.2
Mental Health Treatment Penetration	54.8	54.6	55.4	54.0	0.1
Antidepressant Medication for Adults (12 Weeks)	42.5	44.9	40.5	44.4	-2.2
Antidepressant Medication for Adults (6 Months)	24.6	28.2	22.5	24.2	0.6
Antipsychotic Medication for People with Schizophrenia	44.4	50.8	67.6	51.4	13.7
Diabetes Screening for People with Schizophrenia/Bipolar Disorder	96.7	95.7	95.7	98.1	-4.7
7-Day Follow-Up After ED Visit for Mental Illness	63.3	44.7	59.9	48.5	-12.4
30-Day Follow-Up After ED Visit for Mental Illness	72.7	58.7	73.4	63.8	-8.1
7-Day Follow-Up After Hospitalization for Mental Illness	45.1	38.7	44.8	37.3	5.1
30-Day Follow-Up After Hospitalization for Mental Illness	64.1	59.8	62.9	58.7	-2.3
30-Day Hospital Readmission for a Psychiatric Condition ↓	2.9	8.3	11.1	10.1	14.4
Controller Medication for Asthma	32.1	39.5	36.8	39.2	2.2
Eye Exam for People with Diabetes	39.0	39.0	39.5	36.0	4.0
Hemoglobin A1c Testing for People with Diabetes	74.5	77.2	78.6	80.5	-0.5
Nephropathy Screening for People with Diabetes	84.6	88.2	84.5	84.7	4.6
Emergency Department Visit Rate ↓	173.0	163.2	203.7	208.4	-13.0
Acute Hospital Use among Adults ↓	78.0	82.1	88.9	82.7	8.1
Hospital Readmission within 30 Days ↓	5.0	4.3	6.4	5.7	0.9
Ratio of Home and Community-Based Care Use to Nursing Facility Use	97.3	98.3	92.3	90.4	2.3
Substance Use Disorder Treatment Penetration	39.4	40.1	38.5	39.8	-1.3
Alcohol or Other Drug Treatment: Initiation	44.2	46.8	44.1	42.7	2.8
Alcohol or Other Drug Treatment: Treatment	20.9	20.3	16.9	15.4	0.3
30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	30.9	34.3	26.0	33.7	-0.5
7-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	20.9	21.8	16.3	20.0	1.3

Shaded cells indicate a statistically significant difference between ACHs that did and did not participate in the ACH Health Improvement Project. Blue-shaded cells indicate that participating ACHs improved more than comparison ACHs. Orange-shaded cells indicate participating ACHs performed worse than comparison ACHs. Results marked * are significant at the p<.05 level. Results marked ** are significant at the p<.01 level. Results marked *** are significant at the p<.001 level.



Conclusions

In 2019, six ACHs implemented Pathways Community HUBs to identify and address needs or conditions (e.g., social, economic, and housing) that influence patients' health outcomes. The target populations of each ACH region were based on regional priorities (e.g., those transitioning from jail who had three or more emergency department visits within the past 12 months). ACHs, in partnership with care coordination agencies, elevated community health workers to play an integral role in connecting patients to health and social services. While the program promoted clinical-community linkages, the Pathways Community HUB model was not reimbursable by managed care organizations. Moreover, Health Homes, another community-based care coordination program, was embraced by HCA, MCOs, and ACHs as a financially sustainable alternative.

Difference-in-differences estimates for the broad target population (individuals with behavioral health conditions and comorbid physical health chronic conditions) suggested improvements for some measures during the first year. Most notably, Mental Health Treatment Penetration improved overall and was statistically significant in three ACHs. While the change was moderate, it was precisely estimated and not due to large changes in just one ACH.

Other changes were confined to one ACH and might have reflected other activities in that region. There was little evidence that the project improved measures for the narrow target population (high-risk pregnant) during the first year.

There are several potential explanations for why we did not find clearer changes in outcomes associated with this project. First, as with most of the ACH Health Improvement Projects, change strategies within Project 2B were initiated in 2019 and we did not expect to see substantive impacts across large population groups within the first implementation year. Second, sample sizes for some measures were small. We note that variability in sample sizes may have driven statistical significance of differences observed for some of these measures. Third, ACHs not officially participating in this project also engaged in care coordination activities, which could have led to changes for some outcomes among these ACHs similar to participating ACHs.

Health Improvement Project 2C

This chapter presents results of the interim evaluation of MTP Initiative 1 Health Improvement Project 2C, “Transitional Care.”

We first provide an overview of how the MTP approach was intended to transform care in this area. We present a description of this project’s implementation through 2019, including observations from key informant interviews and reviews of program documents collected during this period. We then present results of an analysis of health care claims to compare whether and how health outcomes changed for key populations under this initiative.

Background

When people transition between care settings, such as returning home from a hospital stay or transitioning from acute to long-term care, they can be at risk for disruptions in the continuity of care they receive. These disruptions may stem from a variety of causes ranging from communication breakdowns between care settings, unclear workflows, provision of unclear information that leads to patient or caregiver misunderstandings, or lack of clarity regarding who is accountable for the next step in an individual’s care (Joint Commission, 2012). This can lead to avoidable and costly readmissions to hospital settings or reduced quality of care over time (Verhaegh, et al., 2014).

Care transition interventions aim to support people with complex care needs who are discharged from a hospital, acute care, or institutional setting in order to reduce the avoidable rehospitalization rate of these patients and ensure they are getting the right care in the right place. Research suggests that such care transition interventions can reduce hospital readmission rates (Verhaegh, et al., 2014) and build health system capacity to connect patients with appropriate resources (Ruiz, et al., 2017).

A subset of these interventions focuses specifically on people transitioning into the community following incarceration. People within this population experience high rates of chronic illness coupled with social risk factors, and are at high risk in the months following release from incarceration (Binswanger, et. al, 2007). Jail transition programs aim to increase access to care and reduce recidivism for this population; evaluation results of such programs have been mixed but suggest these programs may show promise in enhancing primary care access and reducing avoidable ED visits when those programs are initiated in correctional settings prior to a person’s reentry into the community (Shavit, et al., 2017).

MTP Approach to Change

Project 2C, “Transitional Care,” was an optional ACH Health Improvement Project comprised of seven approaches to assist Medicaid beneficiaries who were discharged from intensive or institutional settings to their homes, supportive housing, and communities. Three approaches targeted Medicaid beneficiaries with physical and behavioral health needs who were reentering their communities after incarceration. These [approaches to Project 2C](#) are described below.

Evidence-Based Approaches for Transitional Care

- **Interventions to Reduce Acute Care Transfers**, a quality improvement program for the management of acute change in resident condition.
- **Transitional Care Model**, a model of transitional care for high-risk older adults that provides nurse-led in-hospital planning and in-home follow-up.
- **The Care Transitions Intervention**, a multidisciplinary approach incorporating physical, behavioral, and social health needs and perspectives.
- **Care Transitions Interventions in Mental Health**, a set of components of transitional care that can be adapted for managing transitions among persons with serious mental illness.

Evidence-Informed Approaches for Transitions from Incarcerated Settings

- **Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison** (Blandford and Osher, 2013).
- **A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model** (Osher, Steadman and Barr, 2003)
- **American Association of Community Psychiatrists’ Principles for Managing Transitions in Behavioral Health Services** (Sowers and Rohland, 2004).

ACHs that selected Project 2C were required to execute master services agreements for partnering providers and facilitate health systems capacity building by embedding strategies for each core capacity, including financial sustainability, workforce development, and population health management, into their work on Project 2C.

ACHs Participating in Project 2C

Five ACHs selected Project 2C (Cascade Pacific Action Alliance, Greater Columbia ACH, HealthierHere, North Central ACH, and North Sound ACH) and launched care transitions programs in 2019 (see Exhibit 5.1). These ACHs often aligned Project 2C work with other selected project work (Projects 2A, 2B, 2D, and 3D) and promotion of patient-centered medical homes, as they aimed to advance whole-person integrated care.

Exhibit 5.1: ACHs Participating in Project 2C, Transitional Care



Project 2C Implementation

In 2019, ACHs launched their transitional care projects. ACHs delivered health systems and capacity building (i.e., Domain 1) strategies that promoted collaborative partnerships, workforce development, and population health management systems. Key informant interviews and publicly available documents from 2019 indicate **ACHs pursued the following strategies:**

- **Data analysis** was provided by ACHs to support partnering providers in identifying target populations and selecting suitable transitional care models.
- **Learning collaboratives** were convened to facilitate networking and peer learning and to create and pilot innovative tools (e.g., interoperable health information exchanges (HIE) and shared care plans) among partnering providers.
- **Training and technical assistance events** were offered to support partnering providers as they adopted new workflows, referral processes, and quality improvement initiatives to support implementation.

- **Workforce development opportunities** (e.g., internship and training fund, promoting the use of patient navigators) were also offered to recruit and retain community health workers and licensed health professionals to assist with transitional care management and planning.
- **Health information technology (HIT) and HIE systems** (e.g., Collective Medical) were obtained to identify people at risk of an emergency department visit, rehospitalization, or reentry (jail or prison), and to communicate and coordinate care among clinical and community-based providers.
- **Pathways Community HUBs** and community paramedicine models (see Chapter 4), although not HCA-approved strategies for Project 2C, were embraced as strategies to reduce avoidable hospital utilization and to facilitate referrals for clinical and community-based services.

Factors That Facilitated 2C Implementation

One factor was identified as potentially facilitating Project 2C implementation.

ACHs nurtured existing partnerships that were already established through previous initiatives (e.g., State Innovation Model (SIM) grants), as well as their backbone organizations (e.g., CHOICE Regional Network, Benton-Franklin Community Health Alliance, Whatcom Alliance for Health Alliance), which had longstanding presences in their communities. These relationships eased partner engagement necessary to identify regional priorities, and design and implement health improvement projects.

Factors That Impeded 2C Implementation

Two factors may have impeded Project 2C implementation.

- **While statewide investments dedicated to OneHealthPort have promoted the adoption of a standard information exchange platform among health care providers, this strategy has not engaged non-traditional partners such as correctional facilities.** ACHs and partnering providers reported needing community information exchanges or alternative HIT/E tools for managing care transitions involving these non-traditional partners. There was interest among stakeholders in a single statewide HIT/E strategy to reinforce coordinated and integrated care among providers.
- **Stakeholders also reported difficulty encouraging clinicians to use forms that were a Project Toolkit requirement.** Reports suggests that in 2019, not all partnering providers had built Physician Orders for Life-Sustaining Treatment (POLST) into their workflows, and clinicians who used POLST forms may have done so only for patients who they deemed to be at an advanced stage of illness, rather than using the forms more widely. Partnering providers reported needing technical assistance in using the form, including support for building staff awareness of the form, increasing its availability in clinical settings, and incorporating the form into EHRs.

Evaluation Approach

Health Improvement Project 2C was an optional project for ACHs, allowing us to compare outcomes of Medicaid enrollees in regions that did and did not participate in this project. We used a difference-in-differences approach to measure changes in outcomes for these two groups from the pre-intervention period (2017 and 2018) to the post-intervention period (2019).

We adjusted for regional differences in Medicaid enrollees' age, gender, race/ethnicity, urban vs. rural residence, and CDPS risk, that could otherwise explain observed differences across regions. See Appendix B for a detailed description of methodology. Our model tests for changes among the ACHs who selected this particular HIP. Activities in other non-participating ACH regions such as the introduction of a similar program, or other interventions that drive changes in our target populations, may bias our results toward the null.

Target Populations

Our analysis of Project 2C focused on **two populations** identified by ACHs as targeted beneficiaries of their 2C project activities:

- 1 People who have been discharged from a hospital in the last year with co-occurring behavioral and chronic physical health conditions, and
- 2 People experiencing homelessness.

For our first population, we included members with a qualifying hospital discharge within the past calendar year. We defined co-occurring chronic conditions as the presence of physical health and behavioral health (mental health and/or substance use) conditions. We identified behavioral health conditions using psychiatric and substance use CDPS indicators. We identified chronic conditions broadly, using markers from the CMS Chronic Condition Warehouse such as for anemia, asthma, chronic obstructive pulmonary disease, or diabetes. Hospital discharges were identified as acute or non-acute inpatient stays. Hospital stays that ended in death or were related to pregnancy were excluded.

For our second population, we identified people experiencing homelessness as Medicaid beneficiaries whose living arrangement status was designated as “homeless without housing,” “emergency shelter,” or “battered spouse shelter” for at least one month in the previous calendar year in the Automated Client Eligibility System.

An additional population, people transitioning from jail, was identified as relevant to the evaluation; however, data were not available to support inclusion of this population for the interim report. This population may be included in subsequent reports.

Interim Evaluation Results

Results of our evaluation of Health Improvement Project 2C, "Transitional Care," are presented below and reflect changes from a baseline period (2017 and 2018) through a post-implementation period, 2019. We first present outcomes for our first target population for this project area: people discharged from a hospital with a chronic condition. We then present outcomes for our second target population, people experiencing homelessness. *See page 21 of this report for a guide to reading results.*

How are these results impacted by COVID-19?

The COVID-19 outbreak began in Washington State in early 2020, causing widespread disruption to health services delivery across the state. This report presents analysis of claims data through December 2019, prior to the outbreak. It is therefore unlikely that COVID-19 had any effect on measures presented in this report, though future reporting periods may be affected.

Analysis 1: People Discharged from the Hospital with Co-Occurring Behavioral and Chronic Physical Health Conditions

Exhibit 5.2 (next page) displays changes for each metric for people discharged from a hospital with co-occurring behavioral and chronic physical health conditions (our first target population) comparing people in ACH regions participating in Project 2C with people in non-participating ACH regions.

Among ACHs that participated in this project compared to those that did not, there was a statistically significant improvement in the homelessness rate for this target population. Measures of follow up after emergency department visits for alcohol or drug dependence improved across all ACHs, but improved more in comparison ACHs. Relative to the comparison group, performance in these measures was 8 percent lower for the seven-day measure and 30-day measures. We also observed a small (2.2 percent) decrease in substance use treatment penetration and mental health penetration rates.

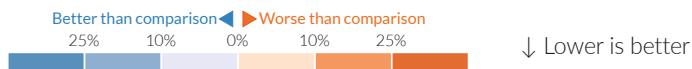
We next present results for each of the five ACH regions participating in Project 2C. Table 5 in the Data Appendix presents ACH-level results for people discharged from the hospital with co-occurring behavioral and chronic physical conditions. In general, we see fewer significant results due to the small populations in each of these measures. However, HealthierHere and North Sound ACH exhibited decreases in rates of follow-up after emergency department visits for alcohol or drug disorder. These measures should be interpreted with some caution, however, because changes in measures of follow-up may be driven by underlying differences in ED utilization patterns across these regions.

Exhibit 5.2: Change in Outcomes for People Discharged from the Hospital with Co-Occurring Conditions

Pre-post rates for participating ACHs, pre-post rates for comparison ACHs, and adjusted difference-in-differences estimates

	Participating ACHs		Comparison ACHs		Difference in Differences
	Pre	Post	Pre	Post	
Homelessness ↓	8.4	9.0	7.0	8.5	-0.8*
Mental Health Treatment Penetration	54.0	54.8	53.5	55.9	-2.3**
7-Day Follow-Up After ED Visit for Mental Illness	65.7	62.4	67.7	61.1	1.6
30-Day Follow-Up After ED Visit for Mental Illness	76.8	74.1	80.9	72.3	3.5
7-Day Follow-Up After Hospitalization for Mental Illness	59.0	47.6	63.4	49.4	1.8
30-Day Follow-Up After Hospitalization for Mental Illness	74.9	66.8	76.6	69.2	-1.5
30-Day Hospital Readmission for a Psychiatric Condition ↓	8.8	11.0	10.1	9.4	4.2
Emergency Department Visit Rate ↓	146.8	149.2	141.4	141.7	-0.5
Acute Hospital Use among Adults ↓	227.7	222.2	223.1	229.7	-10.5
Hospital Readmission within 30 Days ↓	10.0	11.1	10.5	11.4	-0.3
Ratio of Home and Community-Based Care Use to Nursing Facility Use	87.8	90.2	89.5	91.5	0.9
Substance Use Disorder Treatment Penetration	35.0	37.4	31.7	37.3	-2.2*
30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	27.8	30.6	29.6	39.3	-8.5**
7-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	15.4	19.0	18.3	28.1	-8.4**

Shaded cells indicate a statistically significant difference between ACHs that did and did not participate in the ACH Health Improvement Project. **Blue**-shaded cells indicate that participating ACHs improved more than comparison ACHs. **Orange**-shaded cells indicate participating ACHs performed worse than comparison ACHs. Results marked * are significant at the p<.05 level. Results marked ** are significant at the p<.01 level. Results marked *** are significant at the p<.001 level.



Analysis 2: People Experiencing Homelessness

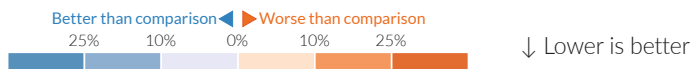
Exhibit 5.3 (next page) displays changes for each metric across each state for people experiencing homelessness (second target population). The relatively small size of this population across the state makes it difficult to draw strong conclusions. Generally, we see a worsening of measures in this area among ACHs participating in Project 2C, relative to non-participating ACHs. Comparison ACHs performed better in rates of follow-up after emergency department for alcohol or drug dependence within 7 and 30 days and substance use disorder treatment penetration. There were not significant differences among other measures.

Exhibit 5.3: Change in Outcomes for People Experiencing Homelessness

Pre-post rates for participating ACHs, pre-post rates for comparison ACHs, and adjusted difference-in-differences estimates

	Participating ACHs		Comparison ACHs		Difference in Differences
	Pre	Post	Pre	Post	
Homelessness ↓	100.0	100.0	100.0	100.0	0.0
Mental Health Treatment Penetration	55.9	53.4	55.2	54.4	0.3
7-Day Follow-Up After ED Visit for Mental Illness	54.6	48.2	54.4	49.9	-2.8
30-Day Follow-Up After ED Visit for Mental Illness	64.8	59.2	67.3	62.3	-2.2
7-Day Follow-Up After Hospitalization for Mental Illness	44.8	35.1	45.0	37.4	-2.9
30-Day Follow-Up After Hospitalization for Mental Illness	61.4	57.1	62.8	56.3	1.3
30-Day Hospital Readmission for a Psychiatric Condition ↓	7.9	8.0	7.7	8.6	2.3
Emergency Department Visit Rate ↓	158.7	162.3	144.8	149.0	-2.7
Acute Hospital Use among Adults ↓	126.8	126.9	112.2	119.2	-8.4
Hospital Readmission within 30 Days ↓	7.4	7.8	7.6	8.7	0.9
Ratio of Home and Community-Based Care Use to Nursing Facility Use	81.5	90.3	81.2	91.0	3.6
Substance Use Disorder Treatment Penetration	44.5	48.5	41.8	49.4	-2.2*
30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	23.4	26.8	27.6	35.0	-4.9*
7-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	13.6	17.2	18.2	25.1	-4.7*

Shaded cells indicate a statistically significant difference between ACHs that did and did not participate in the ACH Health Improvement Project. **Blue**-shaded cells indicate that participating ACHs improved more than comparison ACHs. **Orange**-shaded cells indicate participating ACHs performed worse than comparison ACHs. Results marked * are significant at the p<.05 level. Results marked ** are significant at the p<.01 level. Results marked *** are significant at the p<.001 level.



In the Data Appendix (Table 5) we present results for people experiencing homelessness in each of the five ACH regions participating in Project 2C. We see small but statistically significant declines in substance use disorder treatment penetration in Cascade Pacific Action Alliance and Greater Columbia ACH. HealthierHere demonstrated decreases in rates of follow-up after emergency department visits for alcohol or drug dependence within 7 and 30 days relative to comparison ACHs. Across ACH regions, these findings suggest mixed results in some measures for people experiencing homelessness in ACH regions participating in Project 2C.

Conclusions

Our findings suggest relatively few improvements in most measures across most ACHs participating in Project 2C. In particular, comparison ACHs performed better on measures of follow-up after ED visits for alcohol or drug dependency within 7 and 30 days.

Other results across this project were mixed or not statistically significant, which may be due to the relatively small population size of people who were discharged from the hospital with a co-occurring behavioral and chronic physical condition or who experienced homelessness.

Several ACHs described their care transitions efforts as being integrated with other project areas, and some ACHs not participating in this project area engaged in care coordination activities with similar populations. This overlap across project areas potentially muted any differences we may have otherwise observed in participating and non-participating ACHs.

In the final MTP evaluation report, we will examine health care utilization and quality outcomes through 2020, in addition to certain measures of health care spending, in order to more fully examine changes in these measures for ACHs that did and did not participate in Project 2C.

Health Improvement Project 2D

This chapter presents the results of the interim evaluation of MTP Initiative 1 Health Improvement Project 2D, “Diversion Interventions.”

We first provide background and an overview of how the MTP approach was intended to transform care in this area. We present a description of this project’s implementation through 2019, including observations from key informant interviews and reviews of program documents collected during this period. We then present results of an analysis of health care claims to compare whether and how outcomes changed for target populations under this initiative.

Background

An important element of person-centered care is ensuring that people with complex health care needs receive timely care in the settings that are best situated to meet their needs. Diversion interventions are intended to promote the appropriate use of emergency care services by increasing access to primary care and social services.

Diversion interventions typically focus on people who use emergency services for non-emergency conditions that could be better addressed in other care settings, as well as people who come into contact with law enforcement for reasons related to substance use disorders or serious mental illness.

There is evidence that diversion programs may reduce the time that people spend in jail and help link them to community-based services without increasing risks to public safety (Steadman and Naples, 2005; Sirotich, 2009). Systems-based diversion interventions can also reduce emergency department utilization (Morgan, Chang and Pines, 2013).

MTP Approach to Change

Project 2D, “Diversion Interventions,” is an optional health improvement project for ACHs. The Medicaid Transformation Project Toolkit provides ACHs with **three potential approaches to diversion intervention**: emergency department diversion, community paramedicine, and law enforcement-assisted diversion.

- **Emergency department (ED) diversion approaches** do not require a specific model, but ACH implementations must include two elements. First, EDs must establish linkages to primary care providers, a necessary step to notifying the primary care provider of the ED visit and establishing a care plan. Second, EDs must develop a process for identifying people who present with minor conditions and do not have a primary care provider, with a goal of establishing an appointment with a primary care provider.
- **Community paramedicine models** allow paramedics to function outside their customary emergency response and transport roles, offering new types of community-based health care services that bridge primary care and emergency care. ACHs implementing community

paramedicine must work with first responders, emergency providers, and primary care providers to develop protocols that may include, for example, transporting beneficiaries with non-emergency needs to urgent care centers or patient-centered medical homes, as alternatives to the emergency department.

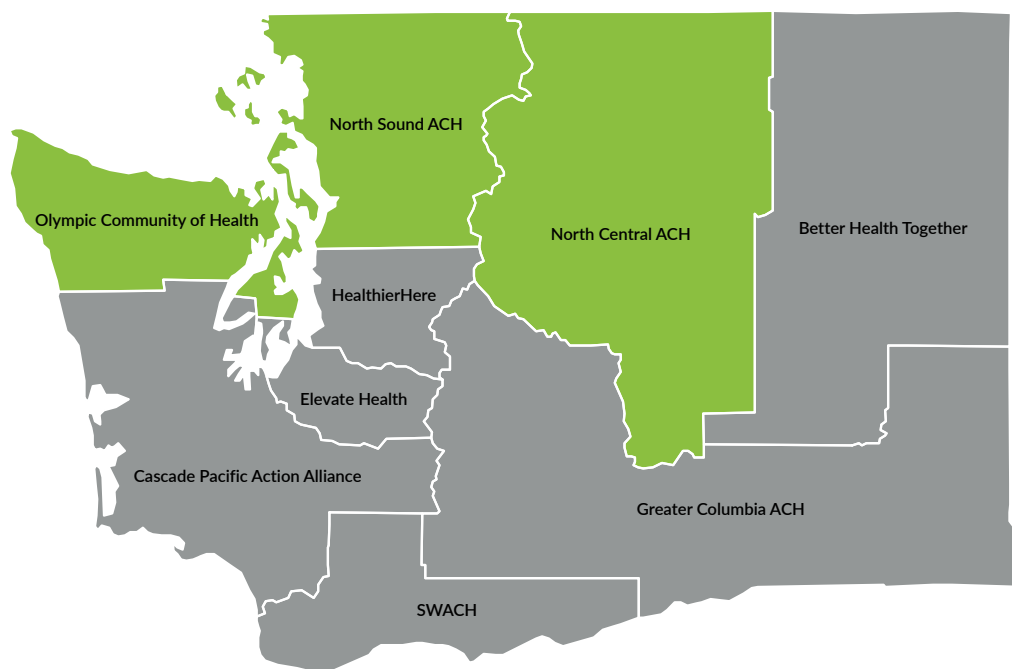
- **The LEAD model** (LEAD National Support Bureau, n.d.) focuses on people who come into contact with law enforcement, offering officers an alternative to booking people into jail for criminal activity that stems from unmet behavioral health needs or poverty. ACHs implementing LEAD are directed to assess resources and assistance from the LEAD National Support Bureau. Implementation activities include engaging law enforcement and generating buy-in, including obtaining commander-level support and providing intensive case management to link diverted people to housing, vocational and educational opportunities, treatment, and community services.

ACHs that opted to participate in Project 2D were required to execute master services agreements for partnering providers and, for LEAD, establish a community advisory group that included representation from community members, health care and social services, law enforcement, and community public safety leaders. ACHs participating in 2D were also required to ensure that participating partners were provided with or had access to necessary training and technical assistance resources.

ACHs Participating in Project 2D

Three ACHs selected Project 2D (North Central ACH, North Sound ACH, and Olympic Community of Health) (see Exhibit 6.1). Their health improvement projects launched in 2019. These ACHs worked to align diversion interventions with other health improvement projects that promoted coordinated care between clinical and community providers, including Projects 2B, 2C, and 3D.

Exhibit 6.1: ACHs Participating in Project 2D, Diversion Interventions



Progress Toward Implementing Project 2D

ACHs launched their diversion intervention projects in 2019. Their strategies focused on enhancing population health management systems and workforce development in clinical and community settings. Key informant interviews and publicly available documents from 2019 indicated ACHs prioritized **the following approaches**:

- **Health information technology (HIT) and health information exchange (HIE) systems** (e.g., patient registries, Collective Medical, and regionally developed community information exchanges such as Health Commons) to identify and monitor Medicaid beneficiaries that frequently accessed EDs, and to communicate and coordinate care among clinical and community-based providers;
- **Community paramedicine models** to reduce ED utilization and non-transport calls for EMS and to coordinate with clinical and community-based partners that could treat and refer patients to appropriate services;
- **Pathways Community HUBs**, developed by ACHs in Project 2B for community-based care coordination, and also used by ACHs and partnering providers to facilitate referrals for clinical and community-based services.
- **Trainings for providers** on intervention models (e.g., Pathways), HIT/E and CIE tools (e.g., Collective Medical and Health Commons), and processes (e.g., Ambulance Documentation).

All three participating ACHs implemented evidence-informed strategies that aimed to identify frequent ED use, promote appropriate ED use, and emphasize comprehensive and coordinated care. These strategies were achieved through collaborative partnerships comprised of clinical and community-serving organizations, including hospitals, health systems, federally qualified health centers, EMS agencies, fire departments, and correctional facilities.

Factors That Facilitated Implementation of Project 2D

Two factors aided Project 2D implementation.

- **Through State Innovation Model (SIM) grants, two of the three ACHs (North Central ACH and Olympic Community of Health) implementing Project 2D had convened and supported earlier efforts in the region.** For example, staff at Olympic Community of Health noted that SIM helped them implement Natural Communities of Care (NCC), bringing together stakeholders who had not previously had an opportunity to work together. NCCs created a referral network and established collaborative service agreements that were beneficial to Project 2D.
- **Participating ACHs (e.g., North Central ACH, North Sound ACH, and Olympic Community of Health) also leveraged existing population health management systems to enhance coordinated and integrated care between providers.** HIT/E systems like Collective Medical and the Pathways Care Coordination System were mechanisms for connecting providers to information that could foster comprehensive care for Medicaid beneficiaries.

Factors That Impeded Implementation of Project 2D

We identified one factor that may have delayed Project 2D implementation. While the State Medicaid HIT Plan promoted an electronic health record (EHR) system for state hospitals to exchange data (e.g., OneHealthPort), clinical and community-based providers who were not using a certified EHR relied on a number of HIT/E systems for population health management. All three ACHs leveraged existing systems. However, these systems required financial investment and

presented their own challenges. For example, in 2019, OCH did not identify a HIPAA-covered entity who could manage Health Commons. Moreover, ACH efforts to promote HIE interoperability, a key element in sharing information between provider, were complicated by the use of multiple HIT/E systems.

Evaluation Approach

Health Improvement Project 2D was an optional project for ACHs, allowing us to compare outcomes of Medicaid enrollees in ACHs that participated in 2D to those that did not. Our evaluation used a difference-in-differences approach to compare changes in outcomes from a pre-intervention period (2018) to a post-intervention period (2019). Because our analysis required a 24-month lookback period, we used only 2018 as the baseline period for this project, representing a departure from other project analyses that used a baseline period of 2017 and 2018.

We adjusted for regional differences in Medicaid enrollees' age, gender, race/ethnicity, urban vs. rural residence, and CDPS risk score. See Appendix B for methodological details. Our model tests for changes among the ACHs who selected this particular HIP. Activities in other non-participating ACH regions such as the introduction of a similar program, or other interventions that drive changes in our target populations, may bias our results toward the null.

Target Populations

Our analysis focused on **two populations** that were described by ACHs as intended beneficiaries of their Project 2D efforts:

- 1 People with three or more emergency department (ED) visits in the year before the intervention.
- 2 People with five or more ED visits in the year before the intervention.

While there was variation across the five participating ACHs in the scale or approach of their diversion interventions, each of the participating ACHs reported a focus on reducing ED utilization among people who were frequent users of emergency care services.

Another population of interest was the group of individuals who had contact with the corrections system. However, data to support this analysis were not available at the time of this publication.

Interim Evaluation Results

Results of our evaluation of Project 2D, Diversion Interventions, are presented below and reflect changes from the baseline period, 2018, through the post-implementation period, 2019, comparing ACHs who participated in 2D to those who did not. We first present outcomes for our broadly defined target population of people with three or more ED visits in the past year. We then present outcomes for our narrowly defined population of people with five or more ED visits in the past year. *See page 21 of this report for a guide to reading results.*

How are these results impacted by COVID-19?

The COVID-19 outbreak began in Washington State in early 2020, causing widespread disruption to health services delivery across the state. This report presents analysis of claims data through December 2019, prior to the outbreak. It is therefore unlikely that COVID-19 had any effect on measures presented in this report, though future reporting periods may be affected.

Analysis 1: People with Three or More Emergency Department Visits

Table 6.2 displays changes for each metric for people with at least 3 ED visits in the year prior to the intervention. We did not see any statistically significant changes among these measures. Two measures, all-cause readmissions and all-cause readmissions after psychiatric hospitalization, moved in the desired direction relative to the comparison group, but these changes were not statistically significant. Overall, there was relatively little evidence of improvement in these selected metrics in 2019.

Exhibit 6.2: Change in Outcomes for People with More Than Three ED Visits

Pre-post rates for participating ACHs, pre-post rates for comparison ACHs, and adjusted difference-in-differences estimates

	Participating ACHs		Comparison ACHs		Difference in Differences
	Pre	Post	Pre	Post	
Homelessness ↓	9.3	9.8	9.3	10.0	0.0
Arrest Rate (Age 18 to 64) ↓	12.9	12.5	11.5	11.5	-0.4
Children and Adolescents' Access to Primary Care	98.1	98.3	96.7	96.9	-0.1
Adults' Access to Primary Care	92.6	93.6	90.3	91.0	0.2
Mental Health Treatment Penetration	57.3	58.2	55.9	55.9	0.6
7-Day Follow-Up After ED Visit for Mental Illness	66.5	59.5	62.9	54.7	0.7
30-Day Follow-Up After ED Visit for Mental Illness	75.9	71.3	73.6	66.8	1.9
30-Day Hospital Readmission for a Psychiatric Condition ↓	8.3	9.2	8.0	9.1	-1.3
Emergency Department Visit Rate ↓	271.2	272.7	275.0	277.9	-1.5
Acute Hospital Use among Adults ↓	182.3	192.2	189.8	195.5	4.4
Hospital Readmission within 30 Days ↓	7.7	7.5	8.0	8.7	-1.6
Ratio of Home and Community-Based Care Use to Nursing Facility Use	92.4	93.5	94.3	95.7	0.4
Substance Use Disorder Treatment Penetration	38.2	40.8	33.5	36.8	-0.6
30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	28.4	34.5	25.6	29.7	0.5
7-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	17.9	21.5	15.9	20.0	-1.0

Shaded cells indicate a statistically significant difference between ACHs that did and did not participate in the Health Improvement Project. **Blue**-shaded cells indicate that participating ACHs improved more than comparison ACHs. **Orange**-shaded cells indicate participating ACHs performed worse than comparison ACHs. Results marked * are significant at the p<.05 level. Results marked ** are significant at the p<.01 level. Results marked *** are significant at the p<.001 level.



In the Data Appendix, Table 5 presents results for people with three or more ED visits in the year prior to the intervention in the three ACHs that chose Project 2D. The percentage of people in this population with arrests and those who were homeless declined slightly in North Central ACH. Olympic Community of Health experienced a decrease in substance use treatment penetration in this population. We did not observe statistically significant changes in other measures.

Analysis 2: People with 5 or More ED Visits

Exhibit 6.3 displays changes for each metric for people with five or more ED visits in the year prior to the intervention. We observed a small (2.3 percent) but statistically significant decrease in hospital readmissions, with this measure decreasing slightly among ACHs who chose Project 2D and increasing across other ACHs. We also observed an improvement in mental health treatment penetration. Other measures for Project 2D among this population showed relatively little change.

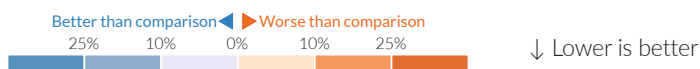
In the Data Appendix, Table 5 presents results for people with five or more ED visits in the year prior to the intervention in the three ACHs that chose Project 2D. We did not observe significant changes among most measures in most ACHs for this population, and patterns generally followed

Exhibit 6.3: Change in Outcomes for People with Five or More ED Visits

Pre-post rates for participating ACHs, pre-post rates for comparison ACHs, and adjusted difference-in-differences estimates

	Participating ACHs		Comparison ACHs		Difference in Differences
	Pre	Post	Pre	Post	
Homelessness ↓	12.5	13.3	12.5	13.5	-0.1
Arrest Rate (Age 18 to 64) ↓	16.5	16.0	15.0	15.2	-0.6
Children and Adolescents' Access to Primary Care	98.7	98.7	97.6	97.6	-0.1
Adults' Access to Primary Care	94.3	95.2	91.9	92.7	0.0
Mental Health Treatment Penetration	58.9	60.1	58.0	57.3	1.3*
7-Day Follow-Up After ED Visit for Mental Illness	67.9	61.2	62.0	54.5	0.4
30-Day Follow-Up After ED Visit for Mental Illness	77.2	72.5	72.9	66.7	1.3
30-Day Hospital Readmission for a Psychiatric Condition ↓	10.3	11.4	9.1	10.5	-1.2
Emergency Department Visit Rate ↓	385.4	388.6	389.5	396.6	-5.1
Acute Hospital Use among Adults ↓	229.7	246.4	239.0	248.7	4.9
Hospital Readmission within 30 Days ↓	9.0	8.9	9.5	10.5	-2.3*
Ratio of Home and Community-Based Care Use to Nursing Facility Use	92.9	94.5	94.6	96.1	0.8
Substance Use Disorder Treatment Penetration	38.7	42.0	33.8	37.5	-0.5
30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	28.5	34.1	26.2	30.5	-0.1
7-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	17.4	21.4	16.5	20.6	-0.6

Shaded cells indicate a statistically significant difference between ACHs that did and did not participate in the ACH Health Improvement Project. Blue-shaded cells indicate that participating ACHs improved more than comparison ACHs. Orange-shaded cells indicate participating ACHs performed worse than comparison ACHs. Results marked * are significant at the p<.05 level. Results marked ** are significant at the p<.01 level. Results marked *** are significant at the p<.001 level.



those seen in the population of people with three or more ED visits. The percentage of individuals in this population who were homeless, as well as hospital readmissions, declined in North Central ACH. Olympic Community of Health experienced a decline in substance use treatment penetration in this population. We did not observe statistically significant changes in other measures.

Conclusions

In our selected measures, we observed relatively little change among the three ACHs who chose Project 2D, though rates of hospital readmissions decreased and mental health treatment penetration improved modestly for people with the highest rates of ED utilization. These findings may reflect the early stage of our results. Implementation efforts that occurred throughout 2019 may not yet have impacted the performance metrics we have evaluated. In addition, some efforts by ACHs such as the LEAD model focused on people who come into contact with law enforcement, a population we did not evaluate because of data limitations.

While some evidence exists to support diversion models, these efforts have a more limited evidence base than some Project Toolkit activities. Thus, ACHs may be testing models and determining the best ways to meet beneficiary and partner needs. The Final Evaluation Report will continue to examine factors that may impact the scale of these interventions and examine whether later periods in the MTP demonstration reveal emerging differences among participating and non-participating ACH regions.

Health Improvement Project 3A

This chapter presents results from the interim evaluation of MTP Initiative 1 Health Improvement Project 3A, “Addressing the Opioid Use Public Health Crisis.” Additional evaluation findings pertaining to Washington State’s substance use disorder waiver amendment are presented in Chapter 15.

We first provide background and an overview of how the MTP approach was intended to transform care in this area. We present a description of this project’s implementation through 2019, including observations from key informant interviews and reviews of program documents collected during this period. We then present results of an analysis of health care claims to compare whether and how health outcomes changed for key populations under this initiative.

Background

Opioid use has become a particularly urgent public health issue. Nationally, fatal opioid overdose rates have quadrupled since 1999, and opioid overdoses are now a leading cause of deaths for Americans under 50 (Centers for Disease Control and Prevention, 2020a).

Reducing the deaths and adverse outcomes associated with addiction will require a multipronged effort, with a focus on prevention and treatment, including expansion in the use of FDA-approved medications (e.g., methadone, buprenorphine, naltrexone), increasing the use of evidence-based practices and policies, improving access to care, and attempting to destigmatize treatment.

Medications are considered the gold standard for treating opioid use disorder, but their availability can be limited by existing regulations. For example, to prescribe buprenorphine, physicians, nurse practitioners, and physician assistants must apply for a waiver under the Drug Addiction Treatment Act of 2000. These providers are required to undergo specific addiction and pharmacology training prior to obtaining a special DEA number that is necessary for all prescriptions for buprenorphine.

Because addiction is particularly prevalent among socioeconomically disadvantaged populations, Medicaid offers significant opportunities to confront SUD generally, and the opioid epidemic specifically.

MEDICATIONS FOR OPIOID USE DISORDER AND OVERDOSE

Medications for addiction disorders may help address the need for better treatment. Psychiatry has been transformed by the introduction of drug therapies, but the use of medications for substance use treatment has seen slower uptake, even though medications are now seen as the gold standard for care.

There are three FDA-approved medications used for opioid dependence: methadone, naltrexone, and buprenorphine. Methadone differs slightly from other medications because it must be dispensed by an opioid treatment program. A 2009 Cochrane review concluded that methadone treatment was effective in reducing opioid use, opioid use-associated transmission of infectious disease, and crime when compared to placebo with psychosocial treatment (Mattick, Breen and Davoli, 2009).

Buprenorphine is a newer drug and easier to administer than methadone, with similar effectiveness. A 2014 Cochrane review comparing buprenorphine, methadone, and placebo found no differences in opioid-positive drug tests or self-reported heroin use when treating with methadone or buprenorphine (Mattick, et al., 2014).

Naltrexone is also a newer drug, available in oral and injectable form; the evidence base to support naltrexone as effective in the treatment for opioid use disorder is less developed than that for methadone or buprenorphine, although the injectable version appears to be more effective (Minozzi, et al., 2011; Krupitsky, et al., 2013).

The Centers for Disease Control and Prevention (CDC) recommends that patients with opioid use disorder receive evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone maintenance therapy in combination with behavioral therapies), with oral or long-acting injectable naltrexone also available for consideration for nonpregnant adults (Dowell, Haegerich, and Chou, 2016).

MTP Approach to Change

All ACHs were required to participate in Project 3A. ACHs' strategies in this area must focus on the entire spectrum of **opioid-related outcomes**, including:

- **Prevention of opioid use and misuse.** Evidence-based approaches for prevention include promoting best practices for prescribing opioids for acute and chronic pain; raising awareness and knowledge about the possible adverse effects of opioid use (e.g., by collaborating with the Center for Opioid Safety Education and other partners); preventing opioid initiation and misuse, using, for example, school-based programs to focus on youth; and promoting safe storage and appropriate disposal of opioids.
- **Treatment of opioid use disorder.** Approaches to expanding treatment include building provider capacity to recognize signs of misuse and linking patients to treatment resources; expanding access to medications for opioid use disorders (MOUD), particularly in the criminal justice system; increasing the capacity of harm reduction programs such as syringe exchange programs; and developing programs to treat pregnant women with opioid use disorder.
- **Overdose prevention.** Efforts to intervene in opioid overdoses to prevent death include providing technical assistance and overdose education to providers and expanding the use of naloxone to treat overdoses.

- **Recovery.** Recovery is focused on promoting long-term stabilization and whole-person care, including the provision of peer and other recovery support services designed to improve treatment access and retention and support long-term recovery.

To implement 3A projects, ACHs were expected to convene partnerships encompassing mental health and SUD providers, community-based service providers, executive and clinical leadership, consumer representatives, law enforcement, criminal justice, public health, emergency medical services, and elected officials.

ACHs could build on a variety of promising practices and evidence-supported strategies described in the MTP Project Toolkit. These included the following [clinical guidelines](#), the first two of which are primarily focused on prevention.

- 1 Agency Medicaid Directors' Group's (AMDG) Interagency Guideline on Prescribing Opioids for Pain (Washington State Agency Medical Directors' Group, 2015). The AMDG is a collaboration of state agencies that include the Washington State Health Care Authority, Department of Labor & Industries, Board of Health, Department of Health, Department of Veteran Affairs, Office of the Insurance Commissioner, and Department of Corrections.
- 2 The Centers for Disease Control and Prevention's (CDC) Guideline for Prescribing Opioids for Chronic Pain (Dowell, Haegerich, and Chou, 2016).
- 3 Washington State's Guidelines for Screening and Management for Substance Use During Pregnancy (Washington State Department of Health, n.d.).

The Project Toolkit also referenced two statewide plans, including the 2016 Washington State Interagency Opioid Working Plan (Washington State Department of Health, 2016) and the Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan (Washington State Prevention Enhancement Policy Consortium, 2019).

Project 3A Implementation

Key informant interviews and publicly available documents indicated that approaches to Project 3A varied across regions. This variation reflected a range of activities related to opioids that existed across the state prior to MTP. In 2019, ACHs strategically focused efforts on boosting preexisting regional work and supporting key strategies from the toolkit. [ACH work on Project 3A included:](#)

- **Convening partners through educational activities.** This included work that the ACHs did to: establish rapport across the various sectors involved in addressing opioids, including primary care, behavioral health, community-based organizations, education, and law enforcement; gain community perspective on how prevention, treatment, overdose response, and recovery programs can be improved; and educate communities through events that aimed to increase awareness and reduce stigma, including annual opioid conferences and symposiums.
- **Technical support for training activities to expand the treatment and recovery workforce.** ACHs assisted with recruitment and technical support for MOUD, peer recovery coach training, and offered support to cover training costs to help expand treatment capacity in most regions.
- **Implementing opioid prescribing guidelines.** ACHs supported implementation of clinician prescribing guidelines for patients in need of pain management by making recommendations for guidelines, providing assistance with workflows, and continually communicating with partners about state or national guideline updates.

STATEWIDE OPIOID RESPONSE PLAN

In 2016, Governor Inslee issued an executive order designed to bring together state agencies, local public health organizations, law enforcement, Tribal governments, and other partners to act on opioids.

The [Washington State Opioid Response Plan](#) outlined the strategies and actions that state agencies would implement.

The plan included four priority goals:

- Prevent opioid misuse and abuse.
- Identify and treat opioid use disorder.
- Reduce morbidity and mortality from opioid use disorder.
- Use data and information to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions.

Progress Toward Opioid Interventions

By late 2019, ACH clinical project partners in all regions had implemented workflow changes in adherence to state or federal guidelines for best prescribing practices, including Washington State Opioid Prescribing Guidelines for practitioners, CDC Guidelines for Prescribing Opioids for Chronic Pain, and AMA Safe Prescribing Practices. In some regions (Cascade Pacific Action Alliance, Greater Columbia ACH, Olympic Community of Health, Southwest Accountable Community of Health), clinical partners had implemented team-based care for medication management using the University of Washington's Six Building Blocks.

Health systems, substance use disorder providers, and/or Tribal partners conducted MOUD trainings. They established relationships between community-based organizations and MOUD providers to increase referrals to treatment in most regions (Cascade Pacific Action Alliance, Elevate Health, Greater Columbia ACH, HealthierHere, North Sound ACH, Olympic Community of Health, SWACH).

Harm reduction efforts were also expanded. ACHs worked to increase naloxone availability through syringe exchange programs and by engaging community-based partners and Tribes in several regions (Better Health Together, Cascade Pacific Action Alliance, Elevate Health, North Central ACH, Olympic Community of Health, SWACH).

Factors That Facilitated 3A Implementation

Two factors may have facilitated Project 3A implementation.

- **Project 3A was aligned with the Washington State Interagency Opioid Working Plan.** In most regions, work had already begun to reduce opioid use, expand treatment, and reduce harm through established stakeholder groups. These groups and coalitions often operated at the county level. They included cross-agency partners representing primary care, behavioral health, public health, social services, harm reduction services, educators, law enforcement, people in recovery, and families of people with opioid use disorder. Such groups contributed to Project 3A by helping ACHs identify community needs (e.g., regional care, funding, and workforce gaps) and by sharing ACH strategies with the broader community.

- In ACH regions participating in Project 2B (Care Coordination), implementation of the Pathways Community HUB model also supported Project 3A. The Pathways Care Coordination System (CSS) supported care coordination for people with substance use disorders who were identified in community-based settings.

Factors That Impeded 3A Implementation

Three factors may have impeded the implementation of Project 3A.

- **Workforce shortages limited the number of available MOUD-waivered providers.** Some ACH regions did not appear to have enough providers to meet treatment needs. ACHs also noted that some MOUD-waivered providers did not appear to be actively prescribing MOUD to patients who could benefit from this therapy. ACHs were exploring reasons for this inactivity.
- **Tensions existed between stakeholders promoting substance use disorder services through abstinence or MOUD.** ACHs needed to negotiate with providers holding different views regarding SUD treatment, and build trust across different advocacy and treatment groups. These activities, while important, may have delayed other project activities.
- **ACH partners experienced challenges in accessing a consistent supply of naloxone** to adequately equip staff and high-risk people. The reasons for naloxone shortages reported in 2019 were not entirely clear but may relate to funding or unstable relationships with pharmaceutical suppliers.

Evaluation Approach

Participation in Project 3A was mandatory for all ACHs, removing the potential for a strong comparison group. Thus, we assessed changes among enrollees of all ACH regions from a pre-intervention period of 2017 and 2018 into a post-intervention period of 2019. We analyzed data at the calendar year level, adjusting for age, gender, race/ethnicity, urban vs. rural residence, and CDPS risk. See Appendix B for methodological details.

We note that interventions to address the opioid epidemic preceded the efforts by ACHs. For example, in 2012, hospitals were mandated to implement and strategically use the health information exchange then known as the Emergency Department Information Exchange (EDIE) as part of its “ER is for Emergencies” program. Beginning November 2014, emergency departments in Washington began implementing an automated prescription drug monitoring program (PDMP). In addition, the State of Washington applied for and received an amendment to the current MTP waiver to maintain and expand access to inpatient and residential treatment for substance use disorder, with that amendment becoming effective in July 2018. These interventions were coupled with regional and national efforts to raise awareness about the dangers of opioid prescriptions, addictions, and overdoses. Our current analysis does not separate out the isolated effects of changes implemented by ACHs from other longstanding regional and national efforts.

Target Populations

Our analysis of Project 3A focused on **two populations** who were described by ACHs as intended beneficiaries of their work in this project area:

- 1 **All Medicaid-enrolled adults ages 19-64.** We selected this population to analyze measures that test efforts to prevent opioid misuse, including, for example, the percentage of beneficiaries who are prescribed high-dose chronic opioid therapy.

- 2 People with opioid use disorder**, defined as the presence of an opioid use disorder diagnosis (ICD10 code F11.XXX) within the last 12 months. For this population, we analyzed measures related to efforts to treat OUD, including, for example, the percentage of patients with OUD who received medications.

Interim Evaluation Results

Results of our evaluation of Health Improvement Project 3A are presented below and reflect changes from a baseline period (2017 and 2018) through 2019. We first present outcomes for all Medicaid-enrolled adults ages 19-64. We then present outcomes for people with opioid use disorder. *See page 21 of this report for a guide to reading results.*

How are these results impacted by COVID-19?

The COVID-19 outbreak began in Washington State in early 2020, causing widespread disruption to health services delivery across the state. This report presents an analysis of claims data through December 2019, prior to the outbreak. It is therefore unlikely that COVID-19 had any effect on measures presented in this report, though future reporting periods may be affected.

Analysis 1: All Medicaid-Enrolled Adults Ages 19-64

Exhibit 7.1 displays changes for each metric across the state for all Medicaid-enrolled adults ages 19-64. The percentage of people prescribed high-dose chronic opioid therapy dropped by more than 1 percent for each measure and the percentage of patients prescribed chronic concurrent opioids and sedatives also dropped by slightly more than 2 percent. Opioid use disorder treatment increased by almost six percentage points in this group. Other measures exhibited small or insignificant changes.

In the Data Appendix, Table 4 displays the change in outcomes across all nine ACHs for all Medicaid-enrolled adults. Substance use disorder treatment penetration showed statistically significant increases across all ACHs, with the largest change observed in North Central ACH. The target population in Greater Columbia ACH experienced significant decreases in hospital use, while enrollees in Elevate Health experienced significant increases in hospital and emergency department use. Four ACHs (Better Health Together, Greater Columbia, HealthierHere, and North Sound) showed statistically significant reductions in the percentage of patients prescribed high-dose chronic opioid therapy (greater than 90 mg). There were also statistically significant reductions in the percentage of patients prescribed chronic concurrent opioids and sedatives in Better Health Together, Olympic Community of Health, North Central ACH, HealthierHere, and North Sound ACH, with the largest reduction occurring in Olympic Community of Health.

Exhibit 7.1: Change in Outcomes for All Medicaid-Enrolled Adults Ages 19-64

All-ACH rate in 2017-18, all-ACH rate in 2019, and adjusted pre-post change

	2017-18 All ACHs	2019 All ACHs	Pre-post Adjusted Change
30-Day Hospital Readmission for a Psychiatric Condition ↓	6.5	7.4	1.1
Emergency Department Visit Rate ↓	67.5	68.2	0.1
Acute Hospital Use among Adults ↓	60.8	61.4	-0.3
Hospital Readmission within 30 Days ↓	5.9	6.3	-0.1
Ratio of Home and Community-Based Care Use to Nursing Facility Use	93.0	94.2	1.2***
Patients Prescribed High-dose Chronic Opioid Therapy: >50 mg MED ↓	31.0	30.3	-1.6***
Patients Prescribed High-Dose Chronic Opioid Therapy: >90mg ↓	14.6	13.6	-1.8***
People with an Opioid Prescription who were Prescribed a Sedative ↓	19.4	17.3	-2.2***
Opioid Use Disorder Treatment for People with Treatment Need	51.8	58.7	5.9***

Shaded cells indicate a statistically significant change. Blue-shaded cells indicate an improvement. Orange-shaded cells indicate declining performance. Results marked * are significant at the p<.05 level. Results marked ** are significant at the p<.01 level. Results marked *** are significant at the p<.001 level.



Analysis 2: People with Opioid Use Disorder

Exhibit 7.2 displays changes for each metric across the state for people with opioid use disorder. This population experienced significant reductions in the receipt of high-dose chronic opioid therapy, with both measures dropping by more than four percent. The percentage of patients prescribed chronic concurrent opioids and sedatives also dropped by slightly more than two percent. Substance use disorder treatment penetration increased by six percent. This group also exhibited positive changes in utilization: hospital use decreased by 10.7 visits per 1,000 members; emergency department visits decreased by 7.2 visits per 1,000 member months. The ratio of home and community-based services (HCBS) to institutional (nursing facility) services for long-term care also increased, by 2.7 percent.

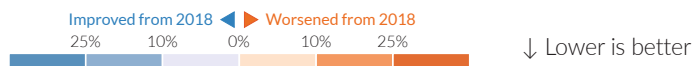
In the Data Appendix, Table 4 displays the change in outcomes across all nine ACHs for people with opioid use disorder. Substance use disorder treatment penetration showed statistically significant increases across all ACHs, with the largest change observed in North Central ACH. People with OUD experienced large decreases in emergency department visits in Elevate Health; the largest reductions in hospital utilization occurred in HealthierHere. The percentage of patients prescribed high-dose chronic opioid therapy (>90 mg) demonstrated significant decreases in four ACHs, and the percentage of patients prescribed chronic concurrent opioids and sedatives decreased significantly in two ACHs. People in this population experienced significant decreases in all-cause hospital readmissions and in readmissions after psychiatric hospitalization in North Central ACH.

Exhibit 7.2: Change in Outcomes for People with Opioid Use Disorder

All-ACH rate in 2017-18, all-ACH rate in 2019, and adjusted pre-post change

	2017-18 All ACHs	2019 All ACHs	Pre-post Adjusted Change
30-Day Hospital Readmission for a Psychiatric Condition ↓	8.0	9.5	2.1
Emergency Department Visit Rate ↓	174.5	167.1	-7.2***
Acute Hospital Use among Adults ↓	189.5	179.7	-10.7**
Hospital Readmission within 30 Days ↓	8.4	9.1	0.1
Ratio of Home and Community-Based Care Use to Nursing Facility Use	90.4	93.5	2.7**
Patients Prescribed High-dose Chronic Opioid Therapy: >50 mg MED ↓	45.0	40.7	-4.8***
Patients Prescribed High-Dose Chronic Opioid Therapy: >90mg ↓	23.0	19.5	-4.1***
People with an Opioid Prescription who were Prescribed a Sedative ↓	22.4	20.5	-2.2*
Opioid Use Disorder Treatment for People with Treatment Need	60.7	67.0	6.0***

Shaded cells indicate a statistically significant change. Blue-shaded cells indicate an improvement. Orange-shaded cells indicate declining performance. Results marked * are significant at the p<.05 level. Results marked ** are significant at the p<.01 level. Results marked *** are significant at the p<.001 level.



Conclusions

In 2019, ACHs leveraged existing federal and state initiatives to address the opioid epidemic. With evidence-supported strategies and local coalitions, ACHs and partners implemented a multipronged approach in support of the state’s goals of prevention, treatment, and recovery. Our evaluation found signs of progress in efforts to address the opioid epidemic, with encouraging patterns in how opioids were prescribed and the percentage of people who were receiving treatment for opioid use disorder. There was weaker evidence that these efforts translated directly into changes in utilization, such as emergency department use, hospitalizations, or readmissions. However, the measures presented here were relatively narrow in scope and may not have captured overall improvements in mortality and morbidity.

This analysis has an important limitation, distinct from other analyses of health improvement projects: we focused on trends for a problem that began to receive intensive federal and state attention prior to the ACH intervention. Nonetheless, the ACH efforts may be unique to or synergistic with these other efforts. We may expect to see larger changes after 2019, the first implementation year.

Our analysis examined changes in opioid-related outcomes for the Medicaid population broadly. Some ACHs focused their efforts on smaller, specific target populations. This focus was often justifiable based on data and community input. However, changes for these smaller populations may not be detectable in our analyses of the larger Medicaid population.

The final MTP evaluation report will span years 2017 through 2020, presenting opportunities to examine outcomes at a later point in implementation.

Health Improvement Project 3B

This chapter presents results of the interim evaluation of MTP Initiative 1 Health Improvement Project 3B, “Reproductive and Maternal/Child Health.”

We first provide background and an overview of how the MTP approach was intended to transform care in this area. We present a description of this project’s implementation through 2019, including observations from key informant interviews and reviews of program documents collected during this period. We then present results of an analysis of health care claims that assessed whether and how health outcomes changed for target populations under this initiative.

Background

The Medicaid program is an essential source of coverage for children and their parents and thus an important lever to improve their health outcomes. Nationally, Medicaid was the source of payment for 42 percent of all 2018 births (National Vital Statistics System, 2019) and Medicaid and the Children’s Health Insurance Program (CHIP) provided coverage for 38 percent of all children (KFF’s State Health Facts, 2019). Mothers and children in the United States have higher mortality rates than those in similar countries, and the health of lower-income mothers and children in the United States is typically worse than their higher-income counterparts. Improvements in Medicaid can thus create significant improvements in the wellbeing of these populations.

Better maternal and child health can be achieved through a variety of efforts, including improving prenatal and postpartum care, providing information about healthy pregnancies to expecting mothers and their partners, increasing the number of well-child visits, and increasing vaccination rates among children.

MTP Approach to Change

Within MTP Initiative 1, Project 3B is optional for ACHs. The Project Toolkit specified **three potential approaches** that may be taken by ACHs opting in to this project area:

- 1 CDC-recommended strategies to improve women’s and men’s health and promote healthy pregnancies (Centers for Disease Control and Prevention, 2020b).** These included smoking cessation or daily folic acid supplementation.
- 2 Home visiting models for high-risk pregnant women.** Examples of federally recognized models included the Nurse-Family Partnership, which provides home visits from specially trained nurses to young women early in pregnancy and continues through a child’s second birthday. Family Spirit, another home-visiting program developed by the Johns Hopkins Center for American Indian Health, uses a culturally specific, strengths-based curriculum specifically for American Indians.

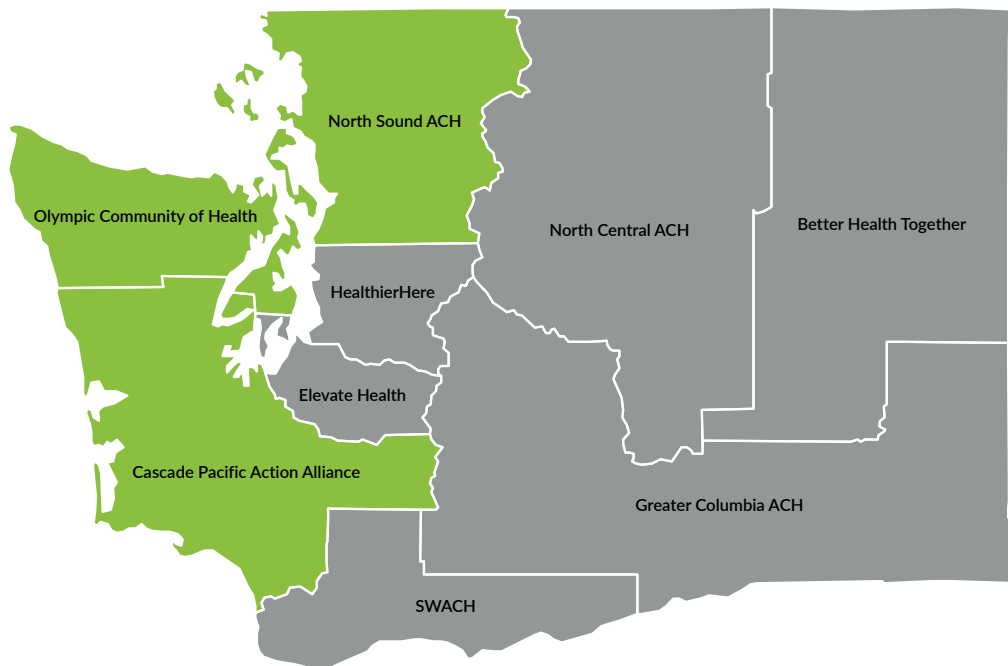
3 Approaches to improve well-child visit rates and childhood immunization rates. The Project Toolkit identified two initiatives, Bright Futures and Stony Brooks Children’s Hospital Enriched Medical Home Intervention, also known as Keeping Families Healthy. Bright Futures is a national health promotion and prevention initiative led by the American Academy of Pediatrics. The core of the initiative is a set of recommendations for child care providers that detail activities at each child care visit (e.g., vision screening, immunizations) along with guidelines for implementation of these activities. Keeping Families Healthy is a medical home intervention program launched by Stony Brook Children’s Hospital in 2011. It offers free home visits by trained community health workers (CHWs) to children considered at risk of poor health outcomes. CHWs check a child’s vaccination status during visits and provide educational material along with other services.

ACHs participating in Project 3B were required to compile a partnering provider list, select an evidence-based approach and target population, develop guidelines and procedures for the intervention, and offer training to participating providers.

ACHs Participating in Project 3B

Three ACHs (Cascade Pacific Action Alliance, North Sound ACH, Olympic Community of Health) elected to participate in Project 3B (see Exhibit 8.1). Selection of 3B was reported to have been influenced by Regional Health Needs Inventory findings related to reproductive health needs.

Exhibit 8.1: ACHs Participating in Project 3B, Reproductive Health



Project 3B Implementation

Key informant interviews and publicly available documents indicated that **ACHs supported implementation of the following strategies** for Project 3B in 2019:

- **Technical assistance for integration of ten CDC evidence-based recommendations.** This included sharing the guidelines with partners and offering support surrounding integration of best practices and strategies for primary care partner workflows.
- **One Key Question training.** ACHs facilitated training on the One Key Question method. One Key Question assesses women's pregnancy intentions and provides counseling accordingly, including a review of their contraception options when appropriate.
- **Technical assistance for implementation of the Bright Futures program.** ACHs provided funding and training assistance for primary care and pediatric partners to integrate the program's evidence-based practices into clinical workflows to improve access and engagement for children.
- **Technical assistance to help build the capacity of regional Nurse-Family Partnerships.** Two ACHs, Cascade Pacific Action Alliance and Olympic Community of Health, supported the expansion of established Nurse-Family Partnership programs by improving partners' awareness of and referrals to regional nurse home visitation programs.
- **Education efforts through learning collaboratives, conferences, and webinars.** ACHs provided education surrounding alignment of Project 3B goals with other MTP projects or health equity topics. Examples of ACH education topics included prevention of substance abuse and child maltreatment, promoting depression screening for pregnant and postpartum women, creating safe spaces for LGBTQ clients, and addressing adverse childhood experiences (ACEs).

Progress Toward Implementing Project 3B

By late 2019, ACHs' and partners' implementation progress varied on Project 3B. The most widely implemented strategies were the CDC's 10 Recommendations and One Key Question pregnancy intention screenings. One Key Question was also connected to ACHs' efforts to develop training and organizational relationships to support patients' access to contraception, including long-acting reversible contraception (LARC). Partners in the Cascade Pacific Action Alliance and North Sound ACH regions focused on increasing access to LARC for patients by establishing cross-organization relationships for care referrals to providers trained in LARC insertion and removal.

Factors That Facilitated Project 3B Implementation

Two factors may have facilitated implementation of Project 3B.

- **ACH educational offerings helped project partners understand the value of reproductive, maternal, and child health strategies** and may have increased partnering providers' motivations to implement improvements in this area. These educational events were informed by regional experts and frequently open to the community, which may have helped partner organizations build a network of support for their efforts that extended beyond contracted partners.
- **In one region (Cascade Pacific Action Alliance), several partners contracted with the ACH for this project alone.** This included area pediatricians, OB/GYN providers, and community-based organizations serving children. The participation of this extended network of partner organizations who focused on a single project might have contributed to earlier and broader implementation of the project in participating ACHs.

Factors That Impeded Project 3B Implementation

Two factors were identified as possibly impeding implementation of this project.

- **Some partner organizations prioritized other projects over Project 3B in their region.** The reasons for this low prioritization varied across ACHs, but stakeholders reported that partners perceived other MTP projects to be more urgent or visible. Some partners perceived pregnant women and children to represent a small proportion of the Medicaid population, believing that focusing on older adults or chronic conditions would target a greater number of Medicaid beneficiaries. ACHs reported needing to engage in educational efforts to overcome these perceptions before proceeding to implementation of 3B activities; this may explain why some partners had not yet proceeded with implementation of Project 3B in late 2019.
- **Patients reportedly did not always understand the value of reproductive health programs.** In interviews, stakeholders pointed to challenges with patient buy-in for interventions to increase child vaccinations. ACHs attempted to address this issue by increasing community outreach and by investing in social media campaigns to educate parents on the importance of vaccinations and well-child visits.

Evaluation Approach

Health Improvement Project 3B was an optional project for ACHs, allowing us to compare outcomes of Medicaid enrollees among ACHs that participated in this project to those that did not. We used a difference-in-differences approach for our quantitative analysis of Project 3B, measuring changes in outcomes in the pre-intervention period (typically calendar year 2017 and 2018) to the post-intervention period (typically calendar year 2019) and separately comparing each of the three ACHs participating in this project to the six ACHs that did not participate in it. Due to differences in the availability of data for some measures, contraception access measures are reported for a baseline period of July 2016 to June 2018 and a post-implementation period of July 2018 to June 2019.

We adjusted for regional differences in Medicaid enrollees' age, gender, race/ethnicity, urban vs. rural residence, and CDPS risk score. See Appendix B for a complete description of methodology. Our model tests for changes among the ACHs who selected this particular HIP. Activities in other non-participating ACH regions such as the introduction of a similar program, or other interventions that drive changes in our target populations, may bias our results toward the null.

Target Populations

Our analysis focused on the following **two target populations** identified as intended beneficiaries of ACHs' work in this project area:

- Women of reproductive age, and
- Pregnant women.

To identify our first population, we defined women of reproductive age as those identified as female and between the ages of 15 and 50 in Medicaid demographic records.

Using indicators provided by Washington State's Department of Social and Health Services, we identified our second population by selecting all enrollees who were pregnant and delivered in the second, third, or fourth quarter, or who were pregnant in the second or third quarter and remained pregnant until the end of the measurement period.

We note that this approach is not perfectly aligned with all ACH target populations for their Project 3B work. For example, some ACHs described their target populations as including mothers of children ages 0-3 and children ages 0-17. However, it was not possible to identify these mother-child dyads in Medicaid claims data. *See page 21 of this report for a guide to reading results.*

How are these results impacted by COVID-19?

The COVID-19 outbreak began in Washington State in early 2020, causing widespread disruption to health services delivery across the state. This report presents an analysis of claims data through December 2019, prior to the outbreak. It is therefore unlikely that COVID-19 had any effect on measures presented in this report, though future reporting periods may be affected.

Interim Evaluation Results

Results of our evaluation of Health Improvement Project 3B, Reproductive and Maternal/Child Health, are presented below. We first present outcomes for our broadly defined target population for this project area: all Medicaid-enrolled women of reproductive age. We then present outcomes for our narrowly defined target population, pregnant women.

Analysis 1: Women of Reproductive Age

Exhibit 8.2 displays results for our first population, women of reproductive age. Although measures of mental health treatment penetration and substance use disorder treatment penetration increased in both participating and non-participating ACH regions, the improvement was larger in non-participating ACHs. These differences between participating and non-participating ACHs were not statistically significant.

In the Data Appendix, Table 5 presents results for women of reproductive age in each of the three ACH regions participating in Project 3B. Relative to ACHs not participating in Project 3B, Cascade Pacific Action Alliance experienced a statistically significant decline in all-cause emergency department visits, mental health treatment penetration, and SUD treatment penetration for this population. North Sound ACH experienced a relative decline in access to contraceptive care (most and moderately effective methods) and mental health treatment penetration. Olympic Community of Health experienced a relative decline in SUD treatment penetration.

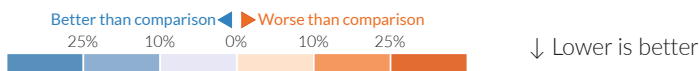
Exhibit 8.2: Change in Outcomes for Women of Reproductive Age

Pre-post rates for participating ACHs, pre-post rates for comparison ACHs, and adjusted difference-in-differences estimates

	Participating ACHs		Comparison ACHs		Difference in Differences
	Pre	Post	Pre	Post	
Timely Prenatal Care	84.8	86.3	85.8	86.8	0.5
Effective Contraception	30.2	29.4	29.2	28.8	-0.4
Long-Acting Reversible Contraceptives	12.4	13.9	16.2	17.0	0.5
Effective Contraception within 60 Days of Delivery	39.1	39.8	41.4	41.1	0.6
Chlamydia Screening for Women	49.5	48.5	52.1	52.0	-1.0
Mental Health Treatment Penetration	54.9	54.9	52.8	53.8	-1.2***
30-Day Hospital Readmission for a Psychiatric Condition ↓	5.4	6.7	6.1	6.7	0.7
Emergency Department Visit Rate ↓	71.3	70.2	70.8	70.7	-1.4
Acute Hospital Use among Adults ↓	42.8	43.2	42.7	42.5	0.0
Hospital Readmission within 30 Days ↓	4.3	4.7	4.8	5.5	0.7
Substance Use Disorder Treatment Penetration	41.6	43.2	34.0	38.6	-2.1***

Shaded cells indicate a statistically significant difference between ACHs that did and did not participate in the ACH Health Improvement Project. **Blue**-shaded cells indicate that participating ACHs improved more than comparison ACHs. **Orange**-shaded cells indicate participating ACHs performed worse than comparison ACHs. Results marked * are significant at the p<.05 level. Results marked ** are significant at the p<.01 level. Results marked *** are significant at the p<.001 level.

Note: 1) The following measures are reported on a State Fiscal Year basis of July to June rather than January to December due to the availability of data: Timely Prenatal Care, Effective Contraception, Long-Acting Reversible Contraceptives, and Effective Contraception Within 60 Days of Delivery.



Analysis 2: Pregnant Women

Exhibit 8.3 displays changes for our second study population, pregnant women (inclusive of women who delivered during the measurement period). We observed no statistically significant differences between the group of ACHs who participated in 3B and those who did not participate.

In the Data Appendix, Table 5 displays results for pregnant women in specific ACH regions participating in Project 3B. In the Cascade Pacific Action Alliance region, all-cause ED visits and substance use disorder treatment penetration declined among pregnant women relative to non-participating ACHs. North Sound ACH exhibited an increase in rates of contraceptive care (most and moderately effective methods). None of the estimates for the other ACHs were statistically significant.

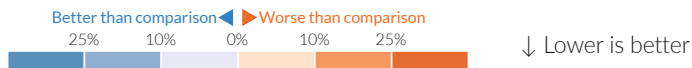
Exhibit 8.3: Change in Outcomes for Pregnant Women

Pre-post rates for participating ACHs, pre-post rates for comparison ACHs, and adjusted difference-in-differences estimates

	Participating ACHs		Comparison ACHs		Difference in Differences
	Pre	Post	Pre	Post	
Timely Prenatal Care	85.8	86.0	86.0	86.1	-0.1
Effective Contraception	35.1	38.2	37.6	37.2	2.9
Long-Acting Reversible Contraceptives	11.7	11.4	15.1	12.7	2.1
Effective Contraception within 60 Days of Delivery	33.4	33.7	36.2	35.6	0.4
Chlamydia Screening for Women	73.0	73.9	74.5	76.1	-0.8
Mental Health Treatment Penetration	48.0	48.7	45.7	45.9	-1.5
30-Day Hospital Readmission for a Psychiatric Condition ↓	1.7	6.4	6.2	9.7	-14.3
Emergency Department Visit Rate ↓	116.0	116.8	120.9	123.1	-2.8
Acute Hospital Use among Adults ↓	50.3	53.2	47.4	47.6	1.6
Hospital Readmission within 30 Days ↓	3.0	3.1	4.3	4.1	-0.1
Substance Use Disorder Treatment Penetration	37.9	39.2	32.3	33.6	-1.7

Shaded cells indicate a statistically significant difference between ACHs that did and did not participate in the ACH Health Improvement Project. **Blue**-shaded cells indicate that participating ACHs improved more than comparison ACHs. **Orange**-shaded cells indicate participating ACHs performed worse than comparison ACHs. Results marked * are significant at the p<.05 level. Results marked ** are significant at the p<.01 level. Results marked *** are significant at the p<.001 level.

Note: 1) The following measures are reported on a State Fiscal Year basis of July to June rather than January to December due to the availability of data: Timely Prenatal Care, Effective Contraception, Long-Acting Reversible Contraceptives, and Effective Contraception Within 60 Days of Delivery.



Conclusions

Generally, our evaluation of Project 3B found limited evidence that this project had meaningfully advanced into an implementation phase by the end of 2019, which was partly attributed to community misperceptions that maternal and reproductive health care offered fewer opportunities to impact performance measures or Medicaid program costs relative to initiatives focused on chronic disease or SUD.

Consistent with this finding, we also see few differences for our two study populations when comparing ACH regions participating in this project to other ACH regions. Relative declines in mental health treatment penetration and substance use treatment penetration among women of reproductive age in participating ACH regions should continue to be monitored, although these changes are small in magnitude and reflect slower improvement rather than absolute declines in ACHs participating in the initiative compared to corresponding increases in ACHs not participating in the initiative.

We note one limitation of this analysis: We were only able to observe measures of contraceptive access midway through 2019 (six months after the beginning of the Project 3B implementation phase) due to the availability of data for some measures. A longer observation period is warranted before drawing conclusions about the impact of Project 3B on contraceptive access.

The final MTP evaluation report will present opportunities to examine Project 3B outcomes through 2020, a later point in MTP implementation when changes between participating and non-participating ACH regions may be more apparent.

Health Improvement Project 3C

This chapter presents results of the interim evaluation of MTP Initiative 1 Health Improvement Project 3C, “Access to Oral Health Services.”

We first provide background and an overview of how the MTP approach was intended to transform care in this area. We present a description of this project’s implementation through 2019, including observations from key informant interviews and reviews of program documents collected during this period. We then present the results of an analysis of health care claims to compare whether and how health outcomes changed for target populations under this initiative.

Background

Medicaid is the predominant means for providing dental insurance coverage for families and people with limited financial resources, a group that has traditionally received substantially less dental care than the rest of the population (U.S. Government Accountability Office, 2000; Haley, Kenney and Pelletier, 2016).

Dental disease is highly prevalent among people with lower incomes. According to the U.S. General Accounting Office Oral Health Report (U.S. General Accounting Office, 2000) about 48 percent of low-income adults had untreated caries (cavities), compared to 18 percent of adults with higher incomes. A similar pattern is prevalent in children (Dye, et al., 2007).

Unfortunately, dental insurance does not necessarily translate to access to oral health services. Medicaid beneficiaries have routinely faced difficulties obtaining recommended care (Soni, 2011). For example, nationally, almost two-thirds of children on Medicaid receive no annual dental services (U.S. Government Accountability Office, 2010). One barrier to access is the capacity and ability of the dental workforce to meet the demand for dental care. Historically, low reimbursement rates have affected dentist participation in Medicaid (U.S. Government Accountability Office, 2012; Warner and Edelstein; 2017).

Oral health integration is one strategy for improving access. Integration may provide an opportunity for people who are reluctant to visit a traditional dentist office to obtain some oral health services in the primary care setting; many people make visits to their primary care physician in the course of a year but do not visit a dentist. Access may also be improved by bringing dental services into the community through non-traditional approaches.

MTP Approach to Change

Within MTP Initiative 1, Project 3C was an optional project for ACHs. ACHs that participated in Project 3C were expected to select evidence-based approaches from the Project Toolkit that included 1) integrating oral health referral into primary care settings and 2) the creation of mobile dental units to improve access to care.

The Project Toolkit suggested a phased approach to planning to integrate oral health into primary care services, beginning with preventive screening of patients in primary care settings, identification of people at high risk, and development of structured referral processes for dentistry. Additional elements of integration included the provision of fluoride varnish for pediatric patients and high-risk adults in primary care settings, and the establishment of clinical guidelines that incorporated **five elements of oral health delivery**:

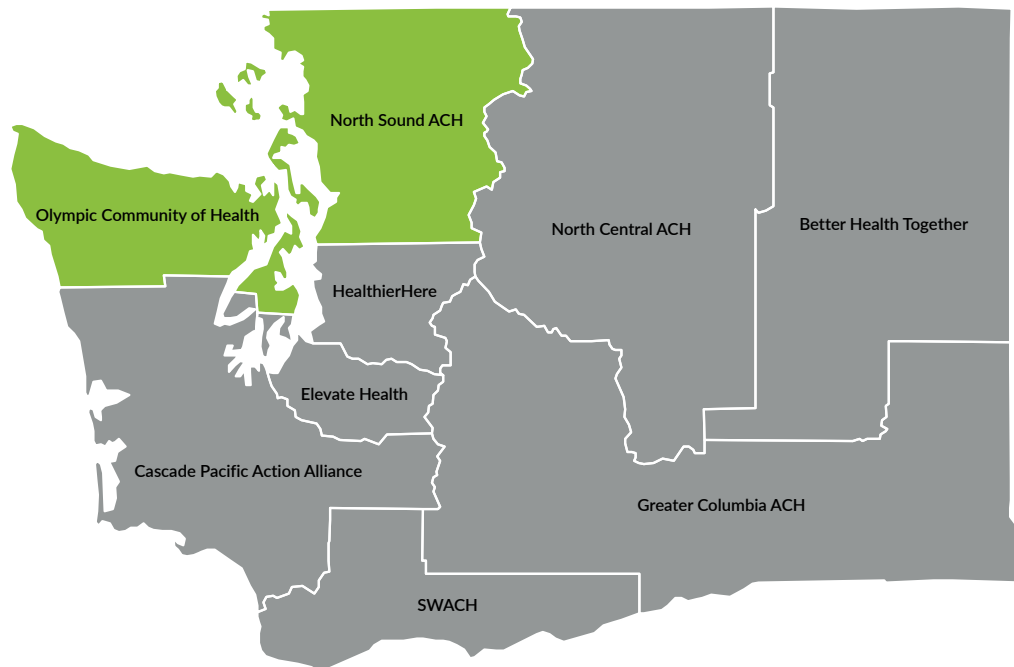
- A written or verbal assessment of symptoms that might indicate risk of oral disease;
- A clinical assessment of signs that might indicate oral health risk or disease;
- Determining the needed response;
- Acting by delivering preventive interventions or appropriate referral;
- Documenting findings in structured data so that quality can be managed.

ACHs implementing mobile dental services could begin with the National Maternal and Child Health Resource Center, which provided a manual to guide the planning and implementation of mobile dental units and portable dental care equipment. ACHs were expected to identify potential locations for mobile dental units in areas where Medicaid beneficiaries access housing, transportation, or other community-based supports, as well as locating potential sites serving rural communities, migrant worker locations, and Native American reservations. Implementation also required the securing of necessary permits and licenses required by the state or locality and the establishment of referral relationships with primary care providers, dental providers, and other specialists as needed.

ACHs Participating in Project 3C

Two ACHs – North Sound ACH and Olympic Community of Health – selected Project 3C (see Exhibit 9.1). Some ACHs did not select this project, but still reported implementing oral health strategies in the context of other MTP projects, or supporting other regional oral health efforts. These types of activities were reported by Better Health Together, Cascade Pacific Action Alliance, Elevate Health, and Greater Columbia ACH.

Exhibit 9.1: ACHs Participating in Project 3C, Access to Oral Health Services



Project 3C Implementation

Key informant interviews and publicly available documents indicated that **ACHs supported the following oral health strategies** for Project 3C in 2019:

- **Technical assistance to integrate oral health preventive services into primary care.** ACHs provided assistance in implementing screenings in primary care settings to identify people at high risk for oral disease. They also provided training in the provision of preventive oral health services such as fluoride, varnishing, or sealants in primary care settings. Participating ACHs helped partners establish referral systems from primary care to dental providers through communication agreements or expanded health information technology (HIT) infrastructure. ACHs also trained partners to use Dentist Link. This free service connected patients to dentists based on need, location, and insurance status.
- **Establishing partnerships to offer mobile school-based care.** ACHs connected education service districts and oral health provider partners in order to increase children's access to preventive oral health care through school programs. The strategy also targeted children living in rural areas with limited or no access to oral health services.
- **Support for building a dental health aide therapist (DHAT) workforce on Native American reservations.** Although not fully implemented, ACHs had begun to explore opportunities for technical assistance to regional Tribes to offer DHATs on reservations.

By late 2019, ACH partners focused on identifying high-risk populations for oral disease through screenings implemented in primary care and behavioral health settings. ACH partners also established local communication agreements across organizations or through shared electronic health records to coordinate care between primary and dental care providers. In Olympic Community

of Health, medical assistants were trained to provide preventive care, including fluoride varnishing. In North Sound ACH, project partners began making patient and client referrals to dental care providers using Dentist Link. Partners in both regions launched mobile dental services and established schedules for dental hygienists to visit school settings.

Factors That Facilitated Project 3C Implementation

Two factors may have facilitated ACHs implementation of Project 3C.

- **Work to promote oral health was already underway before MTP** in the North Sound ACH region, particularly within Federally Qualified Health Centers. North Sound ACH designed its Project 3C activities to complement, leverage, and expand this work. North Sound ACH also absorbed a regional Baby and Child Dentistry program established by its backbone organization, Whatcom Alliance for Health Advancement. This program coordinated the region's school-based oral health project.
- **Project 3C work was supported by funding and planning efforts from Arcora Foundation**, which provided additional start-up funds and technical assistance to 3C project partners. These funds supported medical-dental integration, including practice coaches who trained medical assistants to provide fluoride treatments, oral health education, and referrals to dental care, as needed. Dentist Link, the program used for oral health care referrals by ACH partners, was also funded and operated by the Arcora Foundation. Some ACHs that did not participate in Project 3C (e.g., Better Health Together, Cascade Pacific Action Alliance, and Elevate Health) also worked with the Arcora Foundation to improve dental care in their regions.

Factors That Impeded Project 3C Implementation

Two factors may have impeded implementation of Project 3C.

- **Stakeholders reported that patients were deferring dental care, sometimes due to difficulties scheduling and attending dental appointments.** Delaying or deferring care may have been particularly common for non-emergency dental care.
- **Medicaid was not widely accepted by dentists in some regions.** Stakeholders reported that many dentists operated private practices and had historically not accepted insurance payments for dental care. A lack of provider willingness to accept Medicaid may have limited the potential reach of ACHs' oral health strategies for its target populations.

Evaluation Approach

Health Improvement Project 3C was an optional project for ACHs, which allowed us to compare outcomes of Medicaid enrollees in ACHs that participated in this project to those that did not. Our evaluation used a difference-in-differences approach to compare changes in health outcomes for these two groups from a pre-intervention period (2017 and 2018) to a post-intervention period (2019).

We adjusted for regional differences in Medicaid enrollees' age, gender, race/ethnicity, urban vs. rural residence, and Chronic Illness and Disability Payment System (CDPS) risk score. See Appendix B for methodological details. Our model tests for changes among the ACHs who selected this particular HIP. Activities in other non-participating ACH regions such as the introduction of a similar program, or other interventions that drive changes in our target populations, may bias our results toward the null.

Target Populations

Our analysis of Project 3C focused on **two populations** that were described by ACHs as intended beneficiaries of their 3C efforts:

- 1 All Medicaid beneficiaries, and
- 2 Pregnant women.

Our selection of the first population for this analysis reflected efforts to improve the oral health of the Medicaid population as a whole.

Our second population, pregnant women, was selected because poor oral health may adversely affect pregnant women and their babies (Radnai, et al., 2006; Xiong, et al., 2006; Albert, et al., 2011). Pregnant women and women of reproductive age were identified as priority populations for ACHs participating in this project. Using indicators provided by Washington State's Department of Social and Health Services, we selected all enrollees who were pregnant and delivered in the second, third, or fourth quarter, or who were pregnant in the second or third quarter and remained pregnant until the end of the measurement period.

Interim Evaluation Results

Results of our evaluation of Health Improvement Project 3C, "Oral Health Access," are presented below. We first present outcomes for all Medicaid beneficiaries, followed by results for pregnant women. *See page 21 of this report for a guide to reading results.*

How are these results impacted by COVID-19?

The COVID-19 outbreak began in Washington State in early 2020, causing widespread disruption to health services delivery across the state. This report presents an analysis of claims data through December 2019, prior to the outbreak. It is therefore unlikely that COVID-19 had any effect on measures presented in this report, though future reporting periods may be affected.

Analysis 1: All Medicaid-enrolled beneficiaries

Exhibit 9.2 displays changes for each metric in the two ACHs that chose 3C as a focus area. The use of dental services increased in these ACHs by 1 percent relative to comparison ACHs. In contrast, use of topical fluoride decreased at a greater rate among these two ACHs, although the decrease was relatively small (0.4 percent). Other measures, including periodontal evaluation and emergency department and hospital utilization, remained unchanged.

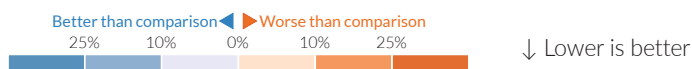
In the Data Appendix, Table 5 displays ACH-level results for all Medicaid-enrolled beneficiaries in the two regions participating in Project 3C. Both ACHs exhibited relative increases in the utilization of dental services, and Olympic Community of Health increased its rate of periodontal evaluation in adults with chronic periodontitis. North Sound ACH experienced a small but significant decrease in the use of topical fluoride. Across ACH regions, these findings suggest that access to dental health services modestly improved in 3C-participating regions relative to other ACH regions.

Exhibit 9.2: Change in Outcomes for All Medicaid Beneficiaries

Pre-post rates for participating ACHs, pre-post rates for comparison ACHs, and adjusted difference-in-differences estimates

	Participating ACHs		Comparison ACHs		Difference in Differences
	Pre	Post	Pre	Post	
Preventive or Restorative Dental Services	44.8	46.6	47.9	48.5	1.1***
Topical Fluoride at a Medical Visit	3.4	3.2	4.7	4.8	-0.4**
Periodontal Exam for Adults	52.9	53.6	50.2	50.4	0.4
Emergency Department Visit Rate ↓	47.4	47.6	50.6	51.4	-0.7
Acute Hospital Use among Adults ↓	55.9	57.1	59.4	59.7	0.4

Shaded cells indicate a statistically significant difference between ACHs that did and did not participate in the ACH Health Improvement Project. **Blue**-shaded cells indicate that participating ACHs improved more than comparison ACHs. **Orange**-shaded cells indicate participating ACHs performed worse than comparison ACHs. Results marked * are significant at the p<.05 level. Results marked ** are significant at the p<.01 level. Results marked *** are significant at the p<.001 level.



Analysis 2: Pregnant Women

Exhibit 9.3 (next page) displays changes for each metric across each state for our second study population, pregnant women. Among the two ACHs participating in this project, the percentage of pregnant women with chronic periodontitis who received periodontal evaluation improved relative to non-participating ACHs, although this was not significant. Other measures did not exhibit statistically significant changes.

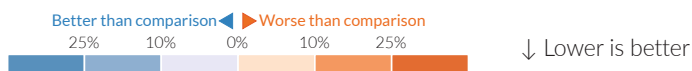
The Data Appendix Table 5 presents results for pregnant women in the two ACH regions participating in Project 3C. We did not observe statistically significant changes for individual ACHs in this target population for these measures.

Exhibit 9.3: Change in Outcomes for Pregnant Women

Pre-post rates for participating ACHs, pre-post rates for comparison ACHs, and adjusted difference-in-differences estimates

	Participating ACHs		Comparison ACHs		Difference in Differences
	Pre	Post	Pre	Post	
Preventive or Restorative Dental Services	38.7	40.7	40.1	40.3	1.4
Topical Fluoride at a Medical Visit	NA	NA	NA	NA	NA
Periodontal Exam for Adults	62.3	67.4	61.9	61.1	5.9
Emergency Department Visit Rate ↓	111.9	116.4	121.2	122.4	2.7
Acute Hospital Use among Adults ↓	47.9	55.6	48.4	47.9	7.1

Shaded cells indicate a statistically significant difference between ACHs that did and did not participate in the ACH Health Improvement Project. **Blue**-shaded cells indicate that participating ACHs improved more than comparison ACHs. **Orange**-shaded cells indicate participating ACHs performed worse than comparison ACHs. Results marked * are significant at the p<.05 level. Results marked ** are significant at the p<.01 level. Results marked *** are significant at the p<.001 level.



Conclusions

In the two ACHs that chose Project 3C, we observed a small increase in utilization of dental services relative to the comparison ACHs. In Olympic Community of Health there was a significant increase in periodontal evaluation in adults with chronic periodontitis. These findings suggest some improvement in the first year of implementation, though this was not consistent across all quality measures (particularly for topical fluoride, which appeared to decrease in North Sound ACH), and we did not observe significant changes in the target population of pregnant women.

While our analysis suggested improvements in access to dental care among participating ACHs, the changes might be seen as moderate. Several reasons might explain why changes were not stronger. First, as with most of the health improvement projects, change was initiated in 2019 and we may not expect to see substantive impacts across large population groups within the first implementation year.

Second, although the analysis focuses on two ACHs who officially selected Project 3C as an area of focus, the comparison group is imperfect. Qualitative data revealed that other ACHs also made efforts to improve oral health, even if they did not officially adopt this health improvement project. Thus, our difference-in-differences estimates may be biased toward the null.

The final MTP evaluation report will present opportunities to examine outcomes through 2020, a later point in MTP implementation, which may reveal more substantial differences emerging among participating ACHs.

Health Improvement Project 3D

This chapter presents the results of the interim evaluation of MTP Initiative 1 Health Improvement Project 3D, “Chronic Disease Prevention and Control.”

We first provide background and an overview of how the MTP approach was intended to transform care in this area. We present a description of this project’s implementation through 2019, including observations from key informant interviews and reviews of program documents collected during this period. We then present results of an analysis of health care claims to compare whether and how outcomes changed for target populations under this initiative.

Background

Approximately 60 percent of Americans have at least one chronic condition, and 42 percent have multiple chronic conditions (Buttorff, Ruder and Bauman, 2017). Uncontrolled chronic disease is the leading cause of avoidable hospitalizations, driving an estimated 498,000 preventable adult inpatient stays and more than \$4.9 billion in avoidable costs within Medicaid in 2017 (McDermott and Jiang, 2017).

To address chronic conditions, health systems need to adopt multidisciplinary services, care coordination, and population health management strategies. Advances in health information technology can be leveraged to screen and identify people at high risk of new chronic disease and monitor them over time (Andrieni, 2016). Interventions that prevent and treat chronic disease may also help control the cost of care by reducing avoidable hospitalization and emergency department visits.

There are a variety of interventions that can improve outcomes for patients with chronic conditions. For example, self-management support provides patients with educations and an array of activities they can engage in to effectively manage their health on a day-to-day basis. These programs have been associated with significant improvements in patient outcomes, particularly for patients with diabetes or hypertension (Reynolds, et al., 2018). A variety of other approaches – including delivery system redesigns and decision supports – have been widely tested and have been associated with improved outcomes; however, success often depends on the specifics of the implementation and may be limited to a narrow of conditions or outcomes (Reynolds, et al., 2018).

MTP Approach to Change

Within MTP Initiative 1, Project 3D was an optional project. The Project Toolkit identified the Chronic Care Model (MacColl Institute for Healthcare Innovation, 1998) as the primary evidence-based model ACHs should draw from when working in this area. The Project Toolkit further outlined **several change strategies** for ACHs to consider:

- **Self-management support strategies**, such as patient motivational interviewing, action plans, chronic disease education, and home monitoring, to equip people to monitor and manage their chronic conditions;
- **Delivery system redesign strategies** to promote interdisciplinary, team-based care and enhance care planning and care management activities;
- **Decision support strategies**, such as the development of new workflows or clinical guidelines, training on evidence-based practices, or access to new tools such as guidelines and prompts embedded within electronic health record systems;
- **Clinical information systems strategies** to facilitate population health management, including tools such as automated reminders, patient registries, information exchanges, and reports;
- **Community-based strategies**, such as community paramedicine, local collaborations on tobacco cessation, food access, and physical activity; and
- **Health care organization strategies**, including quality improvement processes, leadership engagement, and financial alignment of payments and performance.

ACHs Participating in Project 3D

Although Project 3D was an optional project within the toolkit, **all nine ACHs** elected to participate. ACHs participating in Project 3D were required to outline strategies, identify and engage partners through contracts, provide technical assistance, and train and monitor partners' efforts over time.

Project 3D Implementation

Key informant interviews and publicly available documents indicate **the following activities were employed by ACHs** in 2019 to support their implementation of Project 3D:

- **Behavior-focused self-management strategies.** Self-management programs ACHs primarily chose to focus on were Chronic Disease Self-Management (Cascade Pacific Action Alliance, Greater Columbia ACH, North Sound ACH, SWACH) and the Diabetes Prevention Program (Cascade Pacific Action Alliance, Greater Columbia ACH, HealthierHere, North Sound ACH, Olympic Community of Health, SWACH). These peer-led, community-based strategies supported ongoing education and behavior change for people with chronic disease. ACHs worked to increase primary care and behavioral health partners' knowledge of these programs to increase patient referral rates from clinical settings.
- **Technical support for adopting the Chronic Care Model.** Several ACHs (Cascade Pacific Action Alliance, Better Health Together, HealthierHere, and Olympic Community of Health) provided support to adopt the Chronic Care Model. Their efforts included educating clinical partners on the model during learning collaboratives, encouraging adoption of some or all model components appropriate for a given partner's capacity for change or clinical environment, and assisting with the development of quality improvement processes.

- **Training support for community paramedical technicians.** Five ACHs (Cascade Pacific Action Alliance, Elevate Health, Greater Columbia ACH, North Sound ACH, Olympic Community of Health) helped to establish training for paramedics and emergency medical technicians to operate in expanded community paramedicine roles. These roles were reimagined to better address the needs of people who frequently used emergency services, including those with chronic health conditions.
- **Technical support for disease-specific interventions.** Less commonly adopted project strategies included two disease-specific interventions: the Diabetes Self-Management Program (North Sound ACH) and Million Hearts Campaign (Cascade Pacific Action Alliance, HealthierHere).

Progress Toward Chronic Disease Prevention and Control

In 2019, Project 3D partners made progress toward implementing screenings for chronic conditions in behavioral health settings and increasing the use of registries in primary care settings to identify and track patients with chronic conditions. Primary care partners increased referrals to community-based programs, including the Diabetes Prevention Program, Chronic Disease Self-Management, and Diabetes Self-Management Support. With technical assistance from their ACHs, health systems and universities in some regions began to implement training programs to expand the workforce needed for these community-based programs.

Key informant interviews revealed momentum surrounding the Community Paramedicine Program. However, implementation required partnerships with fire and rescue departments. ACHs had varying success establishing these partnerships, which led to county-level variability in Project 3D progress.

Factors That Facilitated Implementation of 3D

Two factors may have facilitated the implementation of Project 3D.

- **Project 3D included several metrics and toolkit strategies that aligned with other project areas.** Partners took advantage of opportunities to align efforts for 3D with other projects, identifying shared target populations or implementing shared strategies. ACHs also leveraged other projects' health information exchange work to support Project 3D. For example, the Pathways Care Coordination System (CSS) from Project 2B was also used to coordinate care for patients with chronic conditions.
- **ACHs supported cross-sector collaboration for Project 3D through learning collaboratives and workgroups** that educated and convened primary care, behavioral health, and substance use providers. These learning collaboratives included education and discussion of opioid use disorder as a chronic disease, chronic disease management in behavioral health settings, and diabetes and mental health.

Factors That Impeded Implementation of 3D

Three factors were identified as possibly having hindered the implementation of Project 3D.

- **Two Project 3D strategies were reliant on workforce development**, including 1) community-based self-management programs, which were led by certified peer trainers, and 2) Community Paramedicine, which required the development of new skill sets in the existing workforce. Workforce shortages, particularly in rural areas, limited the potential of such programs in some regions.

- **While ACHs promoted self-management programs through partnering clinics, regional care coordination HUBs (see Project 2B), and social marketing, the success of self-management programs hinged on patient participation.** Some programs required substantial time commitment from patients. For example, the Diabetes Prevention Program required a one-year commitment and group participation, introducing the potential for inconvenient scheduling options. ACH informants indicated that patients sometimes registered for self-management classes but did not always attend or complete these courses.
- **Project 3D required health information technology to share patient information across clinical and community-based organizations.** This functionality was not widely available in 2019, which may have limited two-way communication about referrals, monitoring of patient engagement, or measurement of the effectiveness of self-management programs.

Evaluation Approach

All nine ACHs opted to participate in 3D, eliminating potential comparison ACH groups. Thus, we assessed changes in outcomes for all ACHs from a pre-intervention period of 2017 and 2018 to a post-intervention period of 2019. Our regressions adjusted for age, gender, race/ethnicity, urban vs. rural residence, and Chronic Illness & Disability Payment System (CDPS) risk. See Appendix B for methodological details.

Target Populations

Our analysis of Project 3D focused on **two target populations** identified as intended beneficiaries of ACHs' 3D efforts:

- 1 People with any physical chronic condition, and
- 2 People with type 2 diabetes.

For the first population, we selected Medicaid beneficiaries with diagnoses in the prior 24 months for the following conditions: type 2 diabetes, asthma, chronic obstructive pulmonary disease, or cardiovascular disease. We used CMS' Chronic Condition Warehouse (CCW) definitions to identify any claims with this diagnosis code in any care settings. We note that SWACH also included a focus on chronic pain in the population they prioritized for their 3D work, but our analysis did not capture this population.

For our second study population, people with type 2 diabetes, we identified people based on the presence of a CDPS flag for type 2 diabetes within the past 24 months. We focused our analysis on the population with type 2 diabetes because, while there was variation across ACHs in their activities, most ACHs identified this group as the intended beneficiaries of their activities.

Interim Evaluation Results

Results of our evaluation of Health Improvement Project 3D, "Chronic Disease Prevention and Control," are presented below and reflect changes from a baseline period, 2017 and 2018, through 2019. We first present outcomes for people with a chronic health condition. We then present outcomes for people with type 2 diabetes. *See page 21 of this report for a guide to reading results.*

How are these results impacted by COVID-19?

The COVID-19 outbreak began in Washington State in early 2020, causing widespread disruption to health services delivery across the state. This report presents an analysis of claims data through December 2019, prior to the outbreak. It is therefore unlikely that COVID-19 had any effect on measures presented in this report.

Analysis 1: People with Any Physical Chronic Condition

Exhibit 10.1 displays changes for each metric across each region for people with any chronic health condition. Changes in quality measures in this domain were generally mixed. There were significant reductions in measures of acute hospitalization and emergency department utilization. Acute hospitalizations fell by more than 16 visits per 1,000 members from a baseline rate of 176 visits per 1,000 member months. Emergency department use decreased by approximately 3.2 visits per 1,000 member months. There was also a notable improvement (3.6 percent) in adult body mass index screening rate, and a small 1.4 percent change in asthma management (asthma medication ratio). We did not observe significant improvements in measures of diabetes care and management (e.g., eye exams or medical attention for nephropathy) or all-cause readmission rates after a hospitalization.

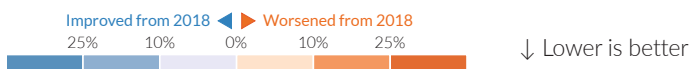
In the Data Appendix, Table 4 displays changes in outcomes across all nine ACHs for people with any chronic health condition. Broadly, trends for individual ACHs were similar to statewide trends. However, we observed some differences; North Central ACH showed the largest improvement in acute hospital use with a decrease of 29 visits per 1,000 members.

Exhibit 10.1: Change in Outcomes for People with Any Physical Chronic Condition

All-ACH rate in 2017-18, all-ACH rate in 2019, and adjusted pre-post change

	2017-18 All ACHs	2019 All ACHs	Pre-post Adjusted Change
Body Mass Index Assessment for Adults	47.6	51.5	3.6***
30-Day Hospital Readmission for a Psychiatric Condition ↓	7.5	8.6	1.9
Controller Medication for Asthma	52.7	54.0	1.4*
Eye Exam for People with Diabetes	47.7	48.3	0.4
Nephropathy Screening for People with Diabetes	89.0	89.1	0.0
Statin Medication for Cardiovascular Disease	83.2	83.5	0.4
Emergency Department Visit Rate ↓	127.3	123.8	-3.2***
Acute Hospital Use among Adults ↓	176.0	163.0	-16.1***
Hospital Readmission within 30 Days ↓	7.3	8.1	0.0

Shaded cells indicate a statistically significant change. Blue-shaded cells indicate an improvement. Orange-shaded cells indicate declining performance. Results marked * are significant at the p<.05 level. Results marked ** are significant at the p<.01 level. Results marked *** are significant at the p<.001 level.



Analysis 2: People with Type 2 Diabetes

Exhibit 10.2 displays statewide changes in measures for people with type 2 diabetes. Generally, we observed small changes across most outcomes for this population. The adult body mass index screening rate increased (3.3 percent). Although the changes were not statistically significant, acute hospitalizations and emergency department utilization worsened slightly. This suggests that decreases in utilization observed in the broader target population occurred among members with chronic conditions other than type 2 diabetes.

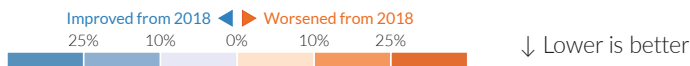
In the Data Appendix, Table 4 displays the change in outcomes for people with type 2 diabetes across the nine ACH regions. Nearly all ACHs exhibited significant improvement in adult body mass index assessments including a 6 percent improvement in one ACH region, Better Health Together. We detected relatively few changes in other metrics, a finding that may be due to the relatively small number of people with this condition in any one individual ACH region.

Exhibit 10.2: Change in Outcomes for People with Type 2 Diabetes

All-ACH rate in 2017-18, all-ACH rate in 2019, and adjusted pre-post change

	2017-18 All ACHs	2019 All ACHs	Pre-post Adjusted Change
Body Mass Index Assessment for Adults	53.9	57.4	3.3***
30-Day Hospital Readmission for a Psychiatric Condition ↓	8.9	10.0	0.2
Controller Medication for Asthma	49.7	51.5	2.0
Eye Exam for People with Diabetes	46.5	46.7	0.1
Nephropathy Screening for People with Diabetes	85.6	85.7	-0.1
Statin Medication for Cardiovascular Disease	87.9	88.3	0.6
Emergency Department Visit Rate ↓	109.6	112.0	2.4
Acute Hospital Use among Adults ↓	185.8	188.6	1.9
Hospital Readmission within 30 Days ↓	8.7	8.8	-0.6

Shaded cells indicate a statistically significant change. Blue-shaded cells indicate an improvement. Orange-shaded cells indicate declining performance. Results marked * are significant at the p<.05 level. Results marked ** are significant at the p<.01 level. Results marked *** are significant at the p<.001 level.



Conclusions

Our findings suggest relatively modest changes in most measures across most ACHs in Project 3D. However, a notable drop in acute hospitalizations and emergency department utilization for people with chronic conditions is promising. Most outcomes associated with management of a specific chronic disease, such as medical attention for nephropathy for patients with diabetes, showed no significant movement.

There are two potential explanations for these findings. First, as with most health improvement projects, the majority of implementation activities for Project 3D began in 2019, and we may not expect to see substantive changes across population groups within the first implementation year. Second, our analysis looks at the population broadly. Some ACHs and partner organizations may have made substantial changes to improve outcomes for their specific patients, and these changes may be washed out in our analysis focusing on the broad population.

The final MTP evaluation report will span the years 2017 through 2020, presenting opportunities to examine outcomes at a later point in implementation. Key factors for examination will include the maturation of ACHs' strategies for specific chronic conditions, and the degree to which these strategies are reflected in measures of disease management.

MTP Initiative 2

Medicaid Alternative Care and Tailored Supports for Older Adults

This section presents an evaluation of the Washington Medicaid Transformation Project Initiative 2 – Long-Term Services and Supports (LTSS). Initiative 2 consists of two programs, **Medicaid Alternative Care** (MAC) and **Tailored Supports for Older Adults** (TSOA), both of which provide support to older adults and their family caregivers. Section 2 includes the following chapters:

- **Chapter 11** presents findings from surveys and key informant interviews related to MAC/TSOA implementation and program participants' satisfaction with the programs.
- **Chapter 12** presents a comparison of health care utilization and health outcomes in older adults who received MAC/TSOA services versus in-home services (traditional Medicaid LTSS).

KEY FINDINGS

Our evaluation of MTP Initiative 2 found the following:

- *Enrollment in MAC and TSOA has been slow to ramp up in the early years of the programs. There appears to be more interest in TSOA than in MAC.*
- *Satisfaction with both programs was high among care recipients and caregivers alike. Participants reported that the program contributed to independence and was beneficial to physical and mental health.*
- *Early evidence suggests that MAC participants had fewer adverse health outcomes following enrollment. These changes were comparable to results for traditional in-home service users.*
- *Only a small proportion of MAC and TSOA participants used traditional LTSS within six months of MAC and TSOA enrollment, suggesting that both programs delayed the utilization of traditional LTSS.*

Recommendations

- 1 Additional outreach efforts may be needed for the MAC and TSOA programs to reach people who could potentially benefit from these programs, given low enrollment observed in the programs' early years.**
- 2 Ensure benefit packages are clearly understood across MAC, TSOA and traditional long term services and supports so that participants can choose benefits that best meet their needs.** The similarity in eligibility criteria for both programs creates a disincentive for participants to select the MAC program's less intensive level of services.
- 3 The state should explore options to improve service scheduling and communication between MAC and TSOA program participants and service providers.** Despite overall satisfaction with MAC and TSOA programs, multiple program participants reported concerns in these areas.

The Interim Evaluation Report focuses on health care use and outcomes of MAC and TSOA program participants. The Final Evaluation Report will expand these analyses to provide additional information about MTP Initiative 2, including:

- Changes in health care costs (including LTSS and acute care costs) for MAC and TSOA program participants;
- Forecasts of LTSS costs, in addition to use, through 2030; and
- Assessment of how program participation shifted during the COVID-19 outbreak in 2020.

Tailored Supports for Older Adults and Medicaid Alternative Care

Washington State's population is aging; the state will be home to more than 1.8 million people age 65 and older by 2040. State estimates suggest that one-fifth of these adults may experience difficulty or need assistance with activities of daily living (Washington State Health Care Authority, 2017b). The majority of long-term care for people in Washington is provided by unpaid family caregivers. These caregivers may experience high rates of mental or physical stress related to their caregiving roles.

State Medicaid programs are required to cover nursing facility care, and have the option to also cover home and community-based services (assisted living, adult family home, adult residential care, in-home services, and other types of services) through Medicaid waivers and amendments to their Medicaid state plans. To become eligible for these Long-Term Services and Supports (LTSS), older adults must demonstrate both financial and functional eligibility. Individuals whose assets and incomes fall below the threshold are eligible for LTSS through Medicaid. Individuals with incomes and assets above the threshold may still receive LTSS; the participant is responsible for a portion of their participation costs based on their income, while the state pays the remainder. In these cases, the state may seek to recover its portion of costs from an individual's estate following that person's death (i.e., estate recovery) (Centers for Medicare and Medicaid Services, 2020b).

Washington State has a history of promoting use of home and community-based services (HCBS) as an alternative to more intensive and costly forms of LTSS. In 2016, HCBS spending accounted for 68 percent of Washington State's Medicaid LTSS spending, compared to a national average of 57 percent (Eiken, et al., n.d.). The State of Washington has also focused on supporting unpaid family caregivers, an essential workforce in long-term care. For example, in 2000, the state established the Family Caregiver Support Program to fund a range of services and supports for unpaid caregivers. An evaluation of the program by the Washington State Institute for Public Policy showed an estimated savings of \$1.67 million in the program's first year (Miller, 2012).









MTP Initiative 2 Approach to Change

Building on the promising results from its Family Caregiver Support Program, Washington State's Medicaid Transformation Project created two alternatives to traditional LTSS for older adults and their caregivers. The Tailored Supports for Older Adults (TSOA) and Medicaid Alternative Care (MAC) programs, created in September 2017, provide supportive services for informal caregivers of people who need LTSS but are not yet using traditional Medicaid-paid LTSS (see Exhibit 11.1). These supportive services include caregiver training and education, counseling on adapting to the role of a caregiver, and respite care or home-delivered meals to relieve caregiver burden. In addition to providing support to older adults and their informal caregivers, the TSOA program is also available to people without an informal caregiver and who are not yet using Medicaid-paid LTSS. Eligibility is reassessed every six months.

Unlike traditional LTSS, neither MAC nor TSOA require participation costs or potential estate recovery from beneficiaries. The goal of the TSOA and MAC program is to provide a limited set of supportive services for people with functional limitations and their unpaid caregivers in order to delay or avoid the need for more intensive and costly Medicaid-funded LTSS. Specifically:

- **Medicaid Alternative Care (MAC)** is intended for people who are already financially eligible for or enrolled in Medicaid.
- **Tailored Supports for Older Adults (TSOA)** is intended for people who, despite having a functional need for services, do not meet the financial qualifications for LTSS despite being at risk of impoverishment.

Exhibit 11.1: Who Is Eligible for MAC and TSOA?

Tailored Supports for Older Adults (TSOA)	Medicaid Alternative Care (MAC)
<p>AGE 55+</p> 	<p>AGE 55+</p> 
<p>Eligible for nursing facility care</p> 	<p>Eligible for nursing facility care</p> 
<p>Not yet eligible for Medicaid, but at risk due to depletion of assets</p> 	<p>Eligible for Medicaid</p> 
<p>Client may or may not have an informal (unpaid) caregiver</p> 	<p>Client has an informal (unpaid) caregiver</p> 

The services available to MAC and TSOA beneficiaries are similar. Exhibit 11.2 describes the types of supportive services provided by TSOA and MAC.

Exhibit 11.2. Types, Recipients, and Dollar Limits of MAC and TSOA Services

	MAC	TSOA
TYPE OF SUPPORTIVE SERVICES PROVIDED	<ul style="list-style-type: none"> • Caregiver assistance services including help with housework, errands, or yardwork; respite care; home-delivered meals; or minor home repairs. • Training and education to help caregivers gain skills and knowledge through support groups, consultation, or group trainings. • Specialized medical equipment and supplies (e.g., assistive technology, emergency response systems, or durable medical equipment). • Health maintenance and therapy supports, including adult day centers, exercise programs, or counseling. 	<ul style="list-style-type: none"> • TSOA provides the same services as are available in MAC. • TSOA also provides Personal Assistance Services to individuals without an informal caregiver. These include, for example, personal care, home-delivered meals, limited transportation, and nursing delegation.
PRIMARY RECIPIENT OF SUPPORTIVE SERVICES	<ul style="list-style-type: none"> • Adult unpaid caregivers of MAC participants 	<ul style="list-style-type: none"> • TSOA participants with adult unpaid caregivers • TSOA participants without unpaid caregivers
DOLLAR LIMIT FOR SUPPORTIVE SERVICES	<ul style="list-style-type: none"> • Step 1: Up to \$250 (lifetime limit) • Step 2: Up to \$500 annually • Step 3: Up to \$4,362 in a six-month period (an average of \$727 per month) 	<ul style="list-style-type: none"> • Step 1: Up to \$250 (lifetime limit) • Step 2: Up to \$500 annually • Step 3: Up to \$4,362 in a six-month period (an average of \$727 per month)

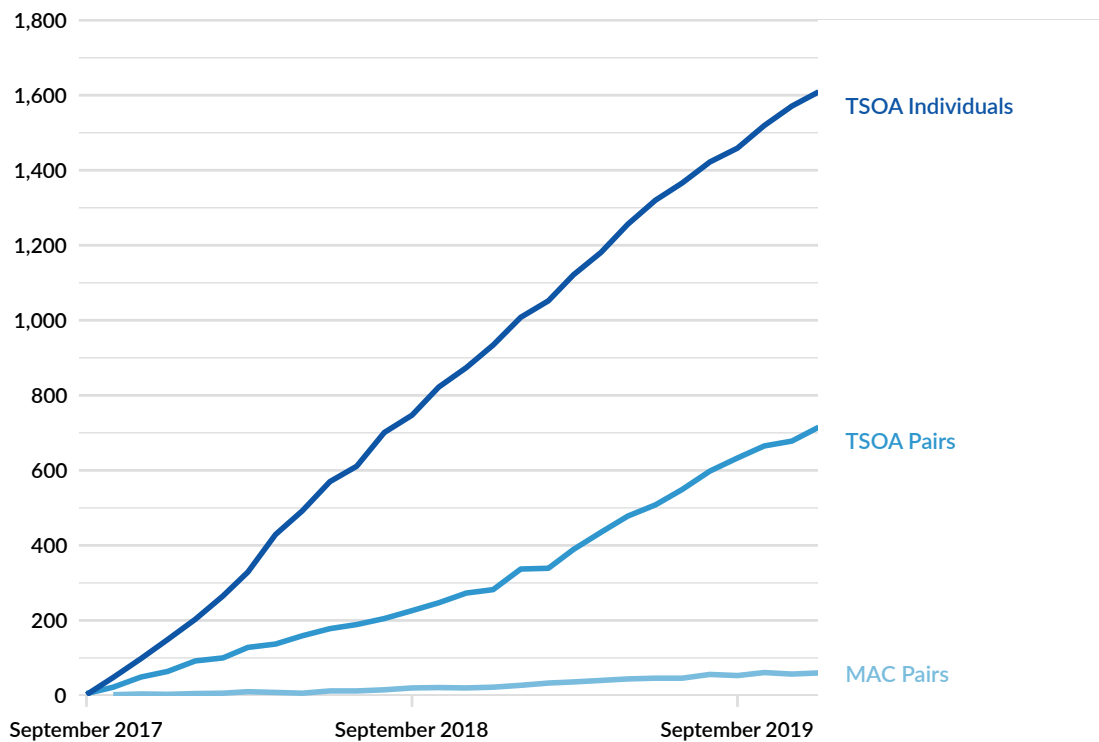
Source: Washington State Health Care Authority, 2017b; Columbia Legal Services, 2017.
 Note: Dollar limits are as of October 2020 and may change in future periods.

Progress Toward Implementing Initiative 2

Enrollment

The MAC and TSOA programs were formally launched in September 2017. Early program documents reflect that Washington State intended to enroll up to 2,500 people in MAC and TSOA in the first year, ramping up to a caseload of 5,000 in year two and 7,500 in year three of the program (Washington State Health Care Authority, 2017b). However, early enrollment in the two programs was lower than these targets, with the two programs enrolling a combined 3,364 people by September 2019. Enrollment in MAC has been lower than anticipated (see Exhibit 11.3).

Exhibit 11.3. Enrollment in TSOA has been substantially higher than enrollment in MAC since the two programs launched.



Source: MAC and TSOA enrollment obtained from Washington State's ProviderOne data system.

Stakeholders reported that MAC enrollment may have been lower than expected because Medicaid beneficiaries were not financially incentivized to enroll in MAC when more intensive LTSS were available without cost through Medicaid in-home services.

In contrast, demand for and enrollment into the TSOA program may have been higher because TSOA provides services prior to a person's impoverishment to help keep people in their homes. People could access services without participation costs or risk of estate recovery they would have otherwise incurred, as this quote illustrates:

I think it's been exciting that we have been able to help people access services that have never been able to access services before. Either they didn't qualify for long-term care, their income is too high or their assets are too high, or they're unable to pay the participation for long-term care. This program has made it possible for people to get services who just haven't been able to access services before. That's probably the most exciting thing. - Participant #167, 2019

Despite higher enrollment in TSOA, informants in 2019 reported challenges reaching family members that filled unpaid care obligations but did not always identify themselves as a caregivers or know that services existed to support them. One informant stated:

We are doing a lot of work right now around dyads, which is the caregiver, care receiver... How do we get them to recognize themselves as caregivers? Who are the right community partners to engage with to help us? [...] That's a heavy lift. It's not like they're out there saying, "I'm a caregiver, so I need help." I just don't think that's something we recognize in our system, because it's not something we typically highlight, that "Hey you might need help too if you're helping somebody else." - Participant #99, 2019

In addition, while stakeholders reported high demand for LTSS across the state, not all applicants who sought services met the eligibility criteria for LTSS. Providers rerouted applicants who did not qualify for LTSS to other resources through a region's network of aging services. One stakeholder noted that while these clients may have ultimately benefited from these referrals to alternative services, these referrals were not reflected in the enrollment numbers for MAC or TSOA:

There has been an unanticipated opportunity to provide even more information and assistance to people looking to access services that may not necessarily be [TSOA or MAC]. What we have found overall is that about one in four to one in five of the referrals that we get for MAC or TSOA actually [enroll in MAC or TSOA]. If they don't [enroll], we help them access other services in our aging network. - Participant #167, 2019

MAC and TSOA Recipient Satisfaction

We next present results from three surveys conducted with individuals enrolled in MAC or TSOA (see Exhibit 11.4). These surveys were designed to measure care recipients' satisfaction with the programs and were administered by the Washington State Department of Social and Health Services in fall 2019.

Exhibit 11.4: Surveys of Care Recipients

Survey	Description
MAC CARE RECIPIENTS	<ul style="list-style-type: none"> This survey was administered to people participating in the MAC program who had an informal caregiver.
TSOA (DYAD) CARE RECIPIENTS	<ul style="list-style-type: none"> This survey was administered to TSOA program participants with an informal caregiver.
TSOA (INDIVIDUAL) CARE RECIPIENTS	<ul style="list-style-type: none"> This survey was administered to targeted TSOA program participants without a caregiver.

Survey responses were tabulated separately for the five surveys conducted. Respondents who indicated they had not yet received services from the MAC or TSOA program were excluded from the analysis related to service satisfaction.

MAC Recipients (those with informal caregivers)

A total of 22 MAC care recipients participated in the MAC Care Recipient Survey. Approximately 60 percent responded that their child or spouse was their main caregiver and 20 percent reported a non-family member as their caregiver.

A substantial portion of MAC care recipients had **significant care needs**. These included:

- Help with at least one activity of daily living (77 percent), such as bathing (50 percent), walking (50 percent), dressing (46 percent), and getting out of bed/chair (36 percent).
- About 23 percent had a fall that caused injuries, or three or more falls, during the last six months.
- About 25 percent reported that they or their family had concerns about their memory, thinking, or ability to make decisions.
- About 18 percent had considered moving to a nursing home or assisted living facility; 36 percent had considered moving to other housing.

MAC care recipients expressed **high satisfaction with the application process**.

- About 85 percent of respondents found it easy to apply for the MAC program.
- All respondents reported that the staff who helped them apply for the program listened to them. Ninety-three percent reported that staff explained things clearly and that they had a say in what kind of services they would receive.

MAC care recipients also expressed **high satisfaction with MAC services provided**.

- Ninety percent responded that the MAC providers treated them with courtesy and respect, 95 percent reported that staff listened to what they said, and 85% reported that staff explained things clearly. Eighty-five percent responded that the MAC program helped them as quickly as they needed.
- About 90 percent of respondents were satisfied with the MAC program. About 75 percent thought the MAC program would help keep them from moving to a nursing home or adult family home.

When asked about the **benefits of the MAC program**, respondents typically mentioned:

- Physical health benefits (e.g., increased hygiene, being able to navigate health issues such as chronic conditions or recovery from accidents that interfered with activities of daily living), and
- Mental health benefits (e.g., receiving support from MAC providers who exhibited kindness and flexibility and were willing to listen and offer companionship).

When asked how the MAC program could be improved, most respondents expressed their satisfaction and did not provide any suggestions for improving the program. Among those who identified opportunities for improvement, two **areas for improvement** emerged:

- **Scheduling and availability of MAC agency providers.** Some respondents had difficulty keeping track of appointments for services or tracking who would be delivering the services once appointments were made. In some cases, these challenges were attributed to communication breakdowns with MAC providers. In other cases, challenges were framed as requests for additional program resources such as providing calendars or appointment reminders. Other respondents described that they could use additional hours of support beyond what they or their family members received from the MAC program.
- **Continuity of service providers over time.** Some respondents described that it was challenging to receive MAC services from different MAC providers over time, because respondents had to repeat information about their needs when a new provider was engaged. Lack of continuity in MAC providers made it more difficult to receive help in specific areas, including tracking appointments or medications over time.

TSOA Recipients (those with informal caregivers)

A total of 218 TSOA care recipients participated in the TSOA Dyad Care Recipient Survey. Approximately 70 percent responded that a child or spouse was their main caregiver.

A substantial portion of TSOA program participants with a caregiver had **significant care needs**.

- Most TSOA participants needed help with at least one activity of daily living (77 percent), such as bathing (44 percent), walking (66 percent), and getting out of bed/chair (29 percent).
- About 30 percent had a fall that caused injuries, or three or more falls, during the last six months.
- About 40 percent reported that they or their family had concerns about their memory, thinking, or ability to make decisions.
- About 20 percent had considered moving to a nursing home or assisted living facility, and 33% had considered moving to other housing.

TSOA participants with a caregiver expressed **high satisfaction with the TSOA application process**.

- About 80 percent of respondents found it easy to apply for TSOA.
- About 95 percent reported that staff who helped them apply for the program listened to them, approximately 90 percent reported that staff explained things clearly, and 85 percent responded that they had a say in what kind of services they would receive.

TSOA care recipients also expressed **high satisfaction with the TSOA services provided**.

- Almost 100 percent responded that the TSOA providers treated them with courtesy and respect, 95 percent reported that staff listened to what they said, and 92 percent reported that the staff explained things clearly.
- Most TSOA participants (85 percent) responded that the TSOA program helped them as quickly as they needed.
- About 90% of respondents were satisfied with the TSOA program and 86 percent thought the TSOA program would help keep them from moving to a nursing home or adult family home.

When asked about the **benefits of the TSOA program**, respondents typically mentioned the following:

- **Service benefits.** Respondents described appreciating the support TSOA providers provided in the home, including making meals, household chores, cleaning, and general organization.
- **Caregiver attributes.** Respondents commented on the general “feel-good” experience they had with their caregivers and the flexibility of the caregivers’ skills. They reported that what TSOA providers did on a week-to-week basis was an incredibly valuable aspect of the TSOA program. Respondents used words like “dependable,” “cooperative,” “patient,” and “generous” to describe their TSOA providers. Many respondents compared their relationships with TSOA providers to that of a family member.
- **Other benefits.** Respondents reported that the TSOA program generally helped them in many facets of their lives. Some reported how the TSOA program allowed them the option to stay in their home.

When asked how the TSOA program could be improved, more than half (57 percent) of respondents did not provide any suggestions for improving the program. **Opportunities for TSOA program improvement included:**

- **Scheduling.** Respondents wanted more time with TSOA providers or for the program to send a substitute when assigned staff did not show up. Some respondents reported issues with providers showing up late or not showing up at all.
- **Response times.** Respondents wanted the TSOA program agency to have a faster callback-time, particularly when providers could not come.

TSOA Care Recipients (those without informal caregivers)

A total of 325 care recipients participated in the TSOA Individual Care Recipient Survey.

Survey results suggested that a substantial portion of these unpaired **TSOA care recipients had significant care needs.**

- Most TSOA participants needed help with at least one activity of daily living (72 percent), such as bathing (39 percent), walking (59 percent), and getting out of bed/chair (18 percent).
- About 30 percent had a fall that caused injuries during the last six months.
- More than a third (38 percent) reported that they or their family had concerns about their memory, thinking, or ability to make decisions.

Overall, care recipients expressed **high satisfaction with the TSOA application process.**

- About 83 percent of respondents found it easy to apply for the TSOA program.
- About 90 percent reported that staff who helped them apply for the program listened to them and explained things clearly, and 83 percent responded that they had a say in what kind of services they would get.

Care recipients also expressed **high satisfaction with the TSOA services provided.**

- More than 90 percent responded that the TSOA providers treated them with courtesy and respect, listened to what they said, and explained things clearly. Most TSOA participants (80 percent) responded that TSOA helped them as quickly as they needed.
- About 90 percent of respondents were satisfied with the TSOA program and thought the TSOA program would help keep them from moving to a nursing home or adult family home.

Questions asked about the benefits of the TSOA program received positive responses. Care recipients most commonly described these **benefits of the TSOA program:**

- **Service benefits.** TSOA provided assistance with laundry, household chores, and doctor appointments. Because of this, respondents said they were able to stay in their homes. One respondent explained how the service benefits allowed them to stay out of a rehabilitation facility. Another respondent said the service felt personal and met their needs.
- **Caregiver attributes.** Respondents reported feeling they had things in common with their caregivers and their care was a “person-first” experience. Respondents liked that caregivers asked them what they needed and solicited input in how they wanted their care provided. Respondents used words like “trust,” “wonderful,” and “godsend” to describe the bedside manner of their caregivers. Many reported that the caregivers alleviated stress.

When asked how the TSOA program could be improved, approximately half of respondents did not offer any suggestions for improving the program. One area of opportunity for TSOA program improvement included:

- **Scheduling and service hours.** TSOA program participants requested more service hours, more frequent follow-up visits, and more timely communication with the TSOA agency. Some respondents were unsure what options would be available for them after surgery or if their financial situation changed. The TSOA experience could be improved through a more thorough explanation of benefits, including opportunities for surgical post-care help.

We compared these responses in the final survey with those in the interim survey, conducted in the fall of 2018. Most responses did not change in statistically meaningful ways between the interim and final survey, with a few exceptions. One exception included an increase in the percentage of respondents satisfied with the TSOA program, moving from 84 percent to 91 percent.

Caregiver Satisfaction

We next present the results of two surveys conducted with the informal caregivers of individuals enrolled in MAC or TSOA (see Exhibit 11.5). These surveys were designed to understand caregiver satisfaction with the programs. These surveys were also administered by Washington State Department of Social and Health Services in fall 2019.

Exhibit 11.5: Surveys of Caregivers

Survey	Description
MAC CAREGIVERS	• This survey targeted the informal caregivers of MAC program participants.
TSOA CAREGIVERS	• This survey targeted informal caregivers of TSOA program participants.

MAC Caregivers

A total of 24 informal caregivers of MAC enrollees participated in the survey. Survey results suggested that some MAC caregivers had **significant health care needs** of their own, and struggled with the care they provided.

- About 30 percent described their overall physical health as either fair or poor, 17 percent described overall mental or emotional health as fair, and 21 percent felt that their quality of life was fair.
- Consistent with MAC care recipient survey results, many MAC caregivers reported the person they were caring for needed help with at least one activity of daily living (88 percent), including bathing (59 percent), walking (59 percent), getting out of bed/chair (33 percent), and dressing (38 percent); About 20 percent of MAC caregivers reported the person they were taking care of had a fall that caused injuries or three or more falls during the last six months.
- About 67 percent reported that the person they were caring for had a family member or friend who helped them if needed. Approximately 30 percent of respondents felt overwhelmed or stressed because of the care they provided.
- About half of MAC caregivers reported that they or their family had concerns about the memory, thinking, or the ability of the person they were caring for to make decisions.

Overall, MAC caregivers expressed **high satisfaction with the MAC application process**.

- About 85 percent of respondents found it easy to apply for the MAC program.
- All caregivers reported that staff who helped them apply for the program listened to them. Almost 100 percent responded that staff explained things clearly (95 percent), and 80 percent responded that they had a say in the kind of services they would get.

MAC caregivers also expressed **high satisfaction with the MAC services provided**.

- All responded that the MAC providers treated them with courtesy and respect and listened to what they said, 85 percent reported that staff explained things clearly. Three quarters of MAC participants indicated that the MAC program helped them as quickly as they needed.
- Eight-five percent of respondents were satisfied with the MAC program. However, only 30 percent thought the MAC program would help keep their care recipient from moving to a nursing home or assisted living facility.

When asked about the **benefits of the MAC program**, MAC caregivers typically mentioned:

- **Service benefits.** Respondents indicated that the MAC program filled an important need for help with their family member's tasks, including meal preparation and home cleaning. Respondents appreciated having options for meeting these needs.
- **Mental health benefits.** MAC caregivers also described an increased peace of mind, knowing that a family member was receiving needed supports and would be treated with respect.

TSOA Caregivers

A total of 430 informal caregivers of TSOA enrollees participated in the survey. Survey results suggested that some **TSOA caregivers had significant health care needs of their own** and struggled to provide care to others.

- About 30 percent described their overall physical health as either fair or poor.
- Consistent with TSOA care recipient survey results, many TSOA caregivers reported the person they were caring for needed help with at least one activity of daily living (86 percent), including bathing (65 percent), walking (69 percent), getting out of bed/chair (42 percent), and dressing (45 percent). About 35 percent of TSOA caregivers reported the person they were caring for had a fall that caused injuries or three or more falls during the last six months.
- About 65 percent reported that the person they were caring for had a family member or friend who could help them if needed. Approximately half of respondents felt overwhelmed or stressed by their care responsibilities.
- About 70 percent of TSOA caregivers reported that they or their family had concerns about the memory, thinking, or ability of the person they were caring for to make decisions.

Overall, TSOA caregivers expressed **high satisfaction with the TSOA application process**.

- About 85 percent of respondents found it easy to apply for the TSOA program.
- Most caregivers (95 percent) reported that staff who helped them apply for the program listened to them and 90 percent responded that staff explained things clearly. Approximately 80 percent of respondents indicated that they had a say in the kind of services they would receive.

TSOA caregivers also expressed **high satisfaction with the TSOA services provided**.

- Most (95 percent) responded that TSOA providers treated them with courtesy and respect. About 90 percent of respondents reported that staff listened to what they said and that staff explained things clearly. About 80 percent TSOA participants responded TSOA program helped them as quickly as they needed.
- Eight-five percent of respondents were satisfied with the TSOA program and 67 percent thought the TSOA program would help keep their care recipient from moving to a nursing home or assisted living facility.

When asked about the **benefits of the TSOA program**, respondents typically mentioned:

- **Mental health benefits.** Respondents commented on how the TSOA program allowed them time to take care of themselves and to have respite from caregiving. Respondents often reported feeling relief, mentally and physically, because of the TSOA program. Other respondents, although they weren't receiving the care, commented on how the TSOA providers also helped them by being reliable and doing service-related things around the home.

Opportunities for TSOA program improvement included:

- **Agency issues.** Respondents desired more hours of TSOA program help and indicated that sometimes communication was not clear between TSOA providers, the care recipient, and the informal caregiver. Other respondents requested TSOA providers that could speak additional languages (e.g., “It would be good to have more Laotian-speaking workers”).
- **Other issues.** One respondent wished they had received TSOA services sooner than they did (e.g., “We were in real desperate need of help right away.”). A few respondents felt that the TSOA program benefits were too limited and wished for improved benefits to get more medically necessary services. A handful of respondents also reported being unhappy with the types of agencies HCA is contracting with to provide TSOA services. Other respondents wanted HCA to send the same TSOA provider each week. A few commented that living in a rural area created an obstacle to receiving some TSOA services.

Conclusion

In general, these results suggest that both programs have successfully targeted people with high needs for support care, and satisfaction with both programs has been similarly high. However, enrollment in MAC may have been low due to weak incentives for participants to select this program in lieu of traditional LTSS. In contrast, incentives to enroll in TSOA appear to have been stronger.

Overall, TSOA and MAC care recipients and caregivers reported being satisfied with the program application process, and with services provided by the program. Care recipients indicated that these programs helped them avoid moving to a nursing home or assisted living facility.

TSOA and MAC caregivers reported that the program provided them with a respite, reducing the physical and mental toll of caregiving. However, TSOA and MAC caregivers were less likely than care recipients to believe that these programs would help prevent the need for more intensive support in a nursing home or assisted living facility.

Both TSOA and MAC care recipients and caregivers reported opportunities to improve the program, including improvements to scheduling, service hours, and communication with the agency and TSOA/MAC program staff.

TSOA and MAC Program Participant Outcomes

To understand how MAC program participation was associated with changes in adverse health outcomes and future use of traditional LTSS, we descriptively assessed adverse health outcomes (e.g., hospitalization, emergency visit, and readmission rates) among MAC participants at the start of and six months after their enrollment in the MAC program, as well as with the initiation of any traditional LTSS within six months after their MAC program enrollment.

We could not similarly assess adverse health outcomes for TSOA enrollees; TSOA participants are not enrolled in Medicaid, and therefore we could not use Medicaid claims to examine their health care utilization and outcomes. Thus, we present alternative analyses: We assessed traditional LTSS utilization among a group of TSOA program participants who later enrolled in Medicaid within six months after their TSOA program enrollment. We also conducted a similar analysis for users of Medicaid in-home services, one type of traditional LTSS. Medicaid in-home service users potentially had similar characteristics to MAC and TSOA program participants.

We used Medicaid medical/LTSS and Medicare claims between September 2017 and December 2019 to examine the outcome measures displayed in Exhibit 12.1.

Exhibit 12.1: Outcome Measures Included in Initiative 2 Evaluation

Measures

- Outpatient emergency department visits per 1,000 member months (NCQA HEDIS or similar state-defined alternative).
- Inpatient admissions per 1,000 member months (NCQA HEDIS IHU or similar state-defined alternative).
- Plan all-cause 30-day readmission rates (NCQA HEDIS PCR).
- Initiation of in-home service use (derived from LTSS claim data currently integrated into the state's ICDB).
- Assisted living facility entry (derived from LTSS claim data currently integrated into the state's ICDB).
- Nursing facility entry rates (state-defined measure derived from nursing home claim data currently integrated into the state's ICDB).
- Mortality rates (state-defined measure derived from death certificate records currently integrated into the state's ICDB).
- Medicaid enrollment among TSOA program participants.

Our analysis included people who began to receive MAC, TSOA, or Medicaid in-home services between September 2017 (when MAC/TSOA were implemented) and June 2019 (six months prior to the end of our dataset). We restricted our study population to MAC and Medicaid in-home service users who were enrolled in Medicaid for at least six months before their enrollment in MAC and in-home services. We excluded people who were initially placed in “presumptive eligibility” status for MAC or TSOA but later determined to be ineligible for services.

Results

Our study population included 48 MAC participants, 879 TSOA participants with an informal caregiver, 2,056 TSOA participants without an informal caregiver, and 43,976 Medicaid in-home service recipients. Our sample also included four people who switched between TSOA and MAC during the study period; these individuals were included in our MAC study population.

Exhibit 12.2 compares the demographic characteristics and health status of MAC and Medicaid in-home service users prior to receipt of services. Compared to in-home service program participants, MAC participants were older (71 vs. 64 years old), more likely to be female (73 percent vs. 65 percent), live in rural areas (25 percent vs. 15 percent), and have Medicaid coverage only without dual Medicare coverage (37 percent vs. 30 percent).

Exhibit 12.2: MAC Participants’ Demographics at Baseline, Compared with People Receiving Medicaid In-Home Services

Demographics	MAC participants (N = 48)	TSOA participants with an informal caregiver	TSOA participants without an informal caregiver	Individuals receiving Medicaid in-home services (N = 43,976)
Age (mean(sd))	71(11.5)	Not available	Not available	64(19.4)
Sex, N(%)				
• Male	13(27)	Not available	Not available	15,604(35)
• Female	35(73)	Not available	Not available	28,652(65)
Rural/urban, N(%)				
• Rural	12(25)	Not available	Not available	6,746(15)
• Urban	36(75)	Not available	Not available	36,951(85)
Eligible for Medicare, N(%)				
• Dual-eligible	30(63)	Not available	Not available	30,861(70)
• Not dual-eligible	18(37)	Not available	Not available	13,115(30)

Source: Demographics and MAC and Medicaid in-home service enrollment status obtained from Washington’s ProviderOne data system. TSOA participants are not enrolled in Medicaid.

Exhibit 12.3 compares health care utilization of MAC participants and traditional in-home service users, before and after their receipt of services. At baseline, MAC participants' rate of emergency department visits (125 per 1,000 member months), hospitalizations (59 per 1,000 member months) and readmission rates (26 percent) in the previous six months were relatively high, indicating that they had significant health care needs. These rates were higher than corresponding emergency department visit rates (93 per 1,000 member months), hospitalization rates (30 per 1,000 member months) and readmission rates (17 percent) among in-home service program participants.

We examined health care utilization among MAC and in-home service users again at six months after their enrollment in each program. In these analyses, we further restricted our study population to those who were enrolled in Medicaid for at least six months after the program participation, to allow enough time to measure program participants' outcomes.

In general, rates of emergency department visits, hospitalizations and readmissions tended to decrease from baseline across both service types after six months of program participation.

Exhibit 12.3: MAC Participants' Utilization of Health Services Before and After Program Enrollment, compared with Individuals Receiving Medicaid In-home Services

Baseline Health Care Utilization	MAC participants (N= 48)	TSOA participants with an informal caregiver	TSOA participants without an informal caregiver	People receiving Medicaid in-home services (N= 43,976)
Emergency department visits (per 1,000 member months)	125	NA	NA	93
Hospitalizations (per 1,000 member months)	59	NA	NA	30
30-day readmissions rate (%)	26	NA	NA	17

Health Care Utilization Within 6 Months of Program Enrollment	MAC participants (N = 37)	TSOA participants with an informal caregiver	TSOA participants without an informal caregiver	Individuals receiving Medicaid in-home services (N = 34,372)
Emergency department visits (per 1,000 member months)	81	NA	NA	73
Hospitalizations (per 1,000 member months)	9	NA	NA	22
30-day readmission rate (%)	0	NA	NA	15

Source: Medicaid claims and program enrollment status for MAC and Medicaid in-home services recipients obtained from Washington's ProviderOne data system. TSOA participants are not enrolled in Medicaid.

Because one of the goals of the MAC and TSOA programs is to prevent the need for more intensive LTSS, we examined whether MAC and TSOA program participants went on to use traditional LTSS within six months of their program participation (see Exhibit 12.4). To protect confidentiality due to small numbers, we present aggregated traditional LTSS use across MAC and TSOA program participants.

Within six months of MAC and TSOA program participation, only 2 percent of MAC and TSOA program participants started to use in-home services. We observed that 0.5 percent of MAC and TSOA participants moved to an assisted living facility within six months of receiving services; this rate was similar to the rate for recipients of traditional in-home services (0.2 percent). A slightly higher percentage of MAC and TSOA participants (2 percent) moved to a nursing facility within six months of participating in the programs than recipients of traditional in-home services (1 percent).

Exhibit 12.4: MAC and TSOA Participants' Use of Traditional LTSS and Mortality Rate Within 6 months of Program Enrollment, Compared with Individuals Receiving Medicaid In-Home Services

	MAC and TSOA participants (N = 2,983)	Individuals receiving Medicaid in-home services (N = 43,976)
Initiated In-Home Services, N(%)	62(2)	NA
Assisted Living Facility Entry, N(%)	15(0.5)	82(0.2)
Nursing Facility Entry, N(%)	56(2)	614(1)
Death, N(%)	53(2)	1,301(3)

Source: MAC, TSOA and Medicaid in-home service enrollment status and Medicaid claims for receipt of Long-Term Services and Supports were obtained from Washington's ProviderOne data system. MAC and TSOA results are aggregated to protect confidentiality due to small numbers.

We observed differences in the average number of months participants received services. Exhibit 12.5 compares these program enrollment characteristics for MAC, TSOA, and traditional in-home service users. We observed that the use of MAC and TSOA services was typically shorter in duration than the use of in-home services. MAC program participants were enrolled in the program for, on average, 11 months, and TSOA program participants were enrolled in the program for about 14 months. In contrast, in-home service program participants used services for a longer period, on average 26 months.

The state allowed that participants could enroll in MAC or TSOA with a presumptive status while awaiting a final eligibility determination. Twenty-seven percent of MAC program participants and more than half of TSOA program participants enrolled with presumptive status. The length of presumptive status prior to switching to official participation status was about six months for MAC and three months for TSOA.

Another goal of the TSOA program is to prevent participants from needing to spend down financial assets and receiving traditional Medicaid LTSS. Approximately one-third of TSOA participants went on to enroll in Medicaid within six months of TSOA participation (see Exhibit 12.5). Informal caregivers appeared to play a role in this dynamic: 24 percent of TSOA participants with an informal caregiver became enrolled in Medicaid within six months of their TSOA program participation, compared to 35 percent of TSOA participants without an informal caregiver.

Exhibit 12.5: MAC and TSOA Participants' Program Enrollment, Compared with Individuals Receiving Medicaid In-Home Services

	MAC participants (N = 48)	TSOA participants with an informal caregiver (N = 879)	TSOA participants without an informal caregiver (N = 2,056)	Individuals receiving Medicaid in-home services (N = 44,256)
Length of program enrollment (in months), mean(sd)	11.4(4.7)	13.5(6.6)	14.6(6.2)	25.7(4.0)
People beginning with presumptive status, N(%)	13(27)	520 (56)	1195(55)	Not applicable
Length of presumptive status prior to switching to official participation status (mo) (mean(sd))	5.8(2.3)	3.2(2.6)	3.1(2.5)	Not applicable
TSOA enrollees who later enrolled in Medicaid, N(%)	Not applicable	215(24)	715(35)	Not applicable

Source: MAC, TSOA, and Medicaid in-home service enrollment status obtained from Washington State's ProviderOne data system.

Conclusion

In summary, we found that MAC participants had high rates of emergency department visits, hospitalizations and readmission rates before enrollment in the program, indicating that the program had successfully targeted Medicaid beneficiaries with significant health care needs.

After six months of program participation, emergency department visit, hospitalization and readmission rates dropped among MAC program participants, suggesting that MAC program participation may have reduced the occurrence of adverse health outcomes. Similar reductions occurred among traditional Medicaid-paid in-home service users, suggesting the MAC program was similarly effective to traditional Medicaid-paid LTSS in reducing adverse health outcomes. Additional evaluation is needed to determine the extent to which these changes for MAC program participants can be attributed to the MAC program or to other factors.

While 25-35% of TSOA program participants enrolled in Medicaid within 6 months of their TSOA program enrollment, only a small percentage used traditional LTSS. Likewise, only a small percentage of MAC participants used traditional LTSS within 6 months of MAC program enrollment. Taken together, these findings suggest MAC and TSOA program participation appears to help delay or avoid the use of more intensive traditional Medicaid LTSS

MTP Initiative 3

This section presents an evaluation of the Washington State Medicaid Transformation Project Initiative – Foundational Community Supports (FCS). Initiative 3 consists of two programs, **FCS Supportive Housing** and **FCS Supported Employment**. Both programs provide support to Medicaid beneficiaries with complex care needs who are at high risk of homelessness or unemployment.

Chapter 13 includes:

- **FCS program launch and implementation findings** from our qualitative analyses;
- **Analysis of social outcomes** (including homelessness, arrest rates, and employment) for participants who received FCS housing services, FCS employment services, or both; and
- **Analysis of health care access and utilization measures** for FCS participants receiving supportive housing, supported employment, or both types of services.

KEY FINDINGS

Our evaluation of MTP Initiative 3 found the following:

- *The network of FCS service providers has gradually increased since the launch of the program in 2018. However, service providers reported challenges in finding affordable housing or services for participants in some regions.*
- *Rates of employment increased strongly for Medicaid enrollees who participated in FCS Supported Employment relative to a matched comparison group. These changes were evident in the months following receipt of FCS employment services, suggesting the program successfully integrated participants into the labor force.*
- *Rates of homelessness did not improve for Medicaid enrollees who participated in FCS Supportive Housing relative to the comparison group. Lack of improvement on housing measures may have reflected a lack of affordable housing in some regions.*
- *Employment and homelessness rates did not improve for FCS recipients enrolled in both supportive housing and supported employment.*

Recommendations

The following recommendations relate to our evaluation of MTP Initiative 3, Foundational Community Supports:

- 1 The Health Care Authority and the Aging and Long-Term Support Administration should continue to monitor evidence of positive effects of the FCS Supported Employment program and consider ways to expand access to this program, particularly in rural areas. The program may play an important role in employment stability for Medicaid enrollees during and after the COVID-19 pandemic.**
- 2 The state should explore how to expand affordable housing options for the Medicaid population eligible for FCS Supportive Housing. A lack of housing and shelter resources will likely remain a limiting factor in this program's effectiveness in the absence of further action.**
- 3 The state should investigate whether different or more intensive supports are needed for the population of people eligible for both the FCS housing and employment programs. This population's unique needs may warrant modifications to the program's design.**

Foundational Community Supports

Among Medicaid beneficiaries, there is a subset of people with complex physical and behavioral health conditions who have high social support needs (Mann, 2013). People in this group can be at increased risk of homelessness and substance use disorder and experience barriers to employment. This population is historically underserved by health systems that may be unequipped to meet their needs through traditional models of physical health care. Thus, this population may have recurring episodes of institutionalization or emergency care and may experience substantial barriers to receiving preventive or comprehensive health services. For example, previous research in Washington found that roughly a third of people released from inpatient mental health treatment and half of people released from residential SUD treatment experienced homelessness in the 12 months following their release (Shah, et al., 2012).

While many models exist that aim to address the needs of this population, two models are of particular interest for health systems:

- 1 Supportive housing, and
- 2 Supported employment.

Supportive housing models combine housing services (e.g., providing assistance with finding housing or financial support for obtaining housing) with health care services such as behavioral health treatment. Its effectiveness is supported by a large number of studies. Supported employment programs provide services to people who may need assistance to find or remain in a job. These services may include assistance with job placement or providing job skills coaching for people with developmental disabilities or serious mental illness (Substance Abuse and Mental Health Services Administration, 2009).

MTP Approach to Change

As part of the larger Medicaid Transformation Project, Washington designed Foundational Community Supports (FCS), a new program for Medicaid enrollees with complex health needs at high risk of housing instability or barriers to employment. The FCS program is a collaboration between the Washington Health Care Authority and the Department of Social and Health Services' Aging and Long-Term Support Administration (AL TSA). FCS was established to create a statewide network of providers of supportive housing and supported employment services and connect eligible Medicaid beneficiaries with new housing and employment supports.

Medicaid beneficiaries who have both a functional need for services and also exhibit certain risk factors are eligible for FCS Supportive Housing services, Supported Employment services, or both (Washington State Health Care Authority, 2018). Exhibit 14.1 displays risk and needs-based eligibility criteria for housing or employment services through FCS.

Exhibit 14.1: Groups Eligible for FCS Supportive Housing and Supported Employment Services

	Supportive Housing	Supported Employment
Risk Criteria (<i>must meet at least one</i>)	<ul style="list-style-type: none"> Chronic homelessness Frequent institutional contacts or multiple instances of residential care Frequent turnover of caregiver Predictive Risk Intelligence (PRISM) score of 1.5 or higher 	<ul style="list-style-type: none"> Unable to obtain or maintain employment due to age, physical or mental disability or impairment Frequent episodes of SUD treatment Mental health or SUD diagnosis at risk of deterioration
Needs-based Criteria (<i>must meet at least one</i>)	<ul style="list-style-type: none"> Need for improvement, stabilization or prevention of deterioration of function due to a mental illness or a long-continuing or indefinite complex physical condition Outpatient SUD treatment Assistance with activities of daily living (ADL) 	<ul style="list-style-type: none"> Need for improvement, stabilization or prevention of deterioration of function due to a mental illness Outpatient SUD treatment Assistance with ADL Physical impairments requiring assistance with basic work-related activities

Source: Amerigroup, 2018

Supportive Housing

The FCS Supportive Housing program allows the state to reimburse contracted providers a per diem rate for services that include assistance in finding or applying for housing or negotiating with landlords. In most cases, participants could receive up to 30 days of supportive housing services in a 6-month period, with options for reauthorization or more intensive services for participants with exceptionally high needs (Washington State Health Care Authority, n.d.a). Of note, the FCS Supportive Housing benefit was not designed to provide direct rent assistance or replace other housing supports that Medicaid beneficiaries may have been eligible to receive.

Supported Employment

The FCS Supported Employment program is based on the Individual Placement and Support (IPS) model for people with serious mental illness (IPS Employment Center, 2020). The model emphasizes the integration of employment and health services in community settings, with competitive employment as a goal. The program does not provide or supplement wages directly to participants. FCS services include vocational assessments and job coaching, assistance with job seeking or job placement, and skill building for employment retention (Washington State Health Care Authority, 2017a). The FCS Supported Employment benefit allows for participants to receive up to 30 hours of services in a six month period, with options for reauthorization or higher levels of support for participants deemed to have exceptional needs (Washington State Health Care Authority, n.d.a).

Initiative 3 Implementation

The FCS program officially launched in January 2018, when the first participants were screened and enrolled in the program. Amerigroup was selected as a third-party administrator to contract with FCS providers, assess potential clients' program eligibility, authorize provision of services to eligible clients and process payments to providers. The program provided multiple points of entry for eligible people. Those who were receiving long-term services and supports through Washington State's Aging and Long-Term Support Administration (AL TSA) could apply for FCS through AL TSA. Other

Medicaid enrollees with qualifying physical or behavioral health conditions could access the FCS program via Washington's Health Care Authority (HCA) or through self-referral.

Building the FCS Network

Interviews with stakeholders in 2019 revealed that the FCS program encountered early implementation challenges, including difficulty establishing a network of contracted FCS providers and limited availability of resources such as affordable housing. Early challenges included engaging potential FCS service providers, particularly in rural areas. Among the service providers who joined the FCS network, many lacked prior experience with Medicaid billing. They required technical assistance to navigate benefit rules and regulations. Some organizations lacked fee-for-service billing infrastructure to support the addition of FCS services to their work. One key informant described these challenges as follows:

For providers who'd never contracted with Medicaid before, never done a fee-for-service type of structure before, it's a pretty big shift. You're going from a model where you're getting private or public grants to fund a position, and [...] now you have to build a caseload and figure out how to manage that caseload and bill for services. There's a learning curve to figure out how to structure that successfully financially. So, a lot of providers reported initially, their first month, losing money on FCS, and having to supplement FCS with other resources. – Participant #26, 2019

Building network capacity to support sustainable FCS caseloads was reported to be particularly challenging in rural areas. Lack of affordable housing stock that could be paired with FCS housing services was cited as a limiting factor in the program's expansion of caseloads. FCS housing providers could assist clients with locating and applying for affordable housing when it was available, and maintaining housing if they were already housed, but there were limited options for providers working with clients who were unhoused. As one interviewee noted:

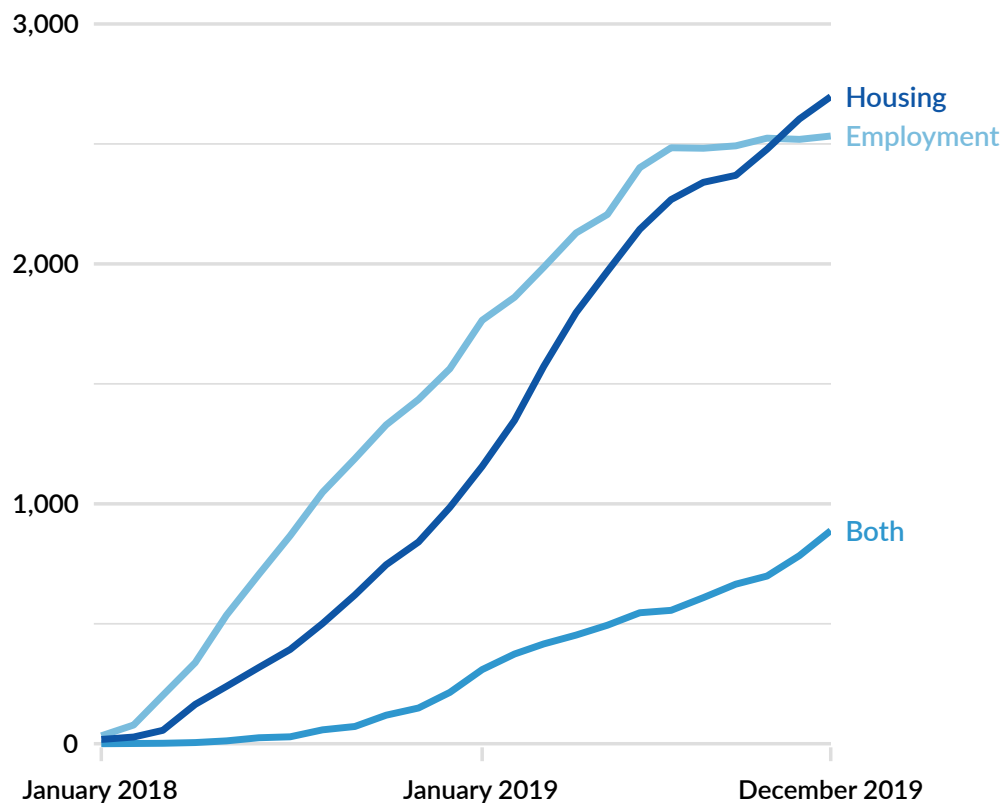
The lack of housing resources is probably one of the bigger challenges I've observed... we have hundreds of people who could benefit. The non-supplantation rules through Medicaid have, I think, slowed this down... it's harder to build a caseload [...] you have just one or two openings a month in your housing, and therefore, because of supplantation rules, you only have a caseload of three people because you have no other housing resources to pair with the FCS services. When you're billing for an encounter that's not going to generate enough revenue to sustain a staff member... That's been a structural challenge. – Participant #26, 2019

While provider engagement was initially slow, the network of contracted FCS providers gradually increased. As of November 2020, there were 458 FCS sites serving most counties in Washington State, including 46 sites with supportive housing providers, 83 sites with supported employment providers, and 329 sites providing both types of services.

Enrollment of FCS Clients

Exhibit 14.2 depicts how FCS program enrollment has grown since the program's launch. Program enrollment in FCS Supportive Housing and FCS Supported Employment steadily increased throughout 2018 and 2019. The number of Medicaid beneficiaries who were simultaneously enrolled in both programs also increased to about 1,000 by the end of 2019 (see Data Appendix, Table 8 for details).

Exhibit 14.2. Enrollment in Foundational Community Supports has steadily increased since December 2019 for FCS housing, FCS employment, and for simultaneous enrollment in both.



Source: Enrollment data for Foundational Community Supports provided by Washington State Health Care Authority and Washington State Department of Social and Health Services.

Evaluation Approach

Our evaluation of Initiative 3 employed a difference-in-differences approach that compared outcomes for FCS enrollees before and after enrollment in FCS to outcomes of a similar comparison group that did not enroll in FCS during the same time period. We measured changes for FCS enrollees from a pre-intervention period (the last two quarters before first FCS enrollment) to a post-intervention period (the third and fourth quarter following first FCS enrollment). We compared these changes for FCS enrollees to a matched comparison group, adjusting estimates to account for differences in patient characteristics that could affect the trajectory of outcomes over time.

We identified FCS enrollees as all Medicaid beneficiaries who received any FCS service in 2018. We limited our analysis to those enrolled in 2018 in order to allow sufficient time in our pre- and post-intervention quarters to observe all outcomes of interest. We distinguished between FCS beneficiaries who (i) enrolled in supportive housing; (ii) enrolled in supported employment; and (iii) enrolled in both programs.

For each individual in these FCS program groups (housing, employment, or both), we identified a comparable person not enrolled in FCS but with similar demographic and health risk characteristics, using a matching approach similar to the one specified in a preliminary evaluation report of the FCS conducted by Washington State's DSHS (Danielson, et al., 2020). We selected FCS participants

and matched Medicaid beneficiaries who were fully enrolled in Medicaid during the four quarters preceding and following first FCS enrollment.

Unlike Danielson et al. (2020), we did not match on prior utilization measures for our main analysis (see Appendix for a more detailed discussion of these two approaches). Instead, we assessed trends over time for all groups to examine whether trends for FCS beneficiaries and their matched comparison group were similar before they began receiving FCS services. We also performed a matching approach with key utilization measures as a sensitivity check. In most cases, results of these sensitivity analyses were similar to the main analyses. We note important differences in results below where these were apparent.

Exhibit 14.3: Demographic Characteristics of FCS Enrollees and a Matched Comparison Group

	FCS Housing (N = 757)	Housing Comparison (N = 757)	FCS Employment (N = 1,295)	Employment Comparison (N = 1,295)	FCS Both (N = 268)	Both Comparison (N = 268)
Mean Age (years)	47.9	48.1	41.3	41.6	40.7	41.1
Gender (% female)	55.4	55.4	50.1	50.1	47.0	47.0
Race						
• % AI/AN	5.3	5.3	3.0	3.0	6.3	6.3
• % Asian	NA	NA	1.2	1.2	NA	NA
• % Black	8.2	8.2	8.3	8.3	7.5	7.5
• % Hispanic	8.7	8.7	8.0	8.0	8.6	8.6
• % Other Race	5.7	5.7	5.3	5.3	5.2	5.2
• % Hawaiian or Pacific Islander	NA	NA	NA	NA	NA	NA
• % White	77.3	77.3	77.1	77.1	77.2	77.2
Mean CDPS Risk Score	2.6	2.6	1.7	1.7	1.9	1.9
Rate of SUD Diagnosis	27.5	27.5	17.8	17.8	39.2	39.2

Note: FCS Both indicates FCS participants who were simultaneously enrolled in FCS Housing and FCS Employment services. NA indicates small numbers are suppressed to protect confidentiality. Source: Demographic data obtained from Washington's ProviderOne data system. FCS program enrollment data obtained from Washington State Health Care Authority and Department of Social and Health Services.

For each of the three FCS program groups, we further stratified our analysis by system affiliation, separating AL TSA-affiliated people from other Medicaid beneficiaries served through the Health Care Authority (i.e., "HCA-affiliated"). We identified AL TSA-affiliated beneficiaries as Medicaid enrollees who received a Comprehensive Assessment Reporting Evaluation (CARE) within 15 months prior to first FCS service receipt. All other FCS enrollees were considered to be HCA-affiliated.

Evaluation Results

Our final study population included 757 people who received housing services, 1,295 people who received employment services, and 268 people who received both services. At baseline, FCS beneficiaries and our comparison groups had similar demographic characteristics and health status for those fields on which matching was performed (age; gender; race, CDPS risk score, and rate of SUD diagnosis (see Exhibit 14.3). As expected, characteristics and outcomes not included in the matching approach (e.g., employment rate) were different between the two groups at baseline (see Exhibits 14.5, 14.7 and 14.8).

Below we present results of our difference-in-difference analyses. We first present results for enrollees in FCS Supportive Housing, followed by results for enrollees in FCS Supported Employment, as well as for enrollees participating in both types of services.

Our analyses broadly examine changes in two types of outcomes for each program:

- Social outcomes, including employment, arrests, and homelessness, and
- Health care utilization and quality.

We provide disaggregated results for AL TSA clients and other clients.

People Receiving FCS Supportive Housing Services

Exhibit 14.4 displays changes in all outcomes for people who received FCS Supportive Housing services, relative to a comparison group who did not receive FCS housing services. *See page 21 of this report for a guide to reading results.*

Rates of homelessness, arrests, and employment did not change for FCS housing beneficiaries relative to their matched comparison group between the pre- and post period. Homelessness for FCS housing beneficiaries increased slightly before program start and then decreased afterwards (see Exhibit 14.5). However, levels of homelessness remained unchanged from the last two quarters before enrollment to the third and fourth quarter following enrollment.

Employment rates declined in a similar manner for both groups. In sensitivity analysis that used an alternative matching approach, we found a relative decline in employment for FCS housing beneficiaries. This appeared to be driven by improvements in employment for the matched comparison group. We observed similar lack of change in homelessness, arrest, or employment for FCS housing beneficiaries who were AL TSA-affiliated and those who were HCA-affiliated (data not shown; see Data Appendix, Table 9).

Acute hospital utilization decreased among FCS housing beneficiaries (see Exhibit 14.4). In sensitivity analyses using an alternative matching approach, hospital utilization did not change, and a variety of other quality measures worsened. This discrepancy suggests that our results may be sensitive to trends among FCS housing beneficiaries that are unrelated to FCS services.

Other health care utilization measures did not change significantly. Acute hospital utilization declined among AL TSA-affiliated but not HCA-affiliated FCS housing beneficiaries (data not shown; see Data Appendix, Table 9). AL TSA-affiliated FCS housing beneficiaries also experienced a relative decline in initiation of alcohol and other drug abuse or dependence treatment, while HCA-affiliated FCS housing beneficiaries did not experience significant changes in health care utilization.

Exhibit 14.4: Change in Outcomes for Participants in FCS Supportive Housing Services

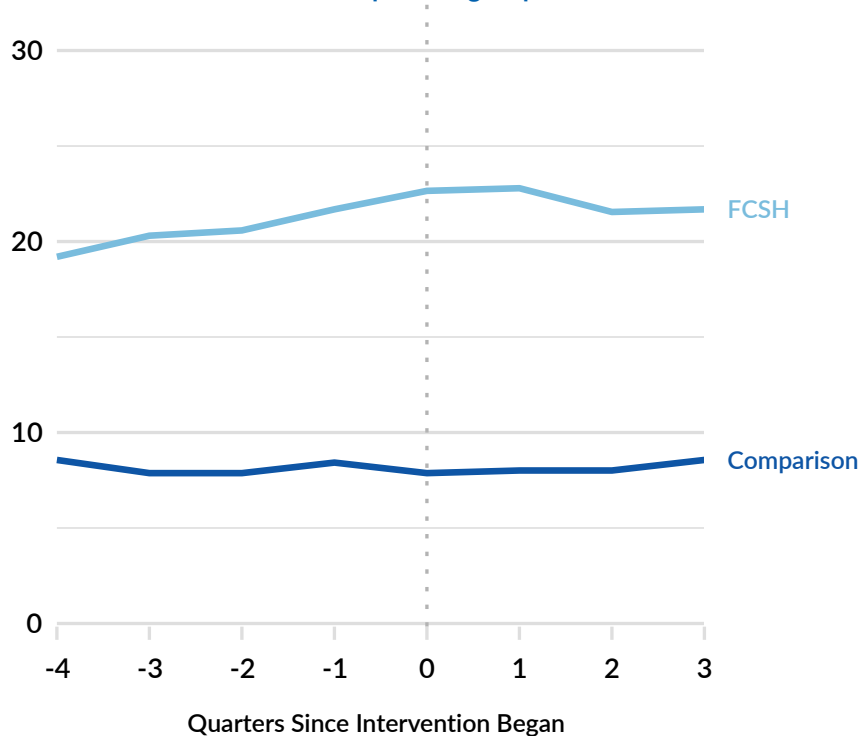
Pre-post rates for FCS housing enrollees, pre-post rates for matched comparison group of Medicaid beneficiaries, and adjusted difference-in-differences estimates

	FCS Housing Participants		Comparison Group		Difference in Differences
	Pre	Post	Pre	Post	
Homelessness ↓	21.8	22.5	8.2	8.5	0.4
Employment (Age 18 to 64)	18.8	16.1	24.1	21.5	-0.1
Arrest Rate (Age 18 to 64) ↓	15.5	13.6	9.9	7.2	0.7
Adults' Access to Primary Care	94.9	95.9	91.4	92.0	0.4
Antidepressant Medication for Adults (12 Weeks)	62.8	53.0	53.3	44.6	-1.0
Antidepressant Medication for Adults (6 Months)	49.8	37.8	43.9	30.9	0.4
Antipsychotic Medication for People with Schizophrenia	60.0	62.9	66.7	81.8	-12.7
Diabetes Screening for People with Schizophrenia/Bipolar Disorder	88.4	88.8	75.5	75.7	0.4
7-Day Follow-Up After ED Visit for Mental Illness	80.4	83.1	81.4	88.5	3.6
30-Day Follow-Up After ED Visit for Mental Illness	86.9	90.8	84.8	95.8	-1.4
7-Day Follow-Up After Hospitalization for Mental Illness	69.8	63.0	59.8	51.6	-4.0
30-Day Follow-Up After Hospitalization for Mental Illness	85.8	82.1	84.3	83.7	-7.3
30-Day Hospital Readmission for a Psychiatric Condition ↓	NA	NA	NA	NA	NA
Controller Medication for Asthma	NA	NA	NA	NA	NA
Eye Exam for People with Diabetes	40.7	39.8	43.8	49.4	-6.2
Hemoglobin A1c Testing for People with Diabetes	76.2	75.1	77.3	76.6	-0.5
Nephropathy Screening for People with Diabetes	91.6	91.0	91.0	91.5	-0.9
Statin Medication for Cardiovascular Disease	81.2	86.0	73.9	74.3	-0.4
Emergency Department Visit Rate ↓	33.7	33.5	15.0	15.8	-1.1
Acute Hospital Use among Adults ↓	25.8	23.1	15.4	20.8	-8.0**
Hospital Readmission within 30 Days ↓	9.4	11.5	6.8	7.0	-0.7
Ratio of Home and Community-Based Care Use to Nursing Facility Use	92.4	91.8	86.0	87.2	-1.3
Substance Use Disorder Treatment Penetration	38.0	43.3	52.7	54.6	1.3
Alcohol or Other Drug Treatment: Initiation	44.3	41.5	44.0	49.5	-9.1
Alcohol or Other Drug Treatment: Treatment	14.1	11.8	19.4	20.1	-4.2
30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	34.6	36.6	27.6	52.7	-15.9
7-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	23.9	27.1	24.1	46.0	-10.2
Patients Prescribed High-dose Chronic Opioid Therapy: >50 mg MED ↓	31.8	31.6	42.1	30.8	2.2
Patients Prescribed High-Dose Chronic Opioid Therapy: >90mg ↓	7.3	8.7	24.3	19.6	1.9
Opioid Use Disorder Treatment for People with Treatment Need	40.2	44.6	64.3	66.1	-1.1



Shaded cells indicate a statistically significant difference between the change in outcomes for FCS Housing participants and the change for the comparison group. Blue shaded cells indicate that FCS Housing participants' outcomes improved more than the comparison group. Orange-shaded cells indicate the change in FCS Housing participants' outcomes was worse than the change in the comparison group. Results marked * are significant at the p<.05 level. Results marked ** are significant at the p<.01 level. Results marked *** are significant at the p<.001 level.

Exhibit 14.5. The percentage of people experiencing homelessness was unchanged for FCS Supportive Housing beneficiaries in the quarters after enrollment in FCS. The trend was similar for the comparison group.



Source: FCS Housing enrollment status obtained from Washington State Health Care Authority and Department of Social and Health Services. Homelessness data obtained from Washington's Automatic Client Eligibility System (ACES).

In sensitivity analyses that used an alternative matching approach and stratified by AL TSA and HCA affiliation, the FCS program was associated with worse performance on some outcomes.

People Receiving FCS Supported Employment Services

Exhibit 14.6 displays changes in outcomes for people who received FCS Supported Employment services, relative to a comparison group who did not receive FCS employment services.

FCS beneficiaries enrolled in supported employment experienced a substantial improvement in their employment rate relative to their matched comparison group (see Exhibit 14.7). Employment decreased slightly for FCS participants before the receipt of FCS services, increasing noticeably after enrollment. In contrast, employment rates for the comparison group exhibited a steady decline.

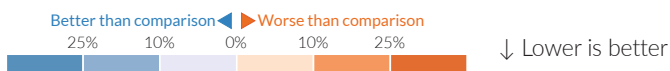
Both AL TSA- and HCA-affiliated FCS Supported Employment beneficiaries experienced an increase in employment, with the increase being higher for those who were HCA-affiliated (data not shown; see Data Appendix, Table 9). Arrest rates declined for HCA-affiliated FCS employment participants but not AL TSA-affiliated FCS employment participants or both groups combined.

The rate of homelessness did not decline for FCS Supported Employment beneficiaries overall or in sub-analyses of HCA or AL TSA-affiliated enrollees. Results of our sensitivity analysis using an alternative matching approach were mostly consistent with these findings, with two exceptions. First, AL TSA-affiliated FCS employment participants did not experience improvement in employment (these results might be influenced by non-parallel trends). Second, the arrest rate did not decline for HCA-affiliated FCS employment participants.

Exhibit 14.6: Change in Outcomes for Participants in FCS Supported Employment Services

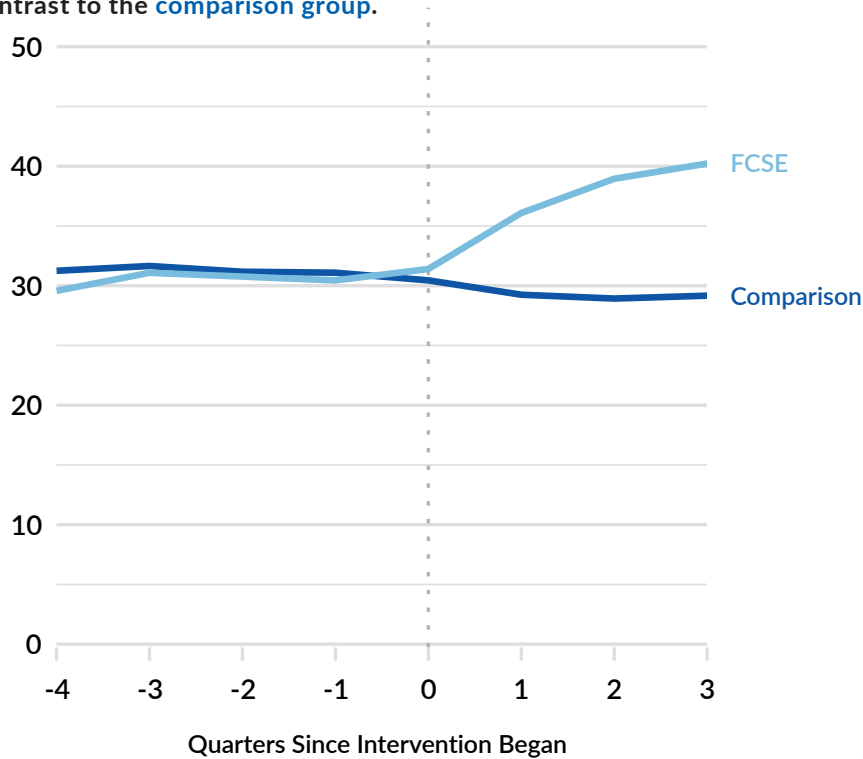
Pre-post rates for FCS employment enrollees, pre-post rates for matched comparison group of Medicaid beneficiaries, and adjusted difference-in-differences estimates

	FCS (both) Participants		Comparison Group		Difference in Differences
	Pre	Post	Pre	Post	
Homelessness ↓	9.6	9.1	7.7	7.1	0.1
Employment (Age 18 to 64)	30.7	39.5	30.9	28.9	10.7***
Arrest Rate (Age 18 to 64) ↓	11.3	8.4	9.4	8.1	-1.6
Adults' Access to Primary Care	93.2	94.4	89.2	90.6	-0.2
Antidepressant Medication for Adults (12 Weeks)	57.3	56.2	56.0	56.0	-1.0
Antidepressant Medication for Adults (6 Months)	43.6	43.6	40.3	44.4	-2.8
Antipsychotic Medication for People with Schizophrenia	63.0	80.1	63.0	71.2	9.1
Diabetes Screening for People with Schizophrenia/Bipolar Disorder	78.0	80.0	80.4	77.8	4.6
7-Day Follow-Up After ED Visit for Mental Illness	84.5	85.9	80.6	69.3	10.3
30-Day Follow-Up After ED Visit for Mental Illness	90.0	93.2	80.6	83.3	1.4
7-Day Follow-Up After Hospitalization for Mental Illness	50.4	69.6	56.2	66.0	12.8
30-Day Follow-Up After Hospitalization for Mental Illness	72.8	86.9	84.1	89.4	10.0
30-Day Hospital Readmission for a Psychiatric Condition ↓	NA	NA	NA	NA	NA
Controller Medication for Asthma	55.1	63.6	48.6	44.8	7.2
Eye Exam for People with Diabetes	52.5	48.2	52.3	50.7	-3.2
Hemoglobin A1c Testing for People with Diabetes	76.4	75.0	81.5	79.7	0.2
Nephropathy Screening for People with Diabetes	85.7	86.7	86.5	90.8	-3.4
Statin Medication for Cardiovascular Disease	81.6	69.7	59.5	53.5	-6.5
Emergency Department Visit Rate ↓	14.2	13.3	14.3	14.2	-0.9
Acute Hospital Use among Adults ↓	10.3	9.4	11.0	12.1	-2.0
Hospital Readmission within 30 Days ↓	5.9	8.7	5.3	5.6	6.1
Ratio of Home and Community-Based Care Use to Nursing Facility Use	98.0	99.1	95.0	94.7	1.1
Substance Use Disorder Treatment Penetration	37.2	44.6	44.8	46.6	4.2*
Alcohol or Other Drug Treatment: Initiation	35.5	42.3	40.2	38.2	7.6
Alcohol or Other Drug Treatment: Treatment	13.3	16.6	14.9	14.6	3.0
30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	34.7	35.4	29.6	31.1	-5.3
7-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	15.3	25.6	27.2	17.3	12.6
Patients Prescribed High-dose Chronic Opioid Therapy: >50 mg MED ↓	16.2	14.2	39.0	39.1	3.2
Patients Prescribed High-Dose Chronic Opioid Therapy: >90mg ↓	NA	NA	NA	NA	NA
Opioid Use Disorder Treatment for People with Treatment Need	47.6	52.7	57.2	62.7	0.9



Shaded cells indicate a statistically significant difference between the change in outcomes for FCS Housing participants and the change for the comparison group. Blue shaded cells indicate that FCS Housing participants' outcomes improved more than the comparison group. Orange shaded cells indicate the change in FCS Housing participants outcomes was worse than the change in the comparison group. Results marked * are significant at the p<.05 level. Results marked ** are significant at the p<.01 level. Results marked *** are significant at the p<.001 level.

Exhibit 14.7: The percentage of people who were employed increased steadily for FCS Supported Employment beneficiaries in the quarters following enrollment, in contrast to the comparison group.



Source: FCS Employment enrollment status obtained from Washington State Health Care Authority and Department of Social and Health Services. Employment status obtained from Washington Employment Security Department.

Substance use disorder treatment penetration improved for FCS employment participants relative to the comparison group, while there were no differences in other measures of health care utilization (see Exhibit 14.6). When stratifying the sample by AL TSA and HCA affiliation, we found that one measure improved for AL TSA-affiliated FCS employment beneficiaries (substance use disorder treatment penetration), and three measures improved for HCA-affiliated FCS employment beneficiaries (follow-up after emergency department visit for alcohol and other drug abuse or dependence, 7 days; and follow-up after emergency department visit for mental illness, 7 and 30 days) (data not shown; see Data Appendix, Table 9).

Results for health care utilization measures were broadly robust to the alternative matching approach, with some differences in the measures that improved for the HCA-affiliated population. Results for most of these measures should be interpreted with caution because they were based on small sample sizes that did not always exhibit similar trends prior to receipt of services.

People Receiving Both FCS Supportive Housing and Supported Employment Services

Exhibit 14.8 displays changes in outcomes for people who simultaneously received both FCS Supported Employment and Supportive Housing services, relative to a comparison group of Medicaid enrollees who did not receive either type of FCS services.

Beneficiaries enrolled in both housing and employment did not experience improvements in rates of homelessness, arrests, or employment, relative to the comparison group. Rates of homelessness, employment, and arrests also remained unchanged for AL TSA- and HCA-affiliated FCS housing and employment beneficiaries (data not shown; see Data Appendix, Table 9).

Exhibit 14.8: Change in Outcomes for Participants in both FCS Employment and Housing Services

Pre-post rates for FCS housing and employment enrollees, pre-post rates for matched comparison group of Medicaid beneficiaries, and adjusted difference-in-differences estimates

	FCS (both) Participants		Comparison Group		Difference in Differences
	Pre	Post	Pre	Post	
Homelessness ↓	26.1	30.7	8.5	10.0	3.0
Employment (Age 18 to 64)	36.7	36.7	32.3	27.6	4.7
Arrest Rate (Age 18 to 64) ↓	27.7	26.3	14.7	13.5	-0.2
Adults' Access to Primary Care	89.4	97.0	90.8	91.9	6.5**
Antidepressant Medication for Adults (12 Weeks)	46.5	45.3	61.4	52.5	11.6
Antidepressant Medication for Adults (6 Months)	36.0	32.6	56.8	38.8	9.9
Antipsychotic Medication for People with Schizophrenia	54.7	79.7	72.7	62.2	42.9***
Diabetes Screening for People with Schizophrenia/Bipolar Disorder	85.1	82.9	93.1	87.9	3.1
7-Day Follow-Up After ED Visit for Mental Illness	86.7	73.9	60.0	75.8	-23.4
30-Day Follow-Up After ED Visit for Mental Illness	90.6	84.5	60.0	90.9	-30.8*
7-Day Follow-Up After Hospitalization for Mental Illness	NA	NA	NA	NA	NA
30-Day Follow-Up After Hospitalization for Mental Illness	97.7	83.8	77.1	75.3	-7.4
30-Day Hospital Readmission for a Psychiatric Condition ↓	NA	NA	NA	NA	NA
Controller Medication for Asthma	NA	NA	NA	NA	NA
Eye Exam for People with Diabetes	37.5	43.5	38.0	49.4	-4.7
Hemoglobin A1c Testing for People with Diabetes	78.6	72.6	90.1	77.9	7.7
Nephropathy Screening for People with Diabetes	89.3	87.1	93.0	85.7	7.5
Statin Medication for Cardiovascular Disease	NA	NA	NA	NA	NA
Emergency Department Visit Rate ↓	26.1	23.7	16.5	16.9	-2.8
Acute Hospital Use among Adults ↓	15.0	12.9	11.9	12.9	-3.1
Hospital Readmission within 30 Days ↓	NA	NA	NA	NA	NA
Ratio of Home and Community-Based Care Use to Nursing Facility Use	91.5	98.2	87.2	90.9	7.8
Substance Use Disorder Treatment Penetration	49.2	59.6	59.7	63.5	5.7
Alcohol or Other Drug Treatment: Initiation	43.3	44.9	44.5	46.1	2.7
Alcohol or Other Drug Treatment: Treatment	14.8	26.3	19.5	17.4	13.3*
30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	48.1	55.4	41.4	42.7	10.1
7-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	NA	NA	NA	NA	NA
Patients Prescribed High-dose Chronic Opioid Therapy: >50 mg MED ↓	NA	NA	NA	NA	NA
Patients Prescribed High-Dose Chronic Opioid Therapy: >90mg ↓	NA	NA	NA	NA	NA
Opioid Use Disorder Treatment for People with Treatment Need	42.7	58.6	65.1	76.8	8.2



Shaded cells indicate a statistically significant difference between the change in outcomes for FCS Housing participants and the change for the comparison group. Blue shaded cells indicate that FCS Housing participants' outcomes improved more than the comparison group. Orange-shaded cells indicate the change in FCS Housing participants outcomes was worse than the change in the comparison group. Results marked * are significant at the p<.05 level. Results marked ** are significant at the p<.01 level. Results marked *** are significant at the p<.001 level.

Several quality measures improved for FCS participants who received both housing and employment services (see Exhibit 14.8). Improvements included adult access to primary care; engagement in alcohol and other drug abuse or dependence treatment; and adherence to antipsychotic medications for individuals with schizophrenia. Among FCS participants, 30-day follow up visits after an ED visit for mental illness was significantly worse. These results were sensitive to the alternative matching approach. Specifically, while adult access to primary care still improved, one measure (all-cause ED visits) worsened. Other healthcare utilization measures did not change in our sensitivity analyses.

We do not report interim evaluation results stratified by AL TSA or HCA affiliation for participants in both FCS housing and employment services because of small sample sizes for these groups.

Conclusions

Our evaluation of the Foundational Community Supports program found strong improvement in the employment rate for FCS beneficiaries (both AL TSA- and HCA-affiliated clients) enrolled in supported employment within three to four quarters after receipt of FCS services.

In contrast, we observed no statistically significant improvement in the rate of homelessness among FCS beneficiaries enrolled in supportive housing. These findings are generally consistent with our qualitative data, which highlighted that FCS benefits were designed to be paired with housing resources in the community, but were not designed in a way that could overcome shortages in affordable housing. Locating housing for clients enrolled in FCS was reported to be a particular challenge for FCS service providers, which may explain why outcomes related to homelessness did not improve for participants after receipt of FCS housing services. We note one limitation of these findings: this measure of homelessness does not reflect other changes in housing status of FCS housing beneficiaries, and alternative measures such as those reported in Danielson, Mancuso and Felver (2020) may detect different types of changes. A trend of declining employment for the FCS housing group appears to have begun prior to FCS enrollment, which may be indicative that FCS engagement tended to follow periods of relative crisis for participants.

Neither employment nor housing rates improved for FCS beneficiaries enrolled in both supportive housing and supported employment. However, we observed promising improvement for these FCS participants in measures of health care quality. It is possible that people who need both FCS housing and employment supports have different and more intensive housing and employment support needs than the populations eligible for employment, or housing, but not both services. These trends should be monitored over time.

Our sensitivity analyses used an alternative matching approach that aimed to more directly control for trends in risk factors or utilization measures. In most cases, this alternate matching approach yielded similar results. Where results differed, we interpret these differences as suggestive that some improvements may be driven by temporary changes in outcomes that are unrelated to FCS.

Our results were based on FCS beneficiaries enrolled in 2018 (the first year of the FCS program) and therefore might reflect initial difficulties in implementing the housing program. Large changes in measures (particularly health outcome measures) shown here should be viewed with caution, as they may have been driven by small sample sizes making results less reliable. The final evaluation report will examine outcomes for FCS participants through a later date, allowing for the inclusion of a larger study population.

MTP Initiative 4

This section presents an evaluation of the Medicaid Transformation Project Initiative 4 – **Washington State's substance use disorder waiver**. Initiative 4 allows the state to receive federal payments for residential and inpatient services and includes a broad set of milestones that are designed to support evidence-based treatment for SUD.

Chapter 14 presents findings from interviews and quantitative analyses focused on SUD outcomes.

Additional detail from this analysis is reported in the Mid-Point Assessment of Washington's SUD waiver.

KEY FINDINGS

Our evaluation of MTP Initiative 4 found the following:

- *Access to and quality of substance use treatment improved in the first year following implementation of Washington's SUD waiver. There were substantial improvements in, for example, measures of Initiation of Alcohol and Other Drug Dependence Treatment, and Access to Preventive Services for Individuals with Substance Use Disorders.*
- *A variety of measures pointed to increased capacity for providers authorized to prescribe medications for opioid use disorders and the number of patients receiving substance use treatment.*
- *Despite this progress, there were implementation challenges, particularly in the state's transition to integrated managed care. According to providers, the transition created delays in payment and adversely affected provider organizations' financial stability. As managed care organizations took on financial risk for residential services, disagreements emerged between payers and providers about the role of residential care in SUD treatment.*

Recommendations

- 1** **Although the 1115 SUD waiver emphasizes the role of IMDs, the Health Care Authority (HCA) should continue to assess the entire system of substance use prevention, treatment, and recovery, with IMDs and residential services serving as part of the continuum of care. HCA will need to ensure that the waiver does not create incentives for unnecessary residential stays; however, we see no evidence that this is currently occurring. HCA should continue to monitor data on admissions, length of stay, and the use of outpatient services.**

2 While the SUD waiver increased the availability of IMDs to receive FFP beyond 15 days, the transition to IMC appears to have created unintended consequences. These may be short-term transitional challenges, but will be important for HCA to monitor:

- **Providers indicated that the IMC transition negatively impacted the timeliness of payment for claims.** In 2020, the state released a new Request for Proposals (RFP) designed to add MCOs to service areas with fewer than five MCOs and where medical and behavioral providers had indicated support for additional MCOs in the IMC program. The new changes are set to be executed in 2021. HCA should assess the extent to which issues around the timeliness of payments are resolved.
- **The IMC transition also created additional barriers to treatment or challenges for residential treatment facilities, including new preauthorization requirements.** HCA should monitor the extent to which providers and MCOs have adapted to these requirements and patient needs.
- **There may be regional capacity issues that restrict access to withdrawal and detoxification services.** Given the urgency of these services and their role in preventing overdose deaths, HCA should consider an assessment of the availability of these services across regions and identify options to reduce bottlenecks.

Although not part of the formal evaluation design, **three important contextual factors** deserve consideration for future state planning:

- **The COVID-19 epidemic resulted in an expansion of telehealth, including services that expanded to SUD.** Although the epidemic creates a separate set of challenges around access and utilization, telehealth's increased availability appears beneficial. The state should assess how telehealth and SUD services can be continued in the future. In particular, telehealth for SUD may improve access in rural areas or increase the ability to provide medications through a combination of mail and telehealth.
- **A recent report identified a sharp increase in fentanyl overdoses on the West Coast,** with the number of fentanyl-involved deaths in King County increasing from 33 in 2017 to 112 in 2019 and a projected number of 174 in 2020 (Shover, et al., 2020). Confronting the potential for greater fentanyl use may require adjustments from providers and payers. For example, a review of the standard prescribed dose of naloxone may be warranted, because overdoses from fentanyl may require larger doses of naloxone to reverse the effects.
- **While the focus of our evaluation and the IMD waiver is primarily a response to the opioid epidemic, methamphetamines represent a significant and growing challenge.** While deaths from opioids have been relatively stable between 2015 and 2018 (with deaths per 100,000 individuals rising slightly from 9.9 to 10.4), deaths from methamphetamines have been increasing, rising from 4.9 deaths per 100,000 individuals in 2015 to 7.1 deaths per 100,000 individuals in 2018 (University of Washington Alcohol and Drug Abuse Institute, 2020). Unlike for opioids, we have not developed effective medications to treat methamphetamine addiction, creating additional challenges to treatment. HCA may be able to improve patient outcomes by explicitly acknowledging the growing importance of methamphetamine and by supporting evidence-based treatments and therapies for methamphetamine addiction.

Washington's Substance Use Disorder Waiver Amendment

In July 2018, the Centers for Medicare and Medicaid Services (CMS) amended Washington State's 1115 Medicaid demonstration waiver to authorize changes in how the state could provide and pay for care for substance use disorders (Centers for Medicare and Medicaid Services, 2018).

This chapter presents interim findings from our evaluation of the Substance Use Disorder (SUD) waiver. We examine how SUD diagnoses, treatment, and treatment capacity changed during the first year of the waiver (through June 2019) and place these findings in the context of the planning and implementation activities occurring across the state during this period.

Washington is one of 26 states to apply for and receive an SUD waiver between 2015 and 2019. Thus, findings from this evaluation have implications for understanding how SUD waivers may impact Medicaid populations broadly.

Background

Institutions for mental disease (IMDs) are facilities (including hospitals, nursing care facilities, or residential treatment facilities) with more than 16 beds that focus primarily on the treatment of behavioral health disorders (including substance use disorders). Since 1965, federal exclusions have typically prohibited the use of Medicaid funds to pay for the treatment of adults aged 21-64 in IMDs (Medicaid and CHIP Payment and Access Commission, 2020).

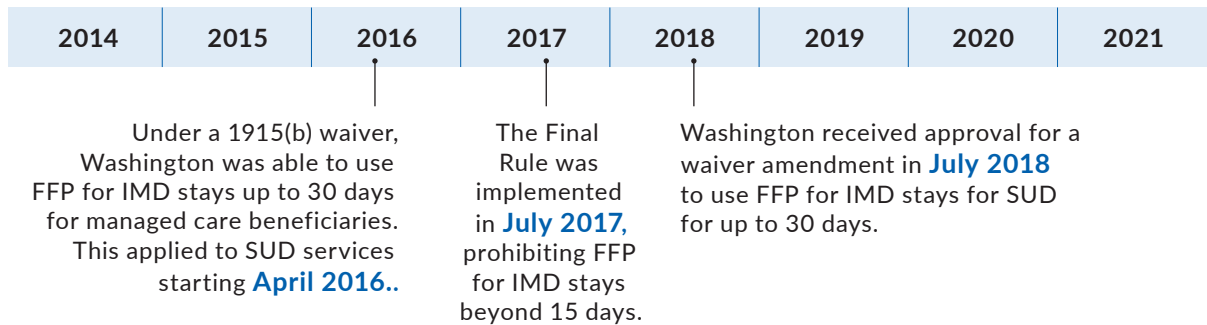
Despite this prohibition, for several years, Washington State had federal approval via a 1915(b) Home and Community-Based Services waiver to use federal Medicaid funds to pay for SUD services provided in IMD facilities for managed care beneficiaries, in lieu of providing those services in non-IMD settings.

Washington's approval to use federal funds to pay for SUD services in IMDs was temporarily revoked in July 2017. With the implementation of the 2016 Managed Care Final Rule, these federal funds, also known as Federal Financial Participation (FFP) payments, were prohibited for IMD stays greater than 15 days (see Figure 1). As a result, Washington was constrained to pay for treatment in IMDs beyond 15 days using only state funding. These changes may have restricted the supply of IMD beds while also reducing the state's ability to fund other SUD-related services.

In July 2018, Washington received an amendment to its 1115 waiver, with the amendment designed to maintain and expand access to residential and inpatient SUD treatment. The amendment authorized Washington "to receive federal financial participation for the provision of all Medicaid state plan services - including a continuum of services to treat addictions to opioids and other substances - for Medicaid enrollees primarily diagnosed with opiate use disorder (OUD) and/or other SUDs who are short-term residents in residential and inpatient treatment facilities that meet the

definition of an institution for mental diseases (IMD)" (Centers for Medicare and Medicaid Services, 2018).

Exhibit X: Policy Changes Affecting Washington State Federal Financial Participation for IMD Stays



MTP Approach to Change

In addition to allowing Washington State to use FFP payments for residential and inpatient services, the SUD waiver also outlined a broad set of **milestones** that included:

- 1 Increasing access to critical levels of care for opioid use disorder (OUD) and other SUDs;
- 2 Achieving widespread use of evidence-based, SUD-specific patient placement criteria;
- 3 Using nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications;
- 4 Achieving sufficient provider capacity at each level of care, including providers authorized to prescribe medications for opioid use disorder;
- 5 Implementing comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
- 6 Improving care coordination and transitions between levels of care.

The SUD waiver amendment also addressed some inconsistencies in how different age groups were treated. Whereas federal IMD regulations allowed FFP payments for SUD treatment in IMDs for individuals older than 65 and younger than 21, Washington's amendment also allowed FFP for services to Medicaid beneficiaries aged 21-64.

Progress Toward Implementing the SUD Waiver

Increasing IMD Capacity

Before the waiver, many residential treatment facilities had limited their capacity to 16 beds as a mechanism for avoiding the IMD regulations. In some cases, a single provider might own multiple smaller, separately licensed facilities. However, these smaller facilities were inefficient and costly to operate. There is some expectation that the IMD waiver might prompt the owners of multiple 16-bed entities to consolidate their operations and become larger IMDs.

The SUD waiver amendment became effective on July 1, 2018. At that time, Washington had 1,643 beds across 118 facilities (not all of which were IMDs) that accepted Medicaid enrollees and billed for SUD services for adults. Between July 1, 2018, and June 30, 2019, Washington added one SUD residential IMD with a total of 210 additional licensed beds. Washington also added four mental health hospital IMDs, totaling 398 new licensed beds (“licensed” beds do not necessarily reflect actual bed capacity, as facilities may be licensed for more beds than they are staffed for). By June 2019, state licensing data reflected that Washington State had a total of 36 licensed IMD facilities, consisting of eight mental health hospital IMDs, four mental health evaluation and treatment IMDs, 22 SUD residential IMDs, and two mental health residential IMDs.

Although the waiver has increased the potential capacity of IMDs, interviewees described other challenges in access to withdrawal or detoxification services. Some early challenges – related to preauthorization requirements from managed care organizations – appear to have been resolved by the Health Care Authority. However, capacity may be constrained in some regions, leading to continued concerns about access to these services.

Competing Priorities and Tensions Between Providers and Managed Care Organizations

At the time of Washington’s implementation of its SUD waiver, the state was also making a transition to integrated managed care (IMC, see Chapter 3 for additional details). Under IMC, managed care organizations (MCOs) moved from responsibility for physical health to responsibility for both physical and behavioral health care. Although the move to IMC was intended to improve access to and treatment for behavioral health, it produced some unintended consequences. In interviews, key informants reported that IMC was associated with new administrative processes, requirements for prior authorization, challenges in obtaining authorization, and severe payment delays. These changes adversely affected the financing and sustainability of residential treatment facilities. According to several providers we interviewed, some residential SUD facilities – particularly smaller facilities – came close to the brink of closure because of cash flow shortfalls and the need to make investments in their administrative and data infrastructure.

The transition to IMC also exposed philosophical differences between MCOs and behavioral health providers. Providers saw themselves as treating complex social-behavioral disorders and described IMDs and residential treatment as an opportunity to remove patients from potentially destructive environments so they could focus on learning new behaviors. In particular, providers viewed 30-day residential or inpatient stays as the minimum appropriate treatment for patients with longer-term substance use disorders.

In contrast, MCOs considered eligibility for residential treatment through a narrow lens of American Society of Addiction Medicine (ASAM) criteria and medical necessity, despite acknowledging the limitations of this lens. Whereas MCOs placed weight on the ASAM criteria as necessary for

determining who should be admitted, providers were sensitized to social factors and the potential for a 30-day stay to serve as an essential step in recovery and treatment. These philosophical differences between providers and MCOs may have hindered progress toward expanding IMD-based treatment options.

Evaluation Approach

Our evaluation focused on the ways in which the demonstration may have increased access to and utilization of SUD treatment services. The primary focus of our evaluation is adults enrolled in Medicaid with a substance use disorder diagnosis (see Data Appendix, Table 7).

Because Washington's SUD waiver was approved by CMS six months later than the other MTP initiatives (which began January 2018), the evaluation of MTP Initiative 4 includes a baseline (pre-implementation) period of July 2017 - June 2018 (i.e., "SUD Year 2018") and a post-implementation period of July 2018 - June 2019 ("SUD Year 2019"). *See page 21 of this report for a guide to reading results.*

How are these results impacted by COVID-19?

The COVID-19 outbreak began in Washington State in early 2020, causing widespread disruption to health services delivery across the state. This chapter presents analyses of claims data through June 2019, prior to the outbreak. It is therefore unlikely that COVID-19 had any effect on measures presented in this report, though future reporting periods may be affected.

Results

Exhibit 15.1 displays statewide changes in key metrics related to access and quality of care. The majority of these measures were calculated on an SUD year basis. The analyses compared a baseline period of July 2017 - June 2018 to a post-SUD waiver period of July 2018 - June 2019. The one exception was the measure adult access to preventive/ambulatory services for Medicaid beneficiaries with substance use disorder, which was calculated on a calendar year basis due to differences in availability of data. For this measure, we excluded 2018 as a "washout" year and calculated results comparing calendar years 2017 to 2019.

The majority of measures of substance use prevention treatment and quality moved in the desired direction. For example, substance use disorder treatment penetration increased by more than 2 percent; access to preventive services for individuals with substance use disorder increased by 4.4 percent; and measures of follow-up after emergency department visit for alcohol or drug dependence (7 day and 30 day) both exhibited statistically significant increases.

The measure Foundational Community Supports beneficiaries with inpatient or residential SUD service(s) increased by more than three percent. Initiation and engagement of alcohol and other drug dependence treatment also increased. The percentage of patients prescribed chronic concurrent opioids and sedatives, and patients prescribed high-dose chronic opioid therapy (greater than 90mg) decreased significantly. The average length of stay in IMDs did not change.

Exhibit 15.1: Change in Access and Quality of Care for People with Substance Use Disorder

Statewide rate June 2017 to July 2018, statewide rate July 2018 to June 2019, and adjusted pre-post change

	2017-18 Statewide	2018-19 Statewide	Adjusted Change
30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	23.9 %	26.2 %	2.2***
30-Day Follow-Up After ED Visit for Mental Illness	73.6 %	71.1 %	-2.1***
7-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	14.9 %	16.2 %	1.3**
7-Day Follow-Up After ED Visit for Mental Illness	63.3 %	59.8 %	-3.2***
Access to Preventive/Ambulatory Health Services for People with SUD	83.7 %	89.4 %	4.4***
Alcohol or Other Drug Treatment: Engagement	12.9 %	14.8 %	1.8***
Alcohol or Other Drug Treatment: Initiation	34.2 %	37.5 %	3.1***
All-Cause Emergency Department Visits per 1000 Beneficiaries	49.0	51.0	-0.7
Average Length of Stay in IMDs	19.5	20.3	0.3
Continuity of Pharmacotherapy for Opioid Use Disorder	60.0 %	56.2 %	-4.2***
FCS Beneficiaries with Inpatient or Residential SUD Service(s)	0.5 %	4.0 %	3.5***
Inpatient Admissions for Substance Use Disorder per 1000 Beneficiaries	18.6	19.8	0.2
Overdose Deaths (count)	567	NA	NA
Overdose Deaths (rate)	0.03 %	NA	NA
People with an Opioid Prescription >90mg MED ↓	17.4 %	16.4 %	-1.4***
People with an Opioid Prescription who were Prescribed a Sedative ↓	21.4 %	19.0 %	-2.6***
Readmissions Among Beneficiaries with SUD	17.8 %	17.5 %	-0.2

Note: Shaded cells indicate a statistically significant change. Blue shaded cells indicate an improvement. Orange-shaded cells indicate declining performance. Results marked * are significant at the p<.05 level. Results marked ** are significant at the p<.01 level. Results marked *** are significant at the p<.001 level. Adult access to preventive/ambulatory health services for Medicaid beneficiaries with substance use disorder was calculated on a calendar year basis due to differences in availability of data. All other measures are presented on a July to June basis.



We also examined measures of health services utilization, as specified by the state's evaluation design (see Exhibit 15.2). These measures assessed simple changes in utilization; we do not present statistically adjusted differences. After the introduction of the SUD waiver, the number of individuals who received some form of SUD treatment increased by 5,691, relative to the prior year. Furthermore, in the first year of the SUD waiver, 7,647 more individuals received medications for substance use disorders, and the number of providers who billed for medications increased by 367. Finally, we saw increases in the number of beneficiaries receiving services for substance use disorders, including early interventions, outpatient services, residential and inpatient services, and withdrawal management.

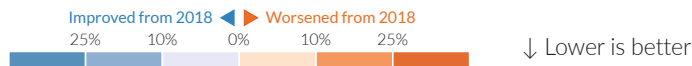
A small number of measures did not move in the anticipated or desired direction. Follow-up after emergency department visit for mental illness (30-day and 7-day measures) decreased slightly, and continuity of pharmacotherapy for opioid use disorder also decreased. In addition, the number of unique Medicaid beneficiaries treated in an IMD for an SUD decreased slightly in the first year after the waiver.

Exhibit 15.2: Change in Health Services Utilization for People with Substance Use Disorder

Statewide rate June 2017 to July 2018, statewide rate July 2018 to June 2019, and pre-post change

	2017-18 Statewide	2018-19 Statewide	Change
Any SUD Treatment	64,601	70,292	5,691
Early Intervention	1,482	1,740	258
Medicaid Beneficiaries Treated in an IMD for SUD	6,861	6,838	-23
Medicaid Beneficiaries with an SUD diagnosis	170,587	168,505	-2,082
Medications for Addiction Treatment	30,251	37,898	7,647
Outpatient Services	37,854	39,729	1,875
Residential and Inpatient Services	9,823	11,156	1,333
Withdrawal Management	8,697	9,548	851

Note: Shaded cells indicate a statistically significant change. **Blue** shaded cells indicate an improvement. **Orange**-shaded cells indicate declining performance. Results marked * are significant at the p<.05 level. Results marked ** are significant at the p<.01 level. Results marked *** are significant at the p<.001 level.



Our final report will include information on changes in overdose deaths and the overdose rate that occurred after the SUD waiver. These data were not available at the time this interim report was created. In the year prior to the SUD waiver, the state recorded 567 overdose deaths in the Medicaid program, resulting in an overdose death rate of .03 percent.

ACH-Level Results

Our evaluation included analysis of SUD measures across each ACH (see Data Appendix, Table 7). Many of these changes mirror statewide changes. For example, access to preventive services for individuals with substance use disorder increased in each ACH. Better Health Together, in particular, showed considerable progress, demonstrating statistically significant changes in 10 out of 16 measures. In contrast, relatively few measures changed in SWACH, and follow-up after emergency department visits for alcohol or drug dependence decreased significantly for this ACH. Substance use disorder treatment penetration increased in seven of the nine ACHs, with the largest increases in Better Health Together and Elevate Health.

Conclusions

Overall, these results suggest that, across many domains, the state has improved its ability to provide substance use treatment to Medicaid enrollees. Among 24 measures, 18 improved, and six demonstrated no change or slightly worse performance. These findings point to significant progress in expanding access and provider capacity, increasing treatment and treatment availability, and improving care coordination.

These findings have important limitations. For example, our ability to measure the quality of life, addiction need, and changes in mortality, morbidity, or addiction severity are limited in administrative data. In addition, the SUD waiver represents one piece of a larger statewide and

national effort to address the opioid epidemic. We cannot attribute the positive changes in this study to the SUD waiver alone. Furthermore, while the quantitative trends are promising, qualitative data suggest ongoing challenges with reimbursement and coordination between MCOs and residential treatment facilities. There is some tension between providers who view residential treatment and appropriate for certain populations, whereas MCOs have concerns about managing utilization. Furthermore, while integrated managed care might improve access to SUD treatment over the longer run, the shift to integrated managed care may have introduced a new level of administrative burden that has introduced challenges for reimbursement.

Future reports will provide additional information on the changes occurring in subsequent years, with some increased ability to discern mortality and overdose trends.

Interim Evaluation Conclusions and Recommendations

Washington's Medicaid Transformation Project (MTP) is an ambitious effort to improve care and outcomes for a wide range of Medicaid beneficiaries, including children, mothers, adults with chronic disease, individuals with mental health and substance use disorders, and people with complex health and social service needs.

- MTP funds Accountable Communities of Health (ACHs), regional entities designed to align health care and social-service sectors and address social determinants of health (SDOH).
- MTP initiatives encompass foundational factors in the performance of the health system, including value-based payment (VBP), health care workforce capacity, and health information technology (HIT).
- MTP initiatives support informal caregivers, with the goal of slowing the transition to use of traditional long-term services and supports (LTSS). MTP also funds housing and employment supports for the most vulnerable Medicaid beneficiaries.
- MTP includes efforts to maintain and expand access to inpatient and residential treatment for substance use disorders.

Three years into MTP, Washington State has demonstrated progress toward its goal of transforming care. Key findings and recommendations of the Interim Evaluation are summarized below.

Statewide Medicaid System Performance Under DSRIP

With regard to Washington's overall Medicaid system performance under the Delivery System Reform Incentive Program (DSRIP), we found substantial improvements in measures related to substance use disorder and chronic conditions. Changes across other performance measure domains were modest or unchanged during this period (see Chapter 1 for details).

Racial and ethnic disparities were evident, and additional effort is needed to achieve equity in the state's transformation of care. Black and American Indian/Alaska Native beneficiaries experienced less access to, or a lower quality of, care on the majority of measures than Medicaid beneficiaries of other races. Asian and Hispanic beneficiaries also experienced lower quality of care on some measures relative to other Medicaid beneficiaries. However, these differences were less pronounced than for Black and American Indian/Alaska Native members.

In summary:

- **Substance Use Disorder Care improved meaningfully across the state for all performance measures.** Quality measures were lower for most communities of color and for higher-poverty areas.
- **Opioid Prescribing and Opioid Use Disorder Treatment exhibited improvements across the state,** including decreases in opioid prescriptions and improvements in access to treatment.
- **Care for People with Chronic Conditions measures improved modestly from 2018 to 2019,** although most measures. American Indian/Alaska Native and Black beneficiaries experienced significant disparities in the quality of care in this domain.
- **Mental Health measures demonstrated mixed performance for Medicaid members as a whole;** some measures were slightly better than average for people with serious mental illness and rural residents than for all Medicaid beneficiaries.
- **Social Determinants of Health measures were largely unchanged from prior years.** High rates of homelessness persisted among people with serious mental illness and American Indian/Alaska Native and Black Medicaid beneficiaries.
- **Access to Primary and Preventive Services measures were mostly unchanged.** Rates of access were similar for urban and rural areas but lower among Native Hawaiian and Pacific Islanders.
- **Oral Health Care measures were largely unchanged.** Some populations, such as people in rural and high-poverty areas and American Indian/Alaska Native and Black beneficiaries, continued to be served at lower rates than the state as a whole.
- **Reproductive and Maternal Health Care measures were stable.** Disparities were evident for Asian, Black, and Hawaiian/Pacific Islander beneficiaries.
- **Prevention and Wellness measures were also relatively stable.** American Indian/Alaska Native beneficiaries had lower rates of preventive screenings and well visits relative to other Washington Medicaid members.
- **ED, Hospital, and Institutional Care Use measures did not change substantially for the state as a whole.** Utilization of these services was higher among people with chronic conditions or serious mental illness.

Recommendations

- 1 **Structural factors may drive differences in access and quality for specific racial and ethnic groups.** These factors may occur at local, regional, or statewide levels. These may include, for example, differences in primary care, behavioral health, or SUD treatment provider availability across neighborhoods, different rates of provider dismissals of patients (e.g., “firing” patients), or beneficiary experiences of racism and discrimination. The state should seek to identify the specific structural issues that may be driving differences in access and quality of care for Medicaid members.
- 2 **The state’s managed care contracts may present untapped options to further promote equity.** Performance measures or shared risk arrangements that incentivize health equity may be an additional mechanism for the state to prioritize health equity and steer resources appropriately.

- 3 **The state should assess the potential for additional collaboration with Tribes** to identify strategies to improve access to and quality of care for Washington's American Indian Medicaid beneficiaries.
- 4 **ACH partnerships with community-based organizations may present opportunities to better reach Washington's American Indian/Alaska Native, Black, and other racial and ethnic minority members.** In particular, ACHs' role in supporting Washington State's COVID-19 response and recovery may be an important mechanism for reducing the pandemic's disproportionate harm to communities of color.
- 5 **More explicit promotion of MTP's emphasis on social determinants of health may be necessary.** The state should explore opportunities to directly engage ACHs and managed care organizations (MCOs) in targeted regional efforts to decrease racial and ethnic disparities in homelessness, arrest rates, and unemployment.

Value-Based Payment

Washington State has demonstrated progress toward MTP goals related to value-based payment, including:

- Achieving targets for VBP participation by MCOs; and
- Expanding participation in VBP arrangements by primary care practices.

As noted in Chapter 1, a 2019 survey conducted by the Health Care Authority (HCA) found that Washington State's MCOs have made particular progress toward the adoption of shared savings and shared risk arrangements. More than half of MCO payments to Medicaid providers in 2018 were made through arrangements that included shared savings and shared risk, compared with 20 percent of commercial payments and 8 percent of Medicare Advantage payments (Washington State Health Care Authority, 2019d).

This topic will be explored in further detail in the MTP Final Evaluation Report, including results from the second round of surveys examining VBP arrangements.

Washington's Health Care Workforce

The interim evaluation includes several findings on the development of workforce capacity:

- **Workforce shortages were cited as one of the top challenges in implementing MTP initiatives.** Specific examples included psychiatrists or clinical social workers to support Health Improvement Project 2A (bi-directional integration), providers eligible to become certified to prescribe medications for addiction treatment in support of Project 3A (opioid interventions), and rural health care providers or first responders who ACHs could engage in implementing chronic disease interventions.
- **ACHs devoted substantial effort to regional workforce development as part of Health Improvement Project (HIP) work.** Planning and early implementation of HIPs often required retraining existing workers for new clinical activities ACHs sought to promote, such as new screening protocols. ACHs also recruited new employees to serve in care coordination or patient navigator roles necessary for project implementation.

- **Community health workers (CHWs) played an important role in ACH and regional progress toward HIP implementation.** Recruitment of CHWs was critical for the implementation of projects such as care coordination hubs, and regions with established CHW workforces at the beginning of the MTP demonstration reported fewer challenges with project rollout. Retention of CHWs was cited as a challenge that hindered implementation progress across multiple areas (see Chapter 4).

This topic will be explored in further depth in upcoming Rapid Cycle Reports and the MTP Final Evaluation Report, including additional findings from surveys and interviews with provider organizations and other stakeholders.

Recommendations

- 1 **The state should assess the potential for supporting the expansion of the community health worker workforce.** Workforce shortages may limit ACH efforts to “scale and sustain” progress made toward HIPs. Difficulty recruiting for these positions may limit ACH progress on care coordination or care transitions.
- 2 **The state should explore opportunities to identify and address factors contributing to turnover in key workforce roles related to MTP projects, such as care coordination.** There may be opportunities to engage MTP stakeholders in more targeted efforts to address common retention challenges across regions. Recruiting and retaining a diverse workforce may also be important for addressing health disparities.

Health Information Technology

A goal of MTP is to promote provider adoption and use of health information technology (HIT) and interoperable health information exchange (HIE) platforms. Our interim evaluation of MTP has found the following to date:

- **ACHs leveraged care coordination platforms developed for Project 2B (Community-Based Care Coordination) to support a wide range of health promotion activities,** including all projects within Domain 2 (Care Delivery Redesign) and most projects in Domain 3 (Prevention and Health Promotion). Once in place, a shared HIT infrastructure could be leveraged to support mutually reinforcing activities that were applicable to most HIPs.
- **MTP required substantial effort from partnering organizations to participate in new HIT/HIE tools.** Stakeholders noted that HIT/HIE platforms may be most easily adopted by medical providers with prior experience with electronic health record systems or OneHealthPort. Behavioral health providers or human service organizations may bear a higher burden to join projects that involve information exchange. As detailed in Chapter 5, ACHs reported the need for community information exchanges or alternative HIT/E tools for these partners.
- **Stakeholders expressed a desire for a statewide HIT/HIE strategy to promote standardization and interoperability.** The diversity of HIT/HIE platforms used across regions and between various types of partnering providers was identified as a challenge for regional coordination or implementation of closed-loop referral networks.
- **There were concerns about the distribution of HIT/HIE costs and effort related to MTP.** Behavioral health providers incurred new costs to acquire electronic health records and reporting systems to meet MCO billing requirements under Integrated Managed Care (IMC). ACHs

expressed concerns regarding the sustainability of the Community Information Exchange (CIE) infrastructure developed for HIPs, citing a lack of renewable funding streams to support that work.

Recommendations

- 1 The state should lead efforts to promote standardization of HIT/HIE platforms across regions and sectors**, with particular attention to lowering barriers to adoption among behavioral health providers.
- 2 The state should consider the potential benefits from a single, standardized CIE** that would facilitate information transfer across regions and avoid fragmentation that could arise with multiple CIEs. The diversity of potential approaches and tools across sectors and regions will hinder locally led efforts to achieve interoperability. ACHs also need clear guidance regarding the state's vision for the financing mechanism that should support CIE.

ACH Performance Through Health Improvement Projects

We evaluated the impact of eight health improvement projects (HIPs) implemented by ACHs, as detailed in Chapters 2-10. These results were based on data from the first year of implementation and most HIPs were in an early stage of implementation at the time of this analysis. ACHs focused on developing the partnerships, workforce, and HIT infrastructure necessary to support new interventions.

We observed a variety of improvements in outcome measures for target populations in projects 2A (e.g., bi-directional integration of physical and behavioral health care) and 3A (e.g., addressing the opioid crisis). There were fewer significant or detectable improvements in analyses of other HIPs.

Care Delivery Redesign Projects

Our results suggest that ACH Health Improvement Projects in Domain 2, "Care Delivery Redesign," are underway, with improvements in some measures during this period. Specifically:

- **All ACHs participated in projects to integrate physical and behavioral health care (2A).** We observed improvements in a number of measures related to mental health treatment in primary care settings and prevention and treatment of substance use disorders.
- **Six ACHs implemented Pathways Community HUBs to support care coordination and information exchange in their regions (2B).** Measures of mental health treatment penetration and follow-up after emergency department visits for substance use disorders improved in participating ACHs relative to non-participating regions.
- **Five ACHs participated in transitional care projects for people exiting from intensive or institutional care settings to their homes, supportive housing, or communities (2C).** For this project, participating ACHs demonstrated poorer performance among some measures than those ACHs that did not select this project.
- **Three ACHs engaged in projects to intervene and redirect Medicaid beneficiaries from correctional settings or emergency departments to primary care, behavioral health, or SUD care when appropriate (2D).** Among high emergency department utilizers (>5 visits per year), rates of mental health penetration improved and hospital readmissions declined in participating ACH regions. However, we observed few other differences across ACHs.

Prevention and Health Promotion Projects

Like Domain 2, a variety of efforts are underway for projects in Domain 3, “Prevention and Health Promotion,” with improvements in some areas in the first year of implementation. Specifically:

- **Opioid prescribing rates and opioid use disorder (OUD) treatment rates improved during this period.** All ACH regions participated in projects to address OUD, emphasizing provider education, training in opioid prescribing approaches, and OUD treatment (3A).
- **Three ACHs participated in projects that addressed reproductive and maternal/child health, focusing on providing technical assistance to providers to implement evidence-based programs for pregnant and postpartum women (3B).** Relative to ACHs who did not participate in 3B, we did not observe improvements in quality measures related to reproductive health.
- **Two ACHs participated in Project 3C, focused on improving oral health access and integration of dental services into primary care.** There were modest improvements in the utilization of some dental services in participating ACHs relative to non-participating ACHs.
- **All ACHs participated in efforts to promote chronic disease prevention and control, promoting partner implementation of screenings and disease self-management programs (3D).** We observed promising improvements in hospitalization rates and emergency department utilization among people with chronic conditions. However, there were relatively few improvements in quality measures related to specific chronic diseases during this period.

Generally, we found few indications of change in measures that could be attributed to ACH Health Improvement Projects to date. However, projects were at an early stage of implementation at the time of this analysis. Measurable impacts of these efforts may not appear in the first year. A lack of measurable change may also reflect the prioritization of effort. For example, ACHs may have placed a lower priority on addressing reproductive, maternal and child health because they believed that these efforts would not change in performance measures. The MTP Final Evaluation Report will examine these measures later in time, providing a more complete picture of the impact of ACH projects on targeted Medicaid beneficiaries.

Recommendations

- 1 **Assessing ACHs’ role in the COVID-19 response** may be important for understanding the overall impact of ACH infrastructure and workforce investments on health system transformation during the demonstration, particularly in light of disruptions to health improvement projects.
- 2 **The state should continue to monitor performance across ACHs.** The COVID-19 pandemic may delay or reverse improvements in performance due to disruptions to the health care delivery system. A more extended period of observation that includes years beyond the pandemic will yield more robust conclusions about the impact of each project.
- 3 **Additional outreach may be needed from HCA to raise awareness among provider organizations and community partners about drivers of Medicaid program costs and service utilization.** Our evaluation identified misconceptions among stakeholders about certain characteristics of Washington’s Medicaid population. For example, there may be opportunities to raise awareness that maternal health care – including delivery and postpartum care – is a substantial component of Medicaid expenditures (Renfro, et al., 2018).

MAC and TSOA

We examined Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) program participants' satisfaction with the program, health outcomes, and use of traditional LTSS. As described in Chapters 11 and 12, we found:

- **Enrollment in both MAC and TSOA ramped up slowly, but satisfaction in both programs was high.** There appears to have been more interest and incentive to enroll in TSOA than in MAC. Care recipients and their informal (unpaid) caregivers expressed high satisfaction with the two programs. Participants reported that the programs contributed to independence and were beneficial to physical and mental health.
- **MAC participants had fewer adverse health outcomes following enrollment.** These changes were comparable to outcomes for traditional in-home service users and reflected a relatively early period in the program's implementation.
- **Only a small proportion of MAC and TSOA participants went on to use traditional LTSS within six months of MAC and TSOA enrollment,** suggesting the program may have succeeded in deferring the need for more intensive services among participants.

Recommendations

- 1 **The state should explore options to ensure benefit packages are clearly understood across TSOA, MAC, and traditional long-term services and supports so individuals can make the choice that best meets their needs.** Low enrollment during their initial years suggests additional outreach efforts may be needed for the MAC and TSOA programs to reach people who could benefit from these programs. In addition, the service eligibility criteria for MAC and traditional Medicaid in-home services are similar, creating a potential disincentive for participants to select the MAC program's less intensive level of services.
- 2 **The state should explore options for improvement in scheduling and communication between MAC and TSOA clients, agency staff and service providers.** Despite high overall satisfaction with the programs, several participants reported concerns in these areas.

Foundational Community Supports

Our evaluation of the Foundational Community Supports program, or MTP Initiative 3, found promising early results for Medicaid members who participated in supported employment services, but little evidence of change from participation in supportive housing. As described in Chapter 13, our findings show:

- **Washington has successfully established a statewide network of FCS providers, but gaps in services remain.** The network of FCS service providers has gradually increased since the program launched in 2018. It now covers most counties in the state. Engagement of service providers in rural areas has been challenging, however. Stakeholders also noted that a lack of housing resources in many regions meant that participants had limited options.
- **FCS Supported Employment demonstrated progress increasing employment.** Rates of employment increased strongly for Medicaid enrollees who participated in FCS Supported Employment, relative to a matched comparison group. These changes were clearly evident in the months following receipt of FCS employment services.
- **The impact of FCS Supportive Housing is less clear.** Rates of homelessness did not improve for Medicaid enrollees who participated in FCS Supportive Housing. Stakeholders noted that FCS housing services typically need to be paired with other housing resources. A lack of affordable housing options limited FCS service providers' ability to connect participants with housing after they had enrolled in FCS.
- **Participants who engaged in both FCS housing and FCS employment did not experience improvement in rates of employment or homelessness.** This population may have unique service needs not well addressed by current program design.
- **Measures of health care access and utilization improved for some beneficiary groups.** For example, engagement in primary care and SUD treatment improved for participants who received both types of FCS services. However, these results are based on small sample sizes and should be interpreted with caution.

Recommendations

- 1 **The FCS Supported Employment program may play an important role in employment stability for Medicaid enrollees during and after the COVID-19 pandemic.** The Health Care Authority and the Aging and Long-Term Support Administration should continue to monitor the program for evidence of positive effects and consider ways to expand access, particularly in rural areas.
- 2 **Lack of housing and shelter resources will likely remain a limiting factor in the FCS Supportive Housing program's effectiveness in the absence of further action.** The state should explore how to expand affordable housing options for the Medicaid population that is eligible for this service.
- 3 **The population of people eligible for both FCS Supportive Housing and Supported Employment may need different types of employment services** than FCS participants who only enroll in supported employment (without enrolling in housing). The state should investigate options for better meeting the needs of this subpopulation, which did not exhibit improvements after receipt of employment services.

Substance Use Disorder

Our assessment of the impact of the Medicaid Substance Use Disorder (SUD) amendment to Washington State's 1115 demonstration waiver (described in Chapter 14) found:

- **Access to and quality of substance use disorder treatment improved in the first year of Washington's SUD waiver.** For example, there were substantial improvements in measures of initiation of alcohol and other drug dependence treatment and access to preventive services for individuals with SUDs. The number of patients receiving substance use treatment increased.
- **There was evidence of increased capacity** for providers authorized to prescribe medications for opioid use disorders and increases in the number of institutions for mental disease (IMD) billing for SUD treatment.
- **Despite this progress, there were implementation challenges.** The transition to integrated managed care (IMC) appears to have created unintended consequences for SUD treatment providers, including negatively impacting the timeliness of payment for claims to behavioral health providers and adversely affected provider organizations' financial stability.
- **The IMC transition also created challenges for residential treatment facilities,** including new prior authorization requirements. As managed care organizations (MCOs) took on financial risk for residential services, disagreements emerged between payers and providers about the role of residential care in SUD treatment.

The results of our interim evaluation of Washington State's SUD waiver are documented in detail in a separately published Mid-Point Assessment that includes additional information on progress toward key milestones and budget neutrality. Future evaluation activities will continue to monitor progress toward the SUD waiver goals, allowing further opportunity to observe changes in performance.

Recommendations

- 1 **The state should continue to assess the entire system of substance use prevention, treatment, and recovery,** considering IMDs and residential services as one part of the continuum of care. To ensure that the waiver does not create incentives for unnecessary residential stays, the state should continue to monitor trends in admissions, length of stay, and the use of outpatient services.
- 2 **The state should continue to monitor issues around the timeliness of behavioral health and SUD claims payments** and whether these issues may be resolved as MCO contract changes are executed in 2021.
- 3 **The state should monitor the extent to which providers and MCOs have adapted to new prior authorization requirements for services in IMDs.**
- 4 **There may be regional capacity issues that restrict access to withdrawal and detoxification services.** Given the urgency of these services and their role in preventing overdose deaths, HCA should consider assessing the availability of these services across regions and identifying options to reduce bottlenecks.

SUMMARY OF RECOMMENDATIONS

Specific recommendations for Washington State and the Health Care Authority arising from this interim evaluation include:

- **Address health disparities.** Our analysis of Medicaid system performance through 2019 revealed progress on some measures, as well as persistent racial and ethnic disparities in access and quality of care. HCA should further investigate structural factors that may drive differences among specific groups. The state's managed care contracts may also present options to reduce health disparities.
- **Strengthen the engagement of non-clinical partners in MTP.** Behavioral health, human services, and other community-based partners have faced particular challenges engaging in MTP. Achieving the state's goal of making progress on social factors such as homelessness, encounters with corrections, or unemployment may require further strengthening collaboration between the state, Tribes, ACHs, MCOs, Foundational Community Supports providers, and community-based organizations. The state should also explore how to increase housing options for FCS Supportive Housing participants.
- **Support the recruitment and retention of key workers necessary for MTP success.** Additional efforts may be needed in rural areas where, for example, difficulty recruiting community health worker positions may have restricted ACH progress. In-home caregiver demand is also projected to increase in future years.
- **Provide guidance regarding Washington's vision for community information exchange (CIE),** including the desired financing mechanisms to support CIE platforms. Promote standardization and interoperability of HIT/HIE platforms across regions and sectors, focusing on barriers to participation among behavioral health and SUD treatment providers.
- **Continue to monitor progress on ACH Health Improvement Projects.** ACHs' early activities focused on developing the infrastructure and workforce necessary to implement new interventions. A longer period of observation, and consideration of ACHs' roles in COVID-19 response and recovery, will yield more robust conclusions about the impact of ACH projects.
- **Ensure benefit packages are clearly understood across MAC, TSOA and traditional long term services and supports so that participants can choose benefits that best meet their needs.** Stronger incentives may be needed to promote enrollment in MAC versus traditional Medicaid in-home services.
- **Build on early positive results from the FCS Supported Employment program.** The program may play an important role in employment recovery after the COVID-19 pandemic. Further investigation is needed for whether additional or different employment services are needed for FCS participants who enroll in both supported employment and supportive housing services.
- **Continue to assess the entire system of substance use prevention, treatment, and recovery,** and ensure that the SUD waiver does not create incentives for unnecessary residential stays.
- **Monitor challenges identified in MCO payments made to behavioral health and SUD treatment providers,** including timeliness of payments and appropriateness of prior authorization requirements. Assess whether these challenges gradually resolve following the implementation of integrated managed care and the execution of new MCO contracts in 2021, or whether these challenges persist over time and warrant future changes to IMC.

Evaluation Next Steps

This report documents interim progress toward the MTP demonstration goals, focusing primarily on activities occurring through early 2020 and outcomes observed through late 2019.

Evaluation of MTP is ongoing, with additional data collection and analysis slated to occur, including:

- Interviews with state, ACH, provider organization, and community partner stakeholders to assess implementation progress, challenges, and successes through the end of the demonstration;
- A statewide survey of provider organizations and hospitals to assess VBP adoption and experiences later in the demonstration;
- Ongoing analysis of health care claims and other administrative data to assess changes in performance measures through the end of the demonstration;
- New analyses of measures related to health care costs across all four MTP initiatives;
- Consideration for how COVID-19 affected the trajectory and implementation progress of MTP initiatives in 2020 and beyond.

Interim findings will continue to be reported in quarterly Rapid Cycle Reports. At the time of this report, Washington State was engaged in negotiations with CMS regarding a potential one-year extension of MTP that would add a sixth year to the evaluation; no determination had been made at the time of publication. A Final Evaluation Report is currently planned in January 2022 that will present summative evaluation findings for the demonstration.

Conclusion

Washington State's Medicaid Transformation Program set ambitious goals for improving care delivery and promoting health for Washington's 1.9 million Medicaid beneficiaries between 2017 and 2021. By early 2020, the state had achieved important milestones for structural change. These include transforming payment mechanisms for behavioral health; introducing new options for meeting needs for supportive housing, LTSS, and supported employment; accelerating adoption of value-based payments; and spurring regional action on a range of population health efforts led by Accountable Communities of Health.

There are early signs of success. There have been meaningful improvements in substance use disorder treatment, care for people with chronic conditions, and in some measures of mental health quality and utilization. New employment supports for people with complex needs show early signs of success increasing employment and improving health outcomes. New, less intensive LTSS options for older adults appear to be achieving health outcomes similar to traditional Medicaid in-home services.

Initiatives focused on social determinants of health, homelessness, or health promotion have not yet shown strong evidence of change. ACHs have made investments in workforce and other infrastructure necessary to implement interventions in these areas. Additional efforts will be necessary to address the structural factors that currently limit access to and the quality of care for underserved groups, and more substantial improvements in these outcomes may take longer to emerge.

As Washington State transitions to the final years of the MTP demonstration, the full impact of the COVID-19 outbreak on the state's Medicaid population is not yet known. Monitoring and understanding the pandemic's effects on the Medicaid program and the state's progress in improving quality, controlling costs, and achieving equity will be important areas of focus for the final evaluation.

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Appendix A: Evaluation Measures

This appendix provides detailed information regarding the measures presented in this report. Measures are listed in alphabetical order below.

Please note that some measures are produced multiple times throughout this report for different populations of interest or for different measurement periods. The measurement period and the approach used to construct study populations for each analysis are described in detail in the relevant chapters of this report. See Appendix B of this report for a detailed description of quantitative methods.

1 Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD

This measure appears in Chapter 14 of this report.

Description: The percentage of Medicaid beneficiaries, 20 years of age and older, with a diagnosed substance use disorder who had an ambulatory or preventive care visit in the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA (modified)

2 Acute Hospital Utilization per 1,000 Members

This measure appears in Chapters 1, 3, 4, 5, 6, 7, 8, 9, 10, 11 and 12 of this report.

Description: The rate of Medicaid beneficiaries, 18 years of age and older, with acute hospital discharges. Metric is expressed as a rate per 1,000 members during the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

3 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

This measure appears in Chapters 1, 3, 4 and 13 of this report.

Description: Assesses adults 19–64 years of age who have schizophrenia and were dispensed and remained on an antipsychotic medication for at least 80% of the treatment period.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

4 Adult Access to Preventive/Ambulatory Health Services

This measure appears in Chapters 1, 3, 4, 6, and 13 of this report.

Description: The percentage of Medicaid beneficiaries, 20 years of age and older, who had an ambulatory or preventive care visit in the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

5 Adult Body Mass Index Assessment

This measure appears in Chapters 1 and 10 of this report.

Description: The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

6 All-Cause Emergency Department Visits, per 1,000 Member Months

This measure appears in Chapters 1, 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, and 14 of this report.

Description: The rate of Medicaid beneficiaries with visits to an emergency department, including visits related to mental health and substance use disorder. Metric is expressed as a rate per 1,000 denominator member months in the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: RDA

7 Antidepressant Medication Management (Acute Phase Treatment)

This measure appears in Chapters 1, 3, 4, and 13 of this report.

Description: The percentage of Medicaid beneficiaries 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks).

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

8 Antidepressant Medication Management (Continuation Phase Treatment)

This measure appears in Chapters 1, 3, 4, and 13 of this report.

Description: The percentage of Medicaid beneficiaries 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 days (6 months).

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

9 Any Substance Use Disorder (SUD) Treatment

This measure appears in Chapter 14 of this report.

Description: The number of Medicaid beneficiaries enrolled for at least one month during the measurement year who received any substance use disorder treatment service in the measurement period.

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

10 Assisted Living Utilization

This measure appears in Chapter 12 of this report.

Description: The number of one beneficiaries who enrolled in Tailored Supports for Older Adults (TSOA), Medicaid Alternative Care (MAC), and/or Medicaid in-home services who also entered an assisted living facility, as measured by approved claim, within the first six months of initiation of services. Medicaid beneficiaries were continuously enrolled in Medicaid for at least 6 months preceding initiation of program services (MAC or IHS).

Source: ProviderOne Medicaid claims/encounter data

Steward: CHSE

11 Asthma Medication Ratio

This measure appears in Chapters 1, 3, 4, 10, and 13 of this report.

Description: The percentage of Medicaid beneficiaries, 5-64 years of age, who were identified as having persistent asthma and had a ratio of controller medication to total asthma medications of 0.50 or greater during the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

12 Average Length of Stay in Institutions for Mental Disease (IMD)

This measure appears in Chapter 14 of this report.

Description: The average length of stay for Medicaid beneficiaries enrolled for at least one month during the measurement year and discharged from an IMD residential treatment facility for substance use disorder.

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

13 Breast Cancer Screening

This measure appears in Chapters 1 and 3 of this report.

Description: Assesses women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

14 Cervical Cancer Screening

This measure appears in Chapters 1 and 3 of this report.

Description: Assesses women 21–64 years of age who were screened for cervical cancer using either of the following criteria: 1) Women age 21–64 who had cervical cytology performed every 3 years, or 2) women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

15 Children's and Adolescents' Access to Primary Care Practitioners

This measure appears in Chapters 1, 3, 4, and 6 of this report.

Description: The percentage of Medicaid beneficiaries 12 months to 19 years of age who had an ambulatory or preventive care visit in the measurement year. This includes, but is not limited to, general medical exams and well-child visits.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA (modified)

16 Chlamydia Screening in Women

This measure appears in Chapters 1, 3, and 8 of this report.

Description: The percentage of female Medicaid beneficiaries, 16–24 years of age, identified as sexually active and who had at least one test for chlamydia during the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

17 Colorectal Cancer Screening

This measure appears in Chapters 1 and 3 of this report.

Description: Assesses adults age 50–75 who had appropriate screening for colorectal cancer with any of the following tests: Annual fecal occult blood test, flexible sigmoidoscopy every five years, colonoscopy every 10 years, computed tomography colonography every five years, or stool DNA test every three years.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

18 Comprehensive Diabetes Care: Eye Exam (Retinal) Performed<

This measure appears in Chapters 1, 3, 4, 10, and 13 of this report.

Description: The percentage of Medicaid beneficiaries, 18–75 years of age, with diabetes (type 1 and type 2) who had a retinal or dilated eye exam by an eye care professional during the measurement year, OR a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement year, OR a bilateral eye enucleation during the measurement year

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

19 Comprehensive Diabetes Care: Hemoglobin A1c Testing

This measure appears in Chapters 1, 3, 4, and 13 of this report.

Description: The percentage of Medicaid beneficiaries, 18–75 years of age, with diabetes (type 1 and type 2) who received a Hemoglobin A1c (HbA1c) test during the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

20 Comprehensive Diabetes Care: Medical Attention for Nephropathy

This measure appears in Chapters 1, 3, 4, and 13 of this report.

Description: The percentage of Medicaid beneficiaries, 18–75 years of age, with diabetes (type 1 and type 2) who had a nephropathy screening test or evidence of nephropathy during the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

21 Continuity of Pharmacotherapy for Opioid Use Disorder

This measure appears in Chapters 1, 3, 4, 10 and 13 of this report.

Description: The percentage of Medicaid beneficiaries 18 years of age and older with pharmacotherapy for opioid use disorder who have at least 180 days of continuous treatment.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

22 Contraceptive Care – Long Acting Reversible Contraception

This measure appears in Chapters 1 and 8 of this report.

Description: The percentage of female Medicaid beneficiaries, 15–44 years of age, at risk of unintended pregnancy that are provided a long-acting reversible method of contraception (provision of contraceptive implants, intrauterine devices or systems [IUD/IUS]).

Source: ProviderOne Medicaid claims/encounter data

Steward: U.S. Department of Health and Human Services

23 Contraceptive Care – Most and Moderately Effective Methods

This measure appears in Chapters 1 and 8 of this report.

Description: The percentage of female Medicaid beneficiaries, 15–44 years of age, at risk of unintended pregnancy that are provided a most effective (i.e., sterilization, implants, intrauterine devices or systems [IUD/IUS]) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved method of contraception.

Source: ProviderOne Medicaid claims/encounter data

Steward: U.S. Department of Health and Human Services

24 Contraceptive Care – Postpartum

This measure appears in Chapters 1 and 8 of this report.

Description: The percentage of female Medicaid beneficiaries, 15–44 years of age, who had a live birth that are provided a most effective (i.e., sterilization, implants, intrauterine devices or systems [IUD/IUS]) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA approved method of contraception within 60 days of delivery.

Source: ProviderOne Medicaid claims/encounter data

Steward: U.S. Department of Health and Human Services

25 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication

This measure appears in Chapters 1, 3, 4, and 13 of this report.

Description: Assesses adults 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

26 Early Intervention

This measure appears in Chapter 14 of this report.

Description: The number of Medicaid beneficiaries enrolled for at least one month during the measurement year, who were screened for substance use disorder using the Screening, Brief Intervention, and Referral to Treatment (SBIRT) during the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

27 Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries

This measure appears in Chapter 14 of this report.

Description: The rate of Medicaid beneficiaries who visited the emergency department for a substance use disorder during the measurement year. Results are reported as a rate per 1,000 members.

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

28 Engagement in Alcohol and Other Drug Abuse or Dependence Treatment

This measure appears in Chapters 1, 3, 4, 14, and 15 of this report.

Description: The percentage of Medicaid beneficiaries 13 years of age and older with a new episode of alcohol and other drug abuse or dependence who initiated treatment and had two or more additional AOD services or medications for addiction within 34 days of the initiation visit.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

29 FCS Beneficiaries with Inpatient or Residential SUD Service(s)

This measure appears in Chapter 14 of this report.

Description: The percentage of Medicaid beneficiaries, 12 years of age and older, with a substance use disorder treatment need identified within the past two years, who received at least one qualifying substance use disorder treatment during the measurement year and participated in the Foundational Community Supports (FCS) program.

Source: ProviderOne Medicaid claims/encounter data

Steward: RDA

30 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 days)

This measure appears in Chapters 1, 3, 4, 5, 14, and 15 of this report.

Description: The percentage of emergency department (ED) visits for Medicaid beneficiaries, 13 years of age and older, with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 30 days of the ED visit (31 total days).

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

31 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days)

This measure appears in Chapters 3, 4, 5, 14, and 15 of this report.

Description: The percentage of emergency department (ED) visits for Medicaid beneficiaries, 13 years of age and older, with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 7 days of the ED visit (8 total days).

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

32 Follow-up after Emergency Department Visit for Mental Illness (30 Days)

This measure appears in Chapters 1, 3, 4, 5, 6, 14, and 15 of this report.

Description: The percentage of emergency department (ED) visits for Medicaid beneficiaries, 6 years of age and older, with a principal diagnosis of mental illness or intentional self-harm, who had a follow up visit for mental illness within 30 days of the ED visit (31 total days).

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

33 Follow-up after Emergency Department Visit for Mental Illness (7 Days)

This measure appears in Chapters 3, 4, 5, 6, 14, and 15 of this report.

Description: The percentage of emergency department (ED) visits for Medicaid beneficiaries, 6 years of age and older, with a principal diagnosis of mental illness or intentional self-harm, who had a follow up visit for mental illness within 7 days of the ED visit (8 total days).

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

34 Follow-Up After Hospitalization for Mental Illness (30 Days)

This measure appears in Chapters 1, 3, 4, 5, and 13 of this report.

Description: The percentage of discharges for eligible Medicaid beneficiaries 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

35 Follow-Up After Hospitalization for Mental Illness (7 Days)

This measure appears in Chapters 3, 4, 5, and 13 of this report.

Description: The percentage of discharges for eligible Medicaid beneficiaries 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 7 days after discharge.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

36 In-Home Services Utilization

This measure appears in Chapter 12 of this report.

Description: The number of Tailored Supports for Older Adults (TSOA), Medicaid Alternative Care (MAC) and Medicaid in-home service beneficiaries who received at least one qualifying in-home service within the first six months of initiation of services. Medicaid beneficiaries were continuously enrolled in Medicaid for at least 6 months preceding initiation of program services (MAC or IHS).

Source: ProviderOne Medicaid claims/encounter data

Steward: CHSE

37 Initiation of Alcohol and Other Drug Abuse or Dependence Treatment

This measure appears in Chapters 1, 3, 4, 14, and 15 of this report.

Description: The percentage of Medicaid beneficiaries 13 years of age and older with a new episode of alcohol and other drug abuse or dependence who initiated treatment within 14 days of diagnosis.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

38 Inpatient Admissions for Substance Use Disorder per 1,000 Members

This measure appears in Chapter 14 of this report.

Description: The rate of Medicaid beneficiaries who had an inpatient stay for a substance use disorder during the measurement year. Results are reported as a rate per 1,000 members.

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

39 Long Term Services and Supports (not Assisted Living or Nursing Facility)

This measure appears in Chapter 12 of this report.

Description: The number of beneficiaries who received Medicaid Alternative Care (MAC), Tailored Supports for Older Adults (TSOA), or Medicaid in-home services, who also had at least one approved claim for qualifying long-term services and supports (not including Assisted Living or Nursing Facility services) within the first six months of initiation of services. Medicaid beneficiaries were continuously enrolled in Medicaid for at least 6 months preceding initiation of program services (MAC or IHS).

Source: ProviderOne Medicaid claims/encounter data

Steward: CHSE

40 Medicaid Beneficiaries Treated in an IMD for SUD

This measure appears in Chapter 14 of this report.

Description: The number of Medicaid beneficiaries enrolled for at least one month during the measurement year, who received residential treatment for a substance use disorder in an IMD during the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

41 Medicaid Beneficiaries with SUD Diagnosis (annually)

This measure appears in Chapter 14 of this report.

Description: The number of Medicaid beneficiaries enrolled for at least one month during the measurement year, with a substance use disorder diagnosis and a substance use disorder related service during the measurement year and/or in the 12 months before the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

42 Medicaid Beneficiaries with SUD Diagnosis (monthly)

This measure appears in Chapter 14 of this report.

Description: The number of Medicaid beneficiaries enrolled during the measurement month with a substance use disorder diagnosis and a substance use disorder related service during the measurement month and/or the previous 11 months.

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

43 Medications for Addiction Treatment

This measure appears in Chapter 14 of this report.

Description: The number of Medicaid beneficiaries enrolled for at least one month during the measurement year, who received medication for treatment for substance use disorder during the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

44 Mental Health Treatment Penetration (Broad Version)

This measure appears in Chapters 1, 3, 4, 5, 6, 8, and 13 of this report.

Description: The percentage of Medicaid beneficiaries, 6 years of age and older, with a mental health service need identified within the past two years, who received at least one qualifying service during the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: RDA

45 Nursing Facility Utilization

This measure appears in Chapter 12 of this report.

Description: The number of Tailored Supports for Older Adults (TSOA), Medicaid Alternative Care (MAC) and Medicaid in-home service beneficiaries who entered a nursing facility, as measured by approved claim, within six months of initiation of services. Medicaid beneficiaries were continuously enrolled in Medicaid for at least 6 months preceding initiation of program services (MAC or IHS).

Source: ProviderOne Medicaid claims/encounter data

Steward: CHSE

46 Outpatient Services

This measure appears in Chapter 14 of this report.

Description: The number of Medicaid beneficiaries enrolled for at least one month during the measurement year, who used outpatient services for substance use disorder during the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

47 Overdose Deaths (count)

This measure appears in Chapter 14 of this report.

Description: The number of overdose deaths among Medicaid beneficiaries during the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

48 Patients Prescribed Chronic Concurrent Opioids and Sedatives

This measure appears in Chapters 1, 7, and 15 of this report.

Description: The percentage of Medicaid beneficiaries prescribed chronic opioids and a concurrent chronic sedative prescription, among beneficiaries prescribed chronic opioids.

Source: ProviderOne Medicaid claims/encounter data

Steward: Bree Collaborative

49 Patients Prescribed High-Dose Chronic Opioid Therapy (>50 mg)

This measure appears in Chapters 1, 7, and 13 of this report.

Description: The percentage of Medicaid beneficiaries without a cancer diagnosis who were prescribed chronic opioid therapy greater than or equal to 50mg morphine equivalent dosage for at least 60 consecutive days during the calendar quarter.

Source: ProviderOne Medicaid claims/encounter data

Steward: Bree Collaborative

50 Patients Prescribed High-Dose Chronic Opioid Therapy (>90mg)

This measure appears in Chapters 1, 7, 14, and 15 of this report.

Description: The percentage of Medicaid beneficiaries without a cancer diagnosis who were prescribed chronic opioid therapy greater than or equal to 90mg morphine equivalent dosage for at least 60 consecutive days during the calendar quarter.

Source: ProviderOne Medicaid claims/encounter data

Steward: Bree Collaborative

51 Percent Arrested

This measure appears in Chapters 1, 3, 4, 6, and 13 of this report.

Description: The percentage of Medicaid beneficiaries, 18 to 64 years of age, who were arrested at least once during the measurement year.

Source: ProviderOne Medicaid enrollment data (for identification of Medicaid eligibility); Washington State Identification System (WASIS) arrest database

Steward: RDA

52 Percent Employed

This measure appears in Chapters 1, 3, and 13 of this report.

Description: Percentage of Medicaid members age 18 to 64 with any earnings in the year, as reported by the Washington State Employment Security Department.

Source: ProviderOne Medicaid enrollment data (for identification of Medicaid eligibility); earnings as reported by the Washington State Employment Security Department

Steward: RDA (modified)

53 Percent Homeless (Narrow Definition)

This measure appears in Chapters 1, 3, 4, 5, 6, and 13 of this report.

Description: The percentage of Medicaid beneficiaries who were homeless in at least one month during the measurement year. Definition excludes “homeless with housing” living arrangement code from the Automated Client Eligibility System (ACES)

Source: ProviderOne Medicaid enrollment data (for identification of Medicaid eligibility); DSHS Economic Services Administration’s Automated Client Eligibility System (ACES) living arrangement data

Steward: RDA

54 Periodontal Evaluation in Adults with Chronic Periodontitis

This measure appears in Chapters 1 and 9 of this report.

Description: The percentage of Medicaid beneficiaries, 30 years of age and older, with history of periodontitis who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: Dental Quality Alliance®

55 Plan All-Cause 30-Day Readmission

This measure appears in Chapters 1, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, and 13 of this report.

Description: The percentage of acute inpatient stays of Medicaid beneficiaries, 18 years of age and older, during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA (modified)

56 Providers Enrolled in Medicaid who Billed for Medications for OUD

This measure appears in Chapter 14 of this report.

Description: Number of providers enrolled in Medicaid that billed for MOUD services during the measurement period.

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

57 Psychiatric Inpatient Readmissions (30 days)

This measure appears in Chapters 1, 3, 4, 5, 6, 7, 8, 10, and 13 of this report.

Description: Percentage of hospital psychiatric stays among members age 18 and over with readmission for a psychiatric diagnosis within 30 days.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

58 Ratio of Home and Community-Based Long-Term Services and Support Use to Institutional (Nursing Facility) Utilization

This measure appears in Chapters 1, 3, 4, 5, 6, 7, and 13 of this report.

Description: Months of home and community-based services (HCBS) received by Medicaid members age 18 and over as a percentage of total months of long-term care received. HCBS includes assisted living services, adult residential care services, adult family homes, and in-home personal care services. Total long-term care includes HCBS and nursing home services.

Source: Medicaid enrollment and claims/encounters data, Division of Behavioral Health Services behavioral health services data, CARE assessment diagnoses for mental illness and substance use disorder, Medicare claims/encounters data, and long-term care service data

Steward: RDA

59 Readmissions Among Beneficiaries with SUD

This measure appears in Chapters 15 of this report.

Description: The percentage of acute inpatient stays of Medicaid beneficiaries with a substance use disorder, 18 years of age and older, during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

60 Residential and Inpatient Services

This measure appears in Chapter 14 of this report.

Description: The number of Medicaid beneficiaries enrolled for at least one month during the measurement year, who used inpatient or residential services for substance use disorder during the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

61 Statewide Deaths due to Drug Overdoses

This measure appears in Chapter 14 of this report.

Description: The number of fatal drug overdoses in the state of Washington, not restricted to Medicaid beneficiaries.

Source: Washington State death certificates

Steward: Washington State Center for Health Statistics

62 Statin Therapy for Patients with Cardiovascular Disease (Prescribed)

This measure appears in Chapters 1, 10, and 13 of this report.

Description: The percentage of males, 21–75 years of age, and females, 40–75 years of age, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

63 Substance Use Disorder Treatment Penetration

This measure appears in Chapter 14 of this report.

Description: The percentage of Medicaid beneficiaries, 12 years of age and older, with a substance use disorder treatment need identified within the past two years, who received at least one qualifying substance use disorder treatment during the measurement year.

Source: ProviderOne Medicaid claims, encounter and enrollment data; RSN/BHO encounter data and DBHR-paid behavioral health services for non-integrated managed care regions; Medicare Parts A and B claims and Medicare Part D encounters for dual eligibles.

Steward: RDA

64 Substance Use Disorder Treatment Penetration (Opioid)

This measure appears in Chapters 1, 7, and 12 of this report.

Description: The percentage of Medicaid beneficiaries, 18 years of age and older, with an opioid used disorder treatment need identified within the past two years, who received medication for an opioid use disorder (MOUD) during the measurement year

Source: ProviderOne Medicaid claims/encounter data

Steward: RDA

65 Tailored Supports for Older Adults Beneficiaries who Enroll in Medicaid Within Six Months

This measure appears in Chapter 12 of this report.

Description: The number of Tailored Supports for Older Adults beneficiaries who enrolled in Medicaid within 6 months of initiation of services in the TSOA program.

Source: ProviderOne Medicaid claims, encounter and enrollment data; RSN/BHO encounter data and DBHR-paid behavioral health services for non-integrated managed care regions; Medicare Parts A and B claims and Medicare Part D encounters for dual eligibles.

Steward: RDA

66 Timeliness of Prenatal Care

This measure appears in Chapter 1 of this report.

Description: The percentage of live birth deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment.

Source: ProviderOne Medicaid claims/encounter data; Vital statistics records.

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA

67 Topical Fluoride Application Delivered by Non-Dental Health Professional

This measure appears in Chapters 1 and 9 of this report.

Description: The percentage of Medicaid beneficiaries, 5 years of age and younger, who received a topical fluoride application by a non-dental medical provider during any medical visit.

Source: ProviderOne Medicaid claims/encounter data

Steward: HCA

68 Utilization of Dental Services

This measure appears in Chapters 1 and 9 of this report.

Description: The percentage of Medicaid beneficiaries of all ages who received preventative or restorative dental services in the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: Dental Quality Alliance

69 Well-Child Visits in the First 15 Months of Life

This measure appears in Chapter 1 of this report.

Description: The percentage of Medicaid beneficiaries who turned 15 months old during the measurement year and who had six or more well-child visits during their first 15 months of life.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA (modified)

70 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

This measure appears in Chapter 1 of this report.

Description: The percentage of Medicaid beneficiaries, 3 - 6 years of age, who had one or more well-child visits during the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS(R) Technical Specifications for Health Plans, NCQA (modified)

71 Withdrawal Management

This measure appears in Chapter 14 of this report.

Description: The number of Medicaid beneficiaries enrolled for at least one month during the measurement year, who used withdrawal management services for substance use disorder during the measurement year.

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

Appendix B: Quantitative Methods

In this appendix, we provide detailed information about the measures presented in this report, the data sources we used to calculate these measures, the Medicaid population and subgroups we analyzed, and the statistical methods for conducting those analyses.

Initiative 1: Statewide Measures (Chapter 1)

Metric Selection

We selected 44 metrics from two sets:

- **Pay for Performance (P4P) metrics:** Metrics used by the Washington Health Care Authority (HCA) to award ACHs and their partners for improving outcomes, listed in HCA's Project Toolkit (Washington State Health Care Authority, 2019a).
- **Metrics from the state's Evaluation Design:** Metrics listed in Appendix 1 of Washington State's Evaluation Design for use evaluating each Domain 2 and 3 health improvement project, and Initiative 3 (Washington State Health Care Authority, 2017c).

Refer to Appendix 1 of this report for a list of the expert organization (or steward) that developed the specifications for each metric.

The specific data source for individual measures varied and is identified in Appendix A. The metrics we reported in Chapter 1 were calculated by the State of Washington. We received quarterly records showing whether each Medicaid member met the criteria for each metric (e.g., whether a person had a primary care visit or a recommended test or screening) in the corresponding measurement year. In addition, we received Medicaid enrollment records that included information about each person's demographics, and Medicaid claims/encounters records that identify diagnoses and services each person received. This information enabled us to identify subgroups of Medicaid members and present performance metrics for Accountable Community of Health (ACH) regions and subgroups as described below.

To help understand the performance of Washington State's Medicaid system, we included 2019 US rates for 20 metrics available from the National Centers for Quality Assurance in our presentation of results.

Medicaid Populations and Subgroups

To calculate P4P metrics, Washington State included outcomes for only those Medicaid members with comprehensive physical and behavioral health care benefits and excluded members who were dually eligible for Medicare and Medicaid or had primary insurance other than Medicaid (Washington State Health Care Authority, 2020). We used inclusion flags in the performance metrics data we received to restrict metrics to this population, hereinafter called MTP Medicaid members.

To report metrics for members in each ACH region, we used inclusion flags provided in the data we received to identify MTP Medicaid members who resided in each ACH in each month. Importantly,

when reporting metrics for ACH regions we did not include or exclude members based on the number of months they resided in the regions and qualified for Medicaid. ACH attribution is reported quarterly for each member but if a member moves mid-year they could contribute to different measures for different ACHs.

When reporting statewide metrics, we included or excluded members based on the number of months they resided in the state and qualified for Medicaid. The State of Washington included a member's outcomes in calculating most metrics if the member resided in an ACH region for 11 of 12 months of the measurement year. The state included a member's outcomes in calculating some metrics if the member resided in the region for only seven of 12 months, allowing a less residentially stable population to count in the metric

We identified MTP Medicaid members in subgroups using the following methods:

- **Medicaid enrollment data:** We used information from Medicaid claims/encounters records to identify members by race/ethnicity group, age group, sex, rural or urban geography of residence (identified using the University of Washington's Rural-Urban Commuting Area designations, a crosswalk applied at the ZIP code level), and residence in high-poverty or non-high-poverty areas (defined as ZIP codes in which the median income was in the bottom quintile of Washington State's income distribution according to the American Community Survey in 2017).
- **Medicaid claims/encounters data:** We used information on diagnoses and services from Medicaid claims/encounters data to identify members with chronic conditions, severe mental illness (SMI), and substance use disorder (SUD). For chronic conditions, we identified a person as having a chronic condition in a given month if he or she received at least one diagnosis for a chronic condition, as defined by the Center for Medicare & Medicaid Services Chronic Conditions Warehouse (CCW), within a designated lookback period. We used claims from any place of service (e.g., inpatient, outpatient, or professional setting) to identify chronic conditions.
- **Serious mental illness (SMI):** We identified a person as having SMI in a given month if he or she received at least one of the following diagnoses within the last year: schizophrenia, bipolar disorder, major depression, cyclothymic disorder, post-traumatic stress disorder (PTSD), or obsessive-compulsive disorder (OCD). For schizophrenia, bipolar disorder, depression, and PTSD, we used diagnosis codes from the CCW. For cyclothymic disorder and OCD, we translated ICD-9 codes used to identify people with SMI for CHSE's Oregon Medicaid waiver evaluation into ICD-10 codes, as shown in Exhibit A.1.
- **Substance use disorder (SUD):** We identified a person as having SUD in a given month if he or she received at least one diagnosis for alcohol or drug use within the last year.

Statistical Analyses

We presented changes in measures between 2018 and 2019. These changes were simple differences in means and were not adjusted for any covariates or changes in population demographics.

Exhibit A.1. Diagnosis Codes Used to Identify People with Severe Mental Illness (SMI)

Diagnosis	ICD Code Name	ICD-9	ICD-10
Cyclothymic disorder	Cyclothymic disorder	301.13	F34.0
	Schizotypal personality disorder	301.22	F21
	Other specific personality disorders	301.11	F60.89
	Borderline personality disorder	301.83	F60.3
Obsessive-compulsive disorder	Mixed obsessional thoughts and acts	300.3	F42.2
	Hoarding disorder	300.3	F42.3
	Other obsessive-compulsive disorder	300.3	F42.8
	Obsessive-compulsive disorder, unspecified	300.3	F42.9

Initiative 1: Health Improvement Projects (Chapters 3-10)

Metric Selection

We selected 44 metrics for evaluating the health improvement projects. These metrics are listed in Appendix 1 of Washington State's Evaluation Design for use evaluating each Domain 2 and 3 health improvement project and Initiative 3 (Washington State Health Care Authority, 2017c). Each project used a different set of measures; these are described in more detail in Chapter 2. For example, analyses of Project 2A tested outcomes across 29 measures, while analyses of Project 3C tested outcomes across six measures. Appendix A of this report lists the expert organization that developed the specifications for each metric.

The specific data source for individual measures varied and is identified in Appendix A. The metrics we used in Chapters 3-10 were calculated by the State of Washington. We received quarterly records showing whether each Medicaid member met the criteria for each metric (e.g., whether a person had a primary care visit or a recommended test or screening) in the corresponding measurement year. In addition, we received Medicaid enrollment records that included information about each person's demographics, and Medicaid claims/encounters records that identified diagnoses and services each person received. This information enabled us to identify target populations of Medicaid members and present performance metrics for Accountable Community of Health (ACH) regions and target populations as described below.

Statistical Analyses

As noted in Chapter 2, to evaluate the impact of the eight health improvement projects on health care utilization and outcomes, we examined relevant health measures in regions that participated in a project.

We used two approaches to reflect different levels of project adoption across regions:

- **Pre-post.** Three projects (2A, 3A, and 3D) were implemented by all nine ACHs. In the absence of a suitable comparison group, we compared outcomes in the periods leading up to the intervention year (2017 and 2018) to outcomes in the first intervention year (2019).
- **Difference-in-differences.** Five HIPs were implemented by some, but not all ACHs. In these cases, we conducted a difference-in-differences analysis. In this approach we calculated the change in outcomes among participating ACHs between 2017-2018 and 2019 and subtracted the change in outcomes among the remaining ACHs. This approach is designed to isolate effects that can be attributable to the HIP rather than other statewide changes.

Pre-Post Regressions

The pre-post analysis takes the following form:

$$Y_{it} = b_0 + b_1 * PostTransformation_t + a * X_{it} + e_{it} \quad (1)$$

where Y_{it} is the outcome of interest for individual i in calendar year t , $PostTransformation_t = 1$ if the observation occurs after Medicaid Transformation, and 0 otherwise; X_{it} is a vector of demographic covariates and risk adjusters, and e_{it} is a random error term associated with the unmeasured variation in the outcome of interest. The coefficient of interest, b_1 , estimates how much the outcome variable changed with Medicaid Transformation.

For computational ease and interpretability, we generally used ordinary least squares. We estimated equation (1) separately for each ACH.

Difference-in-Differences Regressions

In its simplest form, the model estimated the average change in outcomes of interest for the treated group, subtracted by the average change in outcomes for a comparison group. In this approach, we measured the change in outcomes among participating ACHs between 2017-2018 and 2019 and subtracted the change in outcomes among non-participating ACHs. Model (2) presents this simple model in a linear regression framework:

$$Outcome_{it} = \alpha_0 + \alpha_1 * Treated_{it} + \alpha_2 * Post_{it} + \alpha_2 * Post_{it} * Treated_{it} + \pi X_{it} + e_{it} \quad (2)$$

where i indexes the individual, and t the time period (our default unit of observation will be the person calendar year). The dependent variable $Outcome_{it}$ represents the outcome variable, measured at, e.g., the person calendar year level. The variable X_{it} represents a vector of individual-level variables (including age, gender, risk adjusters, and regional variables such as urban or rural residence).

In general, we treated 2019 and following years as the *Post* period. We defined *Treated* as an indicator variable taking a value of 1 if the beneficiary was in an ACH that implemented the project in question (e.g., BHT for Project 2B), and 0 otherwise. The coefficient α_2 is the coefficient of interest.

We also estimated equation (2) separately for each ACH that participated in the health improvement project, with the comparison group of ACHs remaining constant.

Covariates

We used the following covariates in our pre-post and difference-in-differences models: sex (female, male, and unknown), age groups (under 18, 18-24, 25-34, 35-44, 45-54, 55-64, 65 and older), race (a single identifier for Alaskan Native, American Indian, Asian, Black, Hawaiian, Not Provided, Other, or Pacific Islander), ethnicity (Hispanic or non-Hispanic), risk adjuster indicators based on the Chronic Illness and Disability Payment System (CDPS), indicators of chronic conditions based on the Chronic Conditions Warehouse, indicators of serious mental illness (based on the definition above), high poverty ZIP code (defined as mean income for the ZIP code below 20 percent of the statewide median income), and residential population density (urban and non-urban ZIP codes as defined by the Rural-Urban Commuting Area Codes). All demographic covariates were defined based on the member's last month of enrollment in the measurement year.

Clustering of Standard Errors

We adjusted our regressions by clustering at the level of the Primary Care Service Area (PCSA). PCSAs are groups of ZIP codes that were originally developed and validated by previous research to represent natural markets of primary care (Dartmouth Atlas Data, 2020; Goodman, et al., 2003).

Initiative 3: Foundational and Community Supports (FCS) (Chapter 13)

Metric Selection

We selected 31 metrics for evaluating the Foundational Community Supports (FCS) program. All of these were also part of Initiative 1 analyses. We excluded some Initiative 1 measures because they were not relevant for this program (e.g., well-child visits in the First 15 months of life). Appendix 1 of Washington State's Evaluation Design provides details of metrics used for our evaluation of this program (Washington State Health Care Authority, 2017c).

The specific data source for individual measures varied and is described in detail in Appendix A. The metrics we used in Chapter 13 were calculated by the State of Washington. We received quarterly records showing whether each Medicaid member met the criteria for each metric (e.g., whether a person had a primary care visit or a recommended test or screening) in the corresponding measurement year. In addition, we received Medicaid enrollment records that included information about each person's participation in FCS programs, service delivery system affiliation (Medicaid beneficiaries served through the Aging and Long-Term Support Administration or Medicaid beneficiaries served through the Health Care Authority), and demographic information.

Sample

We defined three FCS program groups: Medicaid beneficiaries participating in (i) supportive housing; (ii) supported employment; (iii) both supportive housing and supported employment. For each of these FCS program groups, we identified a comparison group using a matching approach similar to the one specified in Danielson, Mancuso and Felver (2020). Specifically, we exact-matched FCS

participants to Medicaid beneficiaries who did not participate in the program using beneficiaries' characteristics (age, gender, primary race, and ethnicity, cumulative CDPS score rounded to the nearest integer (to aid finding exact matches) and a binary variable indicating the presence of an SUD diagnosis) and the quarter of first FCS service receipt. We also required all individuals in the treatment and comparison group to be fully enrolled in Medicaid during the 12 months prior and 12 months following first FCS service receipt.

We repeated the matching approach for each of the three FCS program groups to create three corresponding comparison groups. We used the MatchIt procedure in R to implement our matching approach. Unlike in Danielson, Mancuso and Felver (2020), we did not also match on prior utilization measures for our main analysis. Instead, we tested for parallel trends to assess the quality of our difference-in-differences approach and conducted additional sensitivity analyses related to this approach (see below).

We reported results for each of the three FCS program groups in aggregate as well as stratified by participants' delivery system affiliation (ALTA or HCA).

Statistical Analyses

We estimated the following difference-in-differences regression:

$$Outcome_{it} = \beta_0 + \beta_1 FCS_i + \beta_2 Post_{it} + \beta_3 FCS_i * Post_{it} + \delta X_{it} + \varepsilon_{it}$$

where i is an individual in our sample; t is time relative to first FCS service receipt; FCS_i is an indicator variable equal to 1 if a person was part of one of the three FCS groups (e.g., supportive housing, supported employment, and both); $Post_{it}$ is the third and fourth quarter following the quarter of first FCS receipt; X_{it} is other covariates (age, gender, race and ethnicity, cumulative CDPS score rounded to the nearest integer, and SUD diagnosis flag); and ε_{it} is the error term. We estimated this regression separately for each outcome and each of the three FCS program groups; we then further stratified regressions by service delivery system affiliation. Standard errors were clustered at the PCSA level.

As in other difference-in-differences regressions, the coefficient of interest was the interaction between FCS enrollment and the post-intervention period (i.e., β_3 in the equation above). We defined the pre-intervention period as the two last quarters before first FCS receipt. Thus, β_3 estimated covariate-adjusted changes in outcomes among FCS enrollees during the two quarters preceding first FCS receipt and the third and fourth quarters following first FCS receipt, relative to changes in outcomes among people in the comparison group in the same time periods.

The difference-in-differences approach requires trends in outcomes of the comparison group to accurately represent trends in outcomes of FCS enrollees had they not received any FCS services. We tested for such parallel trends using the four quarters preceding first FCS receipt and the following specification:

$$Outcome_{it} = \gamma_0 + \gamma_1 FCS_i + \gamma_2 t + \gamma_3 FCS_i * t + \lambda X_{it} + \varepsilon_{it}$$

where $\gamma_3 = 0$ corresponds to parallel trends.

In the context of FCS programs, the challenge for identifying effects of the program is that some of FCS recipients' outcomes might increase or decrease around the month of first service receipt because of temporary events (e.g., decline in employment due to job loss). It is difficult to

disentangle such temporary events from program effects unless the comparison group is affected by such events in a similar fashion. Failure to reject a parallel trend test gives us confidence that the comparison group is well matched in that regard, whereas rejection of a parallel trend test suggests that difference-in-differences estimates might at least partially reflect changes in outcomes due to other events.

In interpreting results, we also consulted trend graphs of outcomes for FCS beneficiaries and their comparison group. Such trends help visualize how difference-in-differences estimates correspond to trends over time, whether trends before first FCS are parallel or not, and whether there are data quality issues to consider when interpreting results (e.g., jumps in outcomes, small sample sizes).

We also conducted sensitivity analyses using a matching algorithm that included key utilization measures (homelessness rate, acute hospital use and emergency department visit rate) for the last two quarters prior to first FCS service receipt (the pre-enrollment period in the difference-in-differences model). Results using this alternative matching approach were largely similar to those of our preferred matching approach, with some exceptions.

Initiative 4: Substance Use Disorder Waiver (Chapter 14)

Metric Selection

We selected 29 metrics from the state's Evaluation Design, selecting metrics listed in Chapter 14, which covers the Substance Use Disorder Demonstration Amendment Evaluation Design. Details on these metrics are provided in Appendix A of this report.

The specific data source for individual measures varied and is described in detail in Appendix A. We used a combination of metrics calculated by the State of Washington as well as metrics calculated from raw claims, including Medicaid enrollment records that included information about each person's demographics, and Medicaid claims/encounters records that identified diagnoses and services each person received. For metrics not provided by the state, we used CMS' Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics, Version 3.0 (Mathematica, 2020) to develop our metrics. Data on overdose rates were obtained from Vital Statistics from the State of Washington. Data on facilities that billed Medicaid for SUD services and providers who billed for medications for addiction treatment were obtained from the Washington State Health Care Authority.

Statistical Analyses

Of our 29 metrics, 16 were developed at the beneficiary level. We conducted statistical analyses on these with adjustments described below. Of the remaining measures, we did not conduct adjusted statistical analyses. For example, we reported on the annual number of Medicaid beneficiaries and how this number changed over time, but we did not make statistical adjustments when reporting these changes. In some cases, we did not have data for the post-waiver period, and we reported baseline levels only.

The majority of measures were calculated on a "fiscal year" basis, and the analyses compared a pre-period of July 2017 to June 2018 to a post-SUD waiver period of July 2018 to June 2019. The one exception was the measure Adult Access to Preventive/Ambulatory Health Services for Medicaid beneficiaries with substance use disorder. This measure was calculated on a calendar year basis.

For this measure, we excluded 2018 (which can be considered a washout year), and ran regressions comparing 2017 to 2019.

Pre-Post Regressions

The pre-post analysis takes the following form:

$$Y_{it} = b_0 + b_1 * PostTransformation_t + a * X_{it} + e_{it} \quad (1)$$

where Y_{it} is the outcome of interest for individual i in calendar-year t , $PostTransformation_t = 1$ if the observation occurs after Medicaid Transformation, and 0 otherwise; X_{it} is a vector of demographic covariates and risk adjusters, and e_{it} is a random error term associated with the unmeasured variation in the outcome of interest. The coefficient of interest, b_1 , estimates how much the outcome variable changed with Medicaid Transformation.

For computational ease and interpretability, we generally used ordinary least squares. We estimated equation (1) separately for each ACH.

Covariates

We used the following covariates in our pre-post and difference-in-difference models: age groups (under 18, 18-24, 25-34, 35-44, 45-54, 55-64), race (a single identifier for Alaskan Native, American Indian, Asian, Black, Hawaiian, Not Provided, Other, or Pacific Islander), ethnicity (Hispanic or non-Hispanic), risk adjuster indicators based on the Chronic Illness and Disability Payment System (CDPS), indicators of chronic conditions based on the Chronic Conditions Warehouse, indicators of serious mental illness (based on the definition above), and high-poverty ZIP code (defined as mean income for the ZIP code below 20 percent of the statewide median income). All demographic covariates were defined based on the member's last month of enrollment in the measurement year.

Clustering of Standard Errors

We adjusted our regressions by clustering at the Primary Care Service Area. (Dartmouth Atlas Data, 2020; Goodman, et al., 2003).

Appendix C: Qualitative Methods

In this appendix, we provide detailed information about the qualitative data presented in this report, the data sources we used to develop findings, and the methods for conducting those analyses.

ACH- and State Key Informant Interviews

Qualitative Data Collection

Semistructured interviews with 14 key informants at the state were conducted between January and April 2019. The Initiative 1 qualitative team consulted HCA to develop an initial list of key informants to invite to participate in an interview. Participants were selected for their diverse department representation and to ensure a range of perspectives. As part of each interview, we asked interviewees to recommend other experts we should talk with for a deeper understanding of issues or a different perspective.

We used an iterative sampling strategy to achieve a maximum-variation sample. Our team moved between selecting some key informants for interviews, conducting interviews and analyzing the data, and then using insights from interviews to inform subsequent sample selection. The process of moving between selection, data collection, and analysis helped ensure that a full range of ideas and perspectives surfaced. Interviews lasted approximately one hour and were conducted using video software or over the phone. Interview guides were tailored for each interviewee based on their area of expertise.

From May to November 2019 the Initiative 1 qualitative team conducted nine in-person site visits to each ACH. We completed between five and nine interviews with each ACH based on the ACH's size, number of selected health improvement projects, and organizational structure. In total, we completed 60 semistructured interviews with ACH key informants. Prior to the site visit we conducted an initial planning call with leaders at each ACH to identify participants to interview. ACH interview guides were also tailored for each interviewee based on their area of expertise. Hour-long interviews were primarily conducted in person at the site visit; however, some interviews were completed remotely using video conferencing software to accommodate ACH scheduling needs.

State and ACH interviews were professionally transcribed, and transcripts were de-identified and entered into Atlas.ti (Version 8, Atlas.ti Scientific Software Development GmbH, Berlin, Germany) for data management and analysis.

Qualitative Data Analysis

For the Interim Report, the Initiative 1 qualitative team reviewed segments of interview transcripts and publicly available materials containing information about health improvement project (HIP) planning and implementation. Data sources included state interview transcripts, ACH interview transcripts, HCA's project toolkit, ACH implementation plans, project plans, and semiannual reports.

These data were analyzed using an immersion-crystallization approach (Borkan, 1999). First, the qualitative team reviewed the data together and met weekly to discuss emerging findings and build a code list. Specific codes were developed to tag segments of text related to each HIP area. Team

members then reviewed the collated text pertaining to each project area to describe statewide patterns that related to model selection, the ways in which the toolkit materials were utilized and interpreted, and how ACHs planned to monitor and support their contracted partners with project implementation. This information was populated into a matrix to facilitate examining statewide similarities as well as characteristics that were unique to individual ACHs. Then, team members developed analytic summaries for each project area that were prepared and shared with the larger study team during mixed methods meetings. Initiative 1 qualitative and quantitative team members came together to discuss each project area and its associated performance measures. These discussions helped facilitate sense-making, interpretation, and richer analyses. Following these meetings qualitative team members refined project-related findings and collaborated with a quantitative team member to finalize the results for each project area.

Substance Use Disorder Treatment Provider Interviews

Qualitative Data Collection

The Initiative 4 qualitative team conducted a series of interviews with key informants representing the waiver's main stakeholder groups (SUD providers, MCOs, and beneficiaries) as well as Tribes. The two main aims of these interviews were:

- To identify factors that have affected the achievement of the milestones and targets to date and/or are likely to affect future performance in meeting milestones and targets.
- To assess the risk of potentially missing milestones and performance targets.
- To identify strategies (e.g., changes in policy, payment, outreach, and enforcement) that the state could use to address performance gaps.

In collaboration with the Health Care Authority, the Initiative 4 qualitative team identified a list of potential informants with experience-based knowledge of SUD treatment systems affected by the waiver. The team selected informants to represent multiple sectors within the treatment delivery system, including providers (with an emphasis on residential treatment providers), Tribal providers, patient advocates, MCOs, and representatives from the Health Care Authority and Department of Corrections. Within the provider category, the team aimed to maximize variation in geographic regions, provider size, Tribal and non-Tribal affiliation, and payer mix (predominantly Medicaid versus broad payer mix).

Once the qualitative team and HCA had agreed upon a list, the agency emailed an introductory letter to informants providing background on the assessment. The assessment team followed up to schedule interviews. Interview invitations were sent to potential informants at 26 organizations. Eight informants did not respond to the invitation, and three informants declined (two for availability issues during the COVID-19 pandemic, the other for lack of pertinent information), yielding 14 completed interviews with 19 participants (some organizations including more than one representative). Organizations declining for COVID-19 reasons included two of the three SUD treatment facilities operated by Tribes or Urban Indian Health Programs we contacted, leaving one Tribally specific provider in the sample. Exhibits A.2 and A.3 summarize key informants by category and ACH region.

Exhibit A.2: SUD Waiver Key Informants, by Type

Key Informant Category	Interview Count
SUD provider organizations, general	6
Tribe or UIHP-operated SUD provider organizations	1
Managed care organizations	2
Client advocacy groups	3
State agency staff (Health Care Authority; Department of Corrections)	2

Exhibit A.3: SUD Waiver Key Informants, by ACH Region

	Better Health Together	Cascade Pacific Action Alliance	Elevate Health	Greater Columbia ACH	HealthierHere	North Central ACH	North Sound ACH	Olympic Community of Health	SWACH
SUD provider organizations, general	X	X		X			X	X	
Tribe- or UIHP-operated SUD provider organizations					X				
Client advocacy groups	X				X				

Interviews lasted approximately one hour and followed a semistructured interview guide. Interviews were conducted remotely using the WebEx platform, allowing informants to connect via web video plus audio, web audio only, or phone, according to their preference. Interviewees were asked to describe how the SUD waiver amendment affected SUD service delivery for their organization and across the state. We asked participants to identify and describe factors likely to affect progress toward milestones, as well as factors that might contribute to changes (or lack thereof) in metrics. We also asked interviewees to offer recommendations on actions the state might take to facilitate progress.

Qualitative Data Analysis

Interviews were recorded with informant permission, professionally transcribed, de-identified, and loaded into the Atlas.ti qualitative software application (Version 8, Atlas.ti Scientific Software Development GmbH, Berlin, Germany) for analysis. The Initiative 4 qualitative team developed an analytic codebook centered around milestones and related aspects of waiver implementation, creating additional codes inductively in response to interview content. Three team members reviewed and coded initial interviews jointly, meeting at least weekly, to refine the codebook and develop consistency in coding practice. Subsequent interviews were coded individually. Team members jointly reviewed output by code to summarize the content on each milestone and develop related themes.

Appendix D: summary of EQRO Reports

EQRO 2021 Technical Report

[Link](#) to the full report

Introduction

Information in this report was collected from managed care organizations (MCOs) and behavioral health organizations (BHOs) through review activities based on Centers for Medicare & Medicaid Services (CMS) protocols. Additional activities may be included as specified by contract, including Wraparound with Intensive Services (WISe) program review.

Note: under the direction of Senate Bill E2SSB 6312, Health Care Authority (HCA) as of January 1, 2020, completed a multi-year effort to integrate both physical health and behavioral health services that include mental health, and substance use disorder treatment services into one system for nearly two million Apple Health (Medicaid) clients.

Description of EQR activities

EQR federal regulations under 42 CFR Part 438 specify the mandatory and optional activities that the EQRO must address in a manner consistent with CMS protocols. The 2021 EQR in Washington included the following activities which are in alignment with the CMS protocols:

- Quality Strategy Effectiveness Analysis, includes recommendations for improvement to the quality of health care services for both MCOs and BHOs.
- Compliance Review, assess previous years activities and evaluates both MCO and BHO compliance within a set standard and HCA contracts.
 - Including follow-up of the previous year's corrective action plans (CAPs)
- Performance Improvement Project (PIP) Validation
- Performance Measure Validation, including:
 - Healthcare Effectiveness Data and Information Set (HEDIS®¹) measures
 - Two non-HEDIS measures that are calculated by the Department of Social and Health Services Research and Data Analysis Division (RDA)
 - Mental Health Service Penetration – Broad Definition (MH-B)
 - Substance Use Disorder Treatment Penetration (SUD)
- Value-Based Purchasing (VBP) Performance Measure Recommendation and Evaluation, annual analysis of the performance of Apple Health MCOs providing service to Medicaid enrollees.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS), assess consumers' experiences with their health plans.
- WISe Program Review (Focus Study), a review of the behavioral health agencies (BHAs) that have implemented the WISe service delivery model.
- Behavioral Health Performance Measure Focus Study, an analysis of performance measure variation across MCO, ACH and regional system partners.
- Evaluation of Quality, Access and Timeliness of Health Care and Services, an assessment of how MCOs and BHOs are performing in delivering quality, accessible and timely care.

¹ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Summary of recommendations

In its assessment of the degree to which MCOs and BHOs provided Medicaid enrollees with accessible, timely, and quality care, this 2021 Annual Technical Report explains to what extent the state's managed care plans are meeting federal and state regulations, contract requirements, and statewide goals, and where they need to improve. Comagine Health's recommendations to the state are intended to help improve Washington's overall Medicaid system of care. Subsequent sections offer further discussion.

Quality Strategy Effectiveness Analysis

- Sustain Improvement in clinically meaningful areas (including behavioral health integration) through collaboration among MCOs, with higher performing plans sharing successful strategies that have led to improved measure performance and may help improve all the MCOs performance on these measures.
- Address behavioral health declines to ensure individuals receive necessary treatment and improvements are reflected across all race/ethnicity categories.
- Focus on Preventive Care by maximizing the use of telehealth, providing outreach to ensure preventive care is obtained and focusing on bidirectional integration.
- Prioritize Health Equity by continuing to collaborate with partners around health equity data, including the collection, analysis, reporting and community participation in validating and interpretation to drive health equity work.
- Continue to refine/focus on Value Based Purchasing as a strategy to move improvements forward.
- Refine language for required non-duplication of EQR-Related Activities.
- Continue to focus on collaboration and standardization across MCPs and HCA.
- Focus on strategies to assist MCPs in development and monitoring of their QAPI programs to address necessary improvements and move quality care forward.
- MCPs need to have an effective QAPI program that moves quality care forward with a focus on strategies to assist MCPs in development and monitoring of their QAPI programs to address necessary improvements.

Compliance Review

Overall, the MCPs continue to work to meet the requirements for each of the elements reviewed. The following are recommendations for the MCPs.

Coverage and Authorization of Service

- It is recommended that HCA continue to monitor and provide technical assistance to the MCPs for compliance with the coverage and authorization of service elements. HCA has provided intensive technical assistance to support needed improvements in this standard.

Subcontractual Relationships and Delegation

- Four of the five MCPs (AMG/MCO, AMG/BHSO, CCW/MCO, CCW/BHSO, CHP/MCO, CHP/BHSO, UHC/MCO, UHC/BHSO) will benefit from technical assistance by HCA to ensure the plans meet the requirements for the subcontractual relationships and delegation standard. These elements include:
 - Subcontractual relationships and delegation
 - Written agreements
 - Monitoring of sub-contractor performance
 - Identifying deficiencies and ensuring corrective action is taken

Subcontractual Relationships and Delegation

- HCA should provide technical assistance to all plans regarding program integrity requirements. Four MCOs (CCW, CHPW, MHW, UHC) and four BHSOs (CCW, CHPW, MHW, UHC) did not meet at least one element under this standard.

Performance Improvement Project (PIP) Validation

The challenges of the 2020 COVID-19 pandemic affected the implementation and improvement of the PIPs during the RY2021 period which led to a majority of the PIPs being scored as Partially Met. Thus, the recommendations from the previous year remain, for the most part, the same.

To enhance the MCPs' ability to design a sound PIP, HCA should continue the following activities to engage and guide the MCPs in providing desired quality health outcomes for its enrollees:

- HCA should continue to provide ongoing training specifically focused on the overall study design by establishing a framework for sustainable improvement that stems from well-defined and well-scoped study designs. This would include continuing to work with the MCPs' incorporation of the rapid-cycle process improvement process introduced by HCA in 2021.
- As the 2020 COVID-19 pandemic has shown, it is important the MCPs to be flexible and persistent in trying to work within any disruptions that may be encountered. HCA should work closely with the MCPs when unexpected disruptions occur to determine appropriate pivots of the interventions through evaluation of the study design and the analysis plan to ensure improved outcomes.
- A concise study question will improve the MCP's ability to align the entire PIP study design. HCA should continue to provide technical assistance to the MCPs with a focus on defining, streamlining and simplifying study questions.
- In RY2021, TEAMonitor began implementation of *Protocol 1 Validation of Performance Improvement Projects* updated by CMS in 2019 in its validation of PIPs. HCA should continue to work with the MCPs to help familiarize them with the additional measurements of success within this protocol.

Performance Measure Validation

Through Performance Measure Validation, we highlight areas of distinct improvement in Washington State, measures to proactively monitor in the light of the ongoing COVID-19 pandemic, and opportunities to augment the current dataset to allow deeper future analysis related to health equity. Recommendations are in four areas:

- Sustain improvements in clinically meaningful areas, including:
 - Behavioral health integration
 - Asthma Medication Ratio
 - Prenatal and Postpartum Care
- Address behavioral health declines, including:
 - Mental Health Treatment Penetration for 6-64 years
 - Behavioral health measures for all race/ethnicity categories that have declined
- Focus on Preventive Care
 - Although there were statistically significant declines from MY2019 to MY2020 in multiple preventive care measures (CIS Combo 2 & Combo 10, CHL, AAP and BCS), Breast Cancer Screenings (BCS) have declined over the past two measurement years.
 - As the COVID-19 pandemic continues to impact preventive care,
 - It is recommended that the use of telehealth be maximized to the greatest degree possible for preventive (and acute) care needs.
 - Outreach to individuals to ensure preventive care is obtained, should be prioritized. Plans need to include strategies to support practitioners in catching up on preventive care that was delayed so declines do not continue.

- Continue to focus on bidirectional integration to sustain the behavioral health integration work.
- Continue to Prioritize Health Equity
 - Increased attention needs to be directed at communities of color, particularly Black and Hispanic communities.
 - Additional areas of focus to address health equity needs include:
 - Prenatal and Postpartum Care (PPC) both timeliness of Prenatal Care and Postpartum measures for Hawaiian/Pacific Islanders
 - Prevention and Screening measures for most races/ethnicities
 - Well-Child Visits in the First 30 Months of Life (W30) and Child and Adolescent Well-Care Visit (WCV) for most races/ethnicities
 - Continued collaboration with partners in Washington around health equity data, including the collection, analysis, reporting and community participation in validating and interpreting those data will continue to benefit HCA in driving health equity work in Washington.
 - HCA may consider incorporating equity-focused payment and contracting models in the VBP program as an approach to improving health equity.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

CAHPS is the most comprehensive tool available for assessing consumers' experiences with their health plans. Results of the survey provide consumers, purchasers, health plans and state Medicaid programs with information about a broad range of key consumer issues. While the CAHPS survey helps identify priorities, the MCOs should identify actionable areas for their own quality improvement activities, then conduct a root cause analysis to identify underlying causes and build quality improvement plans. MCOs may look at patient grievances to see what issues show up frequently.

The two sources of information, CAHPS data and grievances, complement each other in attempts to understand the issues and get a complete picture. MCOs should evaluate improvement methods and implement those most relevant to their improvement goals. MCOs should follow a process similar to the Plan-Do-Study-Act (PDSA) model to target low performing measures.

The following questions have the lowest achievement scores and are presented as opportunities for improvement.

- Q15. Usually or always easy to get special medical equipment or devices for child
- Q18. Usually or always easy to get therapy for child
- Q19. Someone from doctor's office helped get therapy for child
- Q21. Usually or always easy to get treatment or counseling for child
- Q45. Customer service usually or always gave help you needed

Wraparound with Intensive Services (WISe) Program Review

In this year's review, some of the agencies provided services during the early days of the COVID-19 PHE, including the *Stay Home, Stay Healthy* orders which may be contributing factors in the agencies' results.

- As the PHE continues, HCA should continue working closely with the MCPs to review the organizations' response to the COVID-19 PHE to address gaps in their emergency or disaster plans to:
 - Identify alternate methods for providing services and supports in the event of a PHE
 - Ensure adaptation of the identified alternative methods for a rapid return to provision of the full range of services

The reviewed agencies experienced difficulties in meeting WISe requirements in regard to the delivery of quality, accessible and timely care.

- HCA should continue providing technical assistance through its WISE Workforce Collaborative to agencies delivering WISE services which includes:
 - Working with the MCPs in providing support for their subcontracted providers
 - Communicating with contracted trainers to ensure alignment with technical assistance and support

Agencies experienced difficulties in meeting WISE requirements including conducting collaborative full CANS, CSCPs, CFTs and crisis plans in a timely manner, in addition to providing clear documentation.

- We recommend the agencies conduct a root-cause analysis to identify the barriers to success in meeting WISE requirements. As interventions are identified, use Plan-Do-Study-Act (PDSA) cycles of improvement to measure the effectiveness of each intervention. Recommended focus areas for improvement include:
 - Complete timely and collaborative crisis plans.
 - Conduct collaborative initial full CANS assessments.
 - Complete collaborative CSCPs within the required timeframe.
 - Conduct CFT meetings at least every 30 days, ensuring each CFT includes educators and/or community partners when identified as areas of need
 - Record therapy notes that clearly reflect the following:
 - Interventions used in therapy sessions
 - Youth and/or caregiver responses to the intervention
 - Progress reviewed and successes celebrated
 - Document the specific content of treatment sessions such as psychoeducation, skill development or evidence-based practice components

Behavioral Health Performance Measure Focus Study

Based on the survey and interview results, Comagine Health identified the following areas for improvement and recommendations for HCA. These are meant to be starting points for further development and discussion toward the ultimate goal of improving behavioral health care and integration statewide. The recommendations are focused on the following areas:

- Workforce shortage
- Health information technology
- Patient health information sharing
- Limited access to data
- Access to services
- Challenges for children and youth in behavioral health treatment

EQRO 2021 comparative and regional analysis

[Link](#) to the full report

Introduction

In 2019, the Washington Legislature passed the Washington State Engrossed Substitute House Bill (ESHB) 1109 requiring HCA's contracted EQRO to annually analyze the performance of Apple Health MCOs providing services to Medicaid enrollees.

MCOs are required to annually report results of their performance on measures reflecting the levels of quality, timeliness and accessibility of health care services furnished to the state's Medicaid enrollees. As part of its work as the external quality review organization (EQRO) for the Washington State Health Care Authority (HCA), Comagine Health reviewed MCO performance on Healthcare Effectiveness Data and Information Set (HEDIS®) measures for the calendar year (CY) 2019. In addition to the HEDIS measures, this report also includes data on two behavioral health measures developed by the state of Washington.

This report illustrates trends in managed care performance across the performance measure set, focusing on performance against benchmarks and year-over-year trends. This report is intended as a description of year-over-year performance at the state, regional and MCO levels. In 2021, Comagine Health analyzed and reported on MCO performance on the VBP measures as selected by HCA for both AH-IMC and IFC contracts. The result of this analysis has a direct effect on the reimbursement to MCOs. MCOs achieved VBP reimbursement if the demonstrated year-over-year improvement or scored in the top national Medicaid quartile of the performance measure.

In addition, in 2021, Comagine Health analyzed the performance of AH-IMC and IFC managed care organizations providing services to clients and made recommendations for 2022 required under the Washington State Budget Proviso 2019 (211)(50) to support HCA decision-making in selecting performance measures required by the Proviso.

Also assessed were statewide performances on two non-HEDIS behavioral health measures that are calculated by the Department of Social and Health Services Research and Data Analysis Division (RDA). The state monitors and self-validates the following two measures, both reflecting behavioral health care services delivered to Apple Health enrollees:

- Mental Health Service Penetration – Broad Definition (MH-B)
- Substance Use Disorder Treatment Penetration (SUD)

Many of the HEDIS measures included in this report are also included in the Washington State Common Measure Set on Health Care Quality and Cost, a set of measures that enables a common way of tracking important elements of health and health care performance intended to inform public and private health care purchasing. Specifically, this report provides the following levels of analysis:

- Statewide performance compared to national benchmarks (when available).
- Individual MCO performance compared to national benchmarks (when available).
- Regional performance on select measures (not all measures provide a sufficient volume of data for regional analyses).

Summary of results

Statistically Significant Improvements

Many behavioral health measures show a strong shift of improvement, as do the access measures. These statistically significant improvements are notable, especially in the context of COVID-19.

There were two years of statistically significant improvement (between MY2018 and MY2019 and between MY2019 and MY2020) for the following measures:

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Initiation of AOD Treatment: Total
- Antidepressant Medication Management (AMM) Acute and Continuation Phase measures
- Follow-Up After Emergency Department Visit for Mental Illness (FUM), Total for both the 7-Day and 30-Day Follow-Up

- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), Total for both the 7-Day and 30-Day Follow-Up
- Substance Use Disorder Treatment Penetration (SUD), 12–64 Years
- Asthma Medication Ratio (AMR), Total

There was a statistically significant improvement between MY2019 and MY2020 for the following measures:

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Initiation of AOD Treatment: Age 13-17
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Engagement of AOD Treatment: Total
- Prenatal and Postpartum Care (PPC), Postpartum Care
- Follow-Up after Hospitalization for Mental Illness (FUH), Total for both the 7-Day and 30-Day Follow-Up
- Use of Opioids at High Dosage (HDO)

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- Asthma Medication Ratio (AMR), Total

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- Prenatal and Postpartum Care (PPC), Postpartum Care
- Follow-Up after Hospitalization for Mental Illness (FUH), Total for both the 7-Day and 30-Day Follow-Up
- Use of Opioids at High Dosage (HDO)

Statistically Significant Declines

While there were measures that showed improvements there were also measures that demonstrated statistically significant decline.

There was a statistically significant decline between MY2019 and MY2020 for the following measures:

- Adults' Access to Preventive/Ambulatory Health Services (AAP), Total
- Mental Health Treatment Penetration (MH-B), 6-64 years
- Childhood Immunization Status (CIS), Combo 2

- Childhood Immunization Status (CIS), Combo 10
- Chlamydia Screening (CHL), Total

Recommendations

Sustain Improvement in Clinically Meaningful Areas:

Recommendations are to continue the current work on behavioral health integration and continuous quality improvement with these measures. Improvement in behavioral health metrics continued from last year with new significant improvement in initiation/engagement of alcohol, substance use and other drug dependence, and for follow up after mental health hospitalization. Continue to monitor these measures to ensure performance in these areas does not decline and look for opportunities to incorporate this new data to address program needs.

All MCOs, except UHC, saw statistically significant improvement for the Asthma Medication Ratio (AMR), Total measure between MY2019 and MY2020. We recommend continued emphasis on this important measure.

Statewide, Prenatal and Postpartum Care (PPC) - Postpartum Care, demonstrated statistically significant improvement between MY2019 and MY2020. AMG demonstrated statistically significant improvement during this same timeframe, where the other four MCOs had no notable year-over-year improvement in rates. Continued focus on Postpartum Care by all MCOs is recommended.

Overall, collaboration among the MCOs, with the higher performing plans sharing successful strategies that have led to improved measure performance may help improve all of the MCOs performance on these measures.

Address Behavioral Health Declines:

The decline in statewide Mental Health Treatment Penetration (MH-B), for 6-64 years rates may be due to restrictions put in place at the beginning of the COVID-19 pandemic that limited in-person visits. CCW, CHPW and MHW demonstrated a statistically significant increase from MY2019 to MY2020. AMG and UHC had significant decreases in mental health treatment penetration during this timeframe. Focused efforts to ensure individuals receive mental health treatment need to be a priority for all MCOs.

Although there have been improvements in the behavioral health measures at the statewide level, that improvement does not translate into improvements for all race/ethnicity categories. See the “Continue to Prioritize Health Equity” section for additional information.

Focus on Preventive Care:

Although there were statistically significant declines from MY2019 to MY2020 in multiple preventive care measures (CIS Combo 2 & Combo 10, CHL, AAP and BCS), Breast Cancer Screenings (BCS) have declined over the past two measurement years. All MCOs demonstrated a significant decrease in BCS this past measurement year. In addition, the urban population received statistically significant higher rates of breast cancer screenings over the rural population. All MCOs need to focus on this important preventive measure.

The COVID-19 pandemic continues to impact preventive care.

- It is recommended that the use of telehealth be maximized to the greatest degree possible for preventive (and acute) care needs.
- Outreach to individuals to ensure preventive care is obtained should be prioritized. Plans need to include strategies to support practitioners in catching up on preventive care that was delayed so declines do not continue.
- HCA should continue to focus on bidirectional integration to sustain the behavioral health integration work. Just as primary care screens for behavioral health needs, build in screening and coordination of preventive care should be built into behavioral health visits. (Certified Community Behavioral Health Clinic – CCBHC – model of care)

Continue to Prioritize Health Equity:

There is sufficient evidence of health disparities in these data to warrant further research and focused effort to better understand details on effectiveness and needs of communities.

The severity of COVID-19 impact has been greater in the non-white populations. Although there have been improvements in the behavioral health measures at the statewide level, that improvement does not translate into improvements for all race/ethnicity categories. As noted above in the “Statistically Significant Improvements” section, the behavioral health program in its present form is working and the positive impact is measurable when looking at the statewide measures. However, increased attention needs to be directed at communities of color, particularly Black and Hispanic communities.

Additional areas of focus to address health equity needs include:

- Prenatal and Postpartum Care (PPC) both timeliness of Prenatal Care and Postpartum measures for Hawaiian/Pacific Islanders
- Prevention and Screening measures for most races/ethnicities
- Well-Child Visits in the First 30 Months of Life (W30) and child and Adolescent Well-Care Visit (WCV) for most races/ethnicities

Continued collaboration with partners in Washington around health equity data, including the collection, analysis, reporting and community participation in validating and interpreting those data will continue to benefit HCA in driving health equity work in Washington.

HCA may consider incorporating equity-focused payment and contracting models in their value-based payment (VBP) program as an approach to improving health equity. According to a report by the Institute for Medicaid Innovation, “The development of equity-focused VBP approaches to support care delivery transformation is an important lever that can help payers advance health equity and eliminate disparities in health care with their provider organizations and members.”

The report outlines six strategies to guide the development of equity-focused VBP approaches to mitigate health disparities:

1. Articulating an equity goal
2. Assessing the payment and care delivery environment
3. Selecting performance measures
4. Setting performance targets
5. Designing the payment approach
6. Addressing operational challenges



STATE OF WASHINGTON
HEALTH CARE AUTHORITY

626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

5/4/2022

NOTICE

Subject: **Washington State Medicaid Transformation Project (MTP) waiver—Notice of MTP waiver renewal application and public comment period**

Effective Date: If approved, the MTP waiver renewal will begin January 1, 2023, and end December 31, 2027

The Washington State Health Care Authority (HCA) will submit a five-year MTP waiver renewal request to the Centers for Medicare & Medicaid Services (CMS). MTP is Washington State's Section 1115 Medicaid demonstration waiver from CMS.

The state is in the last year of the current MTP waiver, which ends December 31, 2022. **If approved, the waiver renewal will begin January 1, 2023, and end December 31, 2027.**

The waiver renewal will provide an additional five years for Washington State to continue to develop projects, activities, and services that improve Washington's health care system. By renewing MTP, the state can continue:

- Expanding coverage and access to care, ensuring people can get the care they need.
- Advancing whole-person primary, preventive, and home- and community-based care.
- Accelerating care delivery and payment innovation focused on health-related social needs.

Learn more at hca.wa.gov/about-hca/medicaid-transformation-project-mtp/mtp-renewal.

Public comment period

As part of the waiver renewal request, HCA will hold a public comment period **from May 12 to June 13, 2022**. During this time, people can share their feedback on the waiver renewal application; the programs that will continue, expand, or begin under the waiver renewal; or share any other comments about the waiver renewal.

Public comment is open to anyone who would like to share feedback. HCA encourages health care and social service providers, Accountable Communities of Health, Tribal Nations, Indian health care providers, managed care organizations, hospitals and health systems, medical associations, community-based organizations, and the public to provide feedback.

The deadline to provide public comment is Monday, June 13, 2022, at 5:00 p.m. Pacific Standard Time.

Share comments by completing a survey at

https://hca.servicenowservices.com/nav.to.do?uri=%2Fassessment%20take2.do%3Fsysparm_assessable_type%3D7abe3e321bf6c95095d6ed3ce54bcb15 or emailing medicaidtransformation@hca.wa.gov. More information—including the draft application, an executive summary, and additional ways to provide public comment—are available at hca.wa.gov/about-hca/medicaid-transformation-project-mtp/mtp-renewal.

For additional information, contact:

Name: Chase Napier, Medicaid transformation manager

Program: Policy Division, MTP

Address: Washington State Health Care Authority

Email address: medicaidtransformation@hca.wa.gov

[MTP renewal page](#) (and public notice language)

The Health Care Authority (HCA) invites you to [provide public comment](#) on our draft application for a **renewal** of our Medicaid Transformation Project (MTP). MTP is Washington State's Section 1115 demonstration waiver from the Centers for Medicare & Medicaid Services (CMS).

The public comment period begins Thursday, May 12 and ends Monday, June 13.

HCA is seeking CMS approval to renew our existing MTP waiver to:

- Expand coverage and access to care, ensuring people can get the care they need.
- Advance whole-person primary, preventive, and home- and community-based care.
- Accelerate care delivery and payment innovation focused on health-related social needs.

If approved, the MTP renewal waiver will provide an additional five years for our state to continue to develop projects, activities, and services that improve Washington's health care system.

On this page

- [Scheduled webinars](#)
- [Public comment](#)
- [About the renewal](#)
- [About MTP](#)
- [Resources](#)

Scheduled webinars

HCA will host three virtual public hearings via webinar to share information about the MTP waiver renewal. Attendees will have an opportunity to ask questions and provide comments. Register for one of the following dates:

- [Thursday, May 26](#) from 12-1 p.m.
- [Tuesday, May 31](#) from 12-1 p.m.
- [Tuesday, June 7](#) from 5:30-6:30 p.m.

If you are unable to attend, we'll be posting the recordings from each webinar on this page.

Public comment

Public comment is open to anyone who would like to share feedback. We encourage health care and social service providers, Accountable Communities of Health (ACHs), Tribal Nations, Indian health care providers (IHCPs), managed care organizations, hospitals and health systems, medical associations, community-based organizations, the public, and others to provide input.

Share your feedback by:

1. Attending a webinar (see dates and times above)
2. Filling out [this online survey](#)
3. Emailing us at medicaidtransformation@hca.wa.gov
4. Mailing us at:

Washington State Health Care Authority, Policy Division
Regarding: MTP renewal public comment
Attention: Tamarra Henshaw
P.O. Box 45502
Olympia, WA 98504-5502

The deadline to provide public comment is **Monday, June 13, 2022, at 5:00 p.m. Pacific Standard Time.**

About the renewal

The Health Care Authority (HCA) and our partners are pursuing an MTP waiver renewal. By renewing MTP, our state can continue toward achieving whole-person care, where Washington residents can receive care for their mind and body and have access to necessary social supports.

Existing MTP programs (within the current MTP waiver) will continue and/or expand under the renewal. These include:

- Long-Term Services and Supports (LTSS)
- Foundational Community Supports (FCS)
- Substance use disorder (SUD) IMD*
- Mental health IMD*

In addition, we will launch four new programs under the renewal:

- Taking Action for Healthier Communities (TAHC), which is currently named “Initiative 1: transformation through ACHs and IHCPs” and referred to as “evolution of Initiative 1.” **Important note:** although this is an existing program of the current MTP waiver, TAHC would be a new program under the renewal. This is because ACHs and others will focus on specific areas of work, rather than choose from multiple community priorities. [Learn more.](#)
- Continuous Medicaid enrollment for children
- Extending coverage for postpartum services
- Re-entry coverage after incarceration

Read our [about the MTP waiver renewal](#) and view a [snapshot of the renewal](#) for more information on these programs. **Note:** these documents are available in multiple languages. See the resources section below.

About MTP

MTP allows our state to improve Washington’s health care system using federal Medicaid funding. Washington State is currently in the last year of the current MTP waiver, which ends December 31, 2022. If approved, the MTP renewal will **begin January 1, 2023, and end December 31, 2027.**

All work under MTP benefits people enrolled in Apple Health (Medicaid).

[Learn more about MTP.](#)

Resources

Renewal:

- [MTP waiver renewal application - draft](#) (full application) | [acronym glossary](#)
 - [Appendix A: health-related services \(HRS\) menu](#)
 - [Appendix B: budget neutrality](#)
 - [Appendix C: interim evaluation findings report](#)
 - [Appendix D: external quality review organization \(EQRO\) reports](#)
 - [Appendix E: Washington State Register notice](#)
 - [Appendix F: full public notice](#)
 - [Appendix G: Dear Tribal Leader Letter](#)
- [MTP renewal executive summary](#), which also serves as Appendix F

Public comment:

Submit your public comments [through our online survey](#) or see the public comment section above for more options.

Learn more:

- [About the MTP renewal](#) (March 2022), also translated in these languages:
 - [អង្គរខ្មែរ - Cambodian \(Khmer\)](#)
 - [中文 - Chinese](#)
 - [한국어 - Korean](#)
 - [ພາສາລາວ - Laotian](#)
 - [Русский - Russian](#)
 - [Af-soomaali - Somali](#)
 - [Español - Spanish](#)
 - [Tiếng Việt - Vietnamese](#)
- [Snapshot of the MTP renewal](#) (March 2022), also translated in these languages:
 - [អង្គរខ្មែរ - Cambodian \(Khmer\)](#)
 - [中文 - Chinese](#)
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 - [Русский - Russian](#)
 - [Af-soomaali - Somali](#)
 - [Español - Spanish](#)
 - [Tiếng Việt - Vietnamese](#)
- [Evolution of Initiative 1](#) (January 2022)
- [FAQ](#) (updated January 2022)

*IMD stands for institution for mental diseases. IMDs are defined as hospitals, nursing facilities, or other institutions with more than 16 beds that primarily provide diagnosis, treatment, or care of persons with mental illnesses. This includes medical attention, nursing care, and related services.

We acknowledge the term “mental disease” may be harmful or stigmatizing. We use it in this context only to reflect the legal terminology used in statute.



STATE OF WASHINGTON
HEALTH CARE AUTHORITY

626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

July 1, 2022

Dear Tribal Leader:

SUBJECT: Medicaid Transformation Project 1115 Waiver Renewal Application
May 16: Updated Round Table and Consultation Dates
July 1: Updated with additional Consultation

In accordance with section 1902(a)(73)(A) of the Social Security Act regarding the solicitation of advice prior to the submission of any Medicaid State Plan Amendment (SPA) or waiver likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations, the Health Care Authority (HCA) hereby seeks your advice on the following matter.

Purpose

The HCA intends to apply for a five-year renewal of the 1115 Medicaid demonstration waiver, commonly referred to as the Medicaid Transformation Project (MTP). An approved application will extend MTP from January 1, 2023 to December 31, 2027.

HCA has reserved the following dates and times for Tribal Roundtables and Tribal Consultation:

Meeting	Date and Time	Webinar URL
Roundtable #1	May 25, 11:00 am – Noon	Occurs during the Tribal Compliance and Operations Workgroup (TCOW) https://us02web.zoom.us/j/87059386741
Roundtable #2	June 15, 11:00 am – Noon	Meeting occurs during the regularly scheduled TCBHAB https://us02web.zoom.us/j/83222756112
Consultation	June 29, 9:00 – 10:30 am	https://us02web.zoom.us/j/89578748141
Consultation Continued	NEW: July 6, 1:00 – 2:00 pm (Tribal Caucus) 2:00 – 3:30 pm (Consultation)	Tribal Caucus (hosted by the American Indian Health Commission) https://us02web.zoom.us/j/87524951513?pwd=eKDBs6_h2LufJ3K3fHLXNgqzkzHcx8.1 Consultation https://us02web.zoom.us/j/85623679649

Summary of Roundtable and Consultation Comments to Date

- Long-term services and supports available through the MTP waiver (MAC and TSOA) should be more accessible for Tribes and Indian health care providers (IHCPs).
- Tribes and the State should work together on implementation of health-related services and in-lieu of services as there is little to no historical context.

Dear Tribal Leader

July 1, 2022

Page 2

- Tribes and IHCPs have vastly different experiences working with Accountable Communities of Health (ACHs).
- There is general support for a Native Hub and questions about implications of a Tribal ACH and state-wide versus local networks.
- IHCPs have completed behavioral health assessments and will do so again, as part of the IHCP-specific Projects. This should be incorporated into the Washington Integrated Care Assessment.

Background and Request Overview

In July 2022, Washington State will submit a renewal application for the 1115 Medicaid demonstration waiver. The application will renew the five initiatives with some changes and add-on projects as follows:

Taking Action for Healthier Communities: This initiative is the next generation of the Accountable Communities of Health (ACHs) and Indian Health Care Provider-specific Projects. Without the financing that was available through the Delivery System Reform and Incentive Payment (DSRIP) program, the funding for this initiative under the renewal will be substantially less. As a result, the state is proposing to target the limited funding that will be available to fund Accountable Communities of Health (ACHs) in the role of Community-Based Care Coordination Hubs and for a coinciding, state-wide, Native Hub, to support the development of tailored strategies for whole person care and then expansion of those strategies across other providers within a region, across the state, and among the Indian Health Care Providers (IHCPs).

Long-Term Services and Supports (LTSS): Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA): This initiative supports Washington's aging population and family caregivers who provide care for their loved ones. The Aging and Long-Term Support Administration (AL TSA) of the Department of Social and Health Services (DSHS) leads this initiative.

LTSS flexibilities and service enhancements: DSHS is proposing to expand the MAC and TSOA benefit package, extend Medicaid-funded long-term services and supports (LTSS) presumptive eligibility to approximately sixty days, and enhance LTSS services.

Community Supports (FCS): This initiative provides supportive housing and supported employment services to Washington State's most vulnerable Medicaid beneficiaries. FCS services are designed to promote self-sufficiency and recovery by helping participants find and maintain stable housing and employment. HCA is not proposing any changes to this initiative.

Substance Use Disorder (SUD) Institution for Mental Disease (IMD) waiver: This initiative allows Washington State to use federal funds to purchase acute inpatient services for Medicaid clients between the ages of 21 and 65 residing in a residential SUD

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treatment facility that qualifies as an IMD. HCA is not proposing any changes to this initiative.

Mental health (MH) IMD waiver: This initiative allows Washington State to use federal funds to purchase acute inpatient services for Medicaid clients between the ages of 21 and 65 residing in a dedicated psychiatric facility that qualifies as an IMD. HCA is not proposing any changes to this initiative.

HCA is also planning to include the following additional initiatives in the renewal application:

Continuous Medicaid enrollment for children: Allow children who meet the following criteria to remain continuously enrolled in Medicaid until age six:

- Medicaid-enrolled
- Household incomes below 215% of the Federal Poverty Level (FPL)
- Continuously reside in-state

Access to Medicaid services before release from the justice system: Provide Medicaid services to individuals 30-days before they exit the justice system, to assist in transition planning and support successful reentry, in accordance with state law passed by the Washington State Legislature.

Expansion of post-partum services covered by Medicaid: Extend Medicaid postpartum coverage from 60-days to 12-months, starting the day the pregnancy ends, in accordance with state law passed by the Washington State Legislature.

Payment transformation through ACHs and managed care organizations (MCOs): Support the provision of health-related services and supports (HRSS), through systematic use of 'in-lieu of services' (ILS) and 'value-added services' (VAS), existing MCO payment mechanisms to address new services such as HRSS.*

* HCA is aware of the need to address parity between Medicaid beneficiaries receiving their coverage through an MCO and those who have coverage without an MCO. We will partner with Tribes and IHCPs on the best way to make these new HRSS available to those we serve.

Health information technology support: Support the implementation of community information exchange (CIE), including resource and referral support for participating community-based organizations and tribal governments and IHCPs.

For this renewal application, HCA is planning to move away from numbered initiatives (e.g., initiative 1, 2, 3, etc.) and focus instead on goals with named programs, policies, and initiatives described to address the goals. We are proposing the following goals for the 1115 waiver renewal:

- 1) Expanding coverage and access to care, ensuring people can get the care they need.
- 2) Advancing whole-person primary, preventive, and home- and community-based care.

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- 3) Accelerating care delivery and payment innovation focused on health-related social needs.

Anticipated impact on Indians/Indian Health Programs/Urban Indian Organizations

The HCA anticipates the 1115 waiver renewal will have numerous positive impacts on AI/AN Medicaid applicants or enrollees, Indian Health Programs, or Urban Indian Health Programs. AI/AN individuals will have more access to Medicaid coverage and services, and IHCPs will have supports for implementing culturally appropriate strategies for whole person care. The HCA would appreciate any input or concerns that Tribal representatives wish to share, including whether this waiver renewal proposal will have disproportionate impact on American Indian/Alaska Native Medicaid applicants or enrollees, Indian Health programs, or Urban Indian Health Organizations.

Copy available

A draft copy of the 1115 waiver renewal application will be available on and after May 12, 2022. The draft will be posted at www.hca.wa.gov/about-hca/medicaid-transformation-project-mtp/mtp-renewal.

Comments and questions

HCA would appreciate any input or concerns that Tribal representatives wish to share regarding the 1115 waiver renewal. To return any comments, please contact Chase Napier, Medicaid Transformation Program Manager, via email at chase.napier@hca.wa.gov, with a courtesy copy to Ann Myers, State Plan Coordinator, at ann.myers@hca.wa.gov, by June 16, 2022.

Please contact Lou McDermott, Deputy Director and Interim Tribal Affairs administrator, by telephone at (360) 725-0891 or via email at lou.mcdermott@hca.wa.gov, if you have tribal affairs-related questions.

Please forward this information to any interested party.

Sincerely,



Charissa Fotinos, MD, MSc
Medicaid and Behavioral Health Medical Director

By email

cc: Lou McDermott, Deputy Director and Interim Tribal Affairs Administrator, OTA, HCA
Mich'l Needham, Chief Policy Officer, PD, HCA
Chase Napier, Medicaid Transformation Program Manager, PD, HCA

Appendix H: summary of public notice and tribal consultation

The state conducted a formal 30-day public comment period, from May 12 to June 13, to solicit feedback about the draft waiver renewal application. HCA held three public hearings to provide information on the waiver renewal process and capture public comment. The state also held two Tribal Roundtables and two Tribal Consultations. In addition, people had the opportunity to share public comment through an online survey and by email and traditional mail.

To fulfill the required post-award public input process, the state discusses MTP implementation with the Apple Health Medicaid Advisory Committee on a quarterly basis, as well as hosting annual public forums that are open to the public. These meetings provided an opportunity to discuss MTP implementation progress and the development of the renewal application, including feedback and comments. The most recent post-award public forum was held on December 13, 2021, where the state discussed the components and requirements for the MTP demonstration and solicited comments and feedback.

HCA announced all meeting dates and shared materials in advance on the HCA website and using GovDelivery. The most recent MTP discussions with the Apple Health Medicaid Advisory Committee occurred earlier this year, on April 29 and June 24. Overall, there is significant support for MTP and the renewal application. In addition, the state developed a collaborative approach to MTP implementation. Examples include Community Advisory Committees organized by the regional ACHs; weekly virtual meetings between ACH leaders and the state; weekly virtual meetings between MCO leaders and the state; and implementing client satisfaction surveys, annual assessments, annual learning symposiums, and ad hoc workgroups.

Dear Tribal Leader Letters (DTLL) and public notice was provided as outlined in Appendices E, F, and G, as required. HCA utilized the Washington State Register along with distribution through GovDelivery and various partnering organizations, including ACH community and partner communications. HCA's [MTP renewal](#) webpage provides links to all public materials, including summary materials in nine languages. The recorded public hearings are also available on this webpage.

During the public comment period, the state received over **200** individual responses and letters with suggestions, questions, and comments of support. The total amount of comments is much greater than the 200 responses, as most individual responses contained multiple suggestions, comments, and/or questions.

The state summarized similar comments into common themes for clarity and better understanding. HCA also summarized the changes made to the final renewal application in response to the public comment period.

Tribal Roundtables and Consultation and Confers

In accordance with federal law¹, the state hosted two Roundtables and two Consultation and Confers with the 29 federally recognized Tribes and two Urban Indian health programs on the 1115 renewal application. Additionally, the American Indian Health Commission of Washington State (Commission) hosted a tribal caucus directly before the second and final Consultation and Confer. These meetings (Roundtables and Consultation and Confers) occurred between May 25, 2022, and July 6, 2022. The Commission was created in 1994 by federally recognized Tribes, Urban Indian health programs, and other Indian organizations to provide a forum for addressing Tribal-State health issues. The Commission's mission is to improve the health of AI/AN people through tribal-state collaboration,

Summarized **feedback** from these Consultation and Confers are listed below with [state responses](#):

- **Tribes and the state should work together on implementing the “in lieu of services,” as this is new and there is little historical context.**

[The state agrees it will be important to continue tribal consultation and regular communication through the implementation process.](#)

- **Some Tribes have experienced a lack of support from their ACH, and there has been varying experiences in working with and support from the ACH, depending on the region.**

[As with the initial MTP waiver, there will be no requirement for Tribes/IHCPs to work with regional ACHs under MTP 2.0. The state will continue to work with ACHs to improve communication and engagement to ensure tribes have the option to participate and that participation is meaningful and collaborative.](#)

- **There was discussion of a Native Hub, including regional versus statewide Hubs and Tribal-specific hubs.**

[We acknowledge there is more work to be done in the development and implementation of a Native Hub. We have pledged to continue these discussions with our IHCP partners.](#)

- **Tribes completed behavioral health integration assessments with the Commission and will do so again. They should not be required to duplicate efforts or engage in culturally irrelevant work through the WA-ICA.**

[We anticipate flexibility for Tribes and IHCPs surrounding integration assessment approaches to avoid duplication.](#)

Summary of changes

The following list summarizes changes the state made within the renewal application, based on comments received during the public comment period. These changes are also addressed with additional context within the comments and responses listed in the Summary of Feedback section.

1.2 Pre-release and re-entry coverage:

¹ Section 1902(a)(73)(A) of the Social Security Act refers to the solicitation of advice prior to the submission of any Medicaid State Plan Amendment (SPA) or waiver.

- Expanded language to include state hospitals and IMDs and noted the alignment between the 30-day pre-release policy and legislative direction.
- Added freedom of choice waiver.

1.4 Contingency management (CM):

- Moved CM from section 3.1.2 (HRS) to section 1.4.

2.1 MAC and TSOA:

- Increased TSOA income eligibility from 300% to 400% of the SSI benefit rate.

3.1.2 Appendix A:

- Consolidated the HRS menu by removing services that do not meet the ILOS framework and/or could be placed with existing domains as complementary supports.
- Added childcare and language access supports to complement housing navigation services.

3.2: FCS

- Extended enrollment from six to 12 months for supportive housing.

Summary of feedback and the state's response

This section contains **summarized** comments, questions, and suggestions received during the public comment period, and the state's response to that feedback.

Renewal package overall

1. **Many comments and suggestions pertained to programs, services, or operational challenges outside of the MTP waiver renewal (e.g., Kidney Disease Program, school-based dental, pediatric programs, and related capacity investments).**

We agree with the importance of these programs and will continue to explore opportunities for alignment and implementation outside of the renewal. While Washington acknowledges the potential benefit and costs of the suggested programs, our main responsibility is to justify waiving a federal requirement and verify legislative authorization. In addition, the state continues to support many strategies and initiatives beyond the MTP waiver renewal and will look for opportunities to address challenges in the appropriate venue.

2. **A few commenters suggested it was difficult to read the entire application and suggested additional resources, such as definitions, a glossary, etc.**

We thank commenters for the suggestion and will be clarifying sections using plain talk without changing the proposed programs. We also added an [acronym glossary](#) and uploaded to our website for public access.

3. **A few commenters stated the importance of community information exchange (CIE) to support this work, including interoperability and alignment across various platforms and solutions. Others asked if the goal was to have systems work together or to create one CIE solution for the state.**

We recognize the importance of CIE and an interoperable system. We are observing investments in CIE in certain Washington communities and recognize the importance of building upon existing capacity wherever possible. HCA is currently operating under legislative direction to provide a recommendation on CIE support.

We are taking into consideration all feedback as we continue to explore this work and develop CIE recommendations and potential funding and procurement strategies. At this point, we anticipate that a solution will likely consider how multiple systems may work together, which will depend on interoperability standards and state support to address gaps, ensure scalability, and bring partners together.

4. A few commenters highlighted the importance of a closed-loop referral system to support the goals of MTP 2.0 related to community services and health equity.

We agree that a system to provide access to resources and mechanisms for referral and tracking (closed-loop referral) will be important to many of the goals and strategies proposed (e.g., FCS, HRS, Community Hubs, and health equity). As noted in other responses, CIE is currently being researched and guided by legislative direction. While it is not identified as a waiver-funded strategy, HCA anticipates funding to support a procurement and future implementation of CIE in conjunction with MTP 2.0.

5. A few commenters had questions regarding community governance, data privacy, and Tribal data sovereignty related to HIE and CIE.

We appreciate these questions and agree that several topics associated with information exchange, data privacy, and governance will be important to discuss and address going forward. These include the role of individuals and communities, use-based access, Tribal data sovereignty, and other policies tied to privacy and security considerations. This work will likely be tied to a broader CIE effort aligned with MTP 2.0 and could include future funding in support of an anticipated procurement and statewide governance and interoperability effort.

6. A few commenters suggested that VBP requires ongoing investment and capacity building, including a potential role for the waiver to advance VBP and further specify accountability and goals for VBP.

We appreciate the recognition of VBP and the importance of this work to advance integrated care. HCA remains committed to VBP and continues to advance VBP through our managed care contract and models, such as Community Health Access and Rural Transformation (CHART) and Multi-payer Primary Care Transformation. VBP was a significant emphasis under MTP and the DSRIP program, and it is important to recognize DSRIP was a time-limited program that cannot be renewed.

That being said, the proposed strategies under MTP 2.0 reflect an ongoing commitment to VBP and paying for health and value strategies, including a greater emphasis on building sustainable payment strategies for HRS and community-based workforce.

7. **A few commenters stated the need to have clear implementation accountability and community voice throughout the waiver, including how to best communicate issues or concerns.**

We recognize the need for community engagement and community voice and will take this feedback into consideration as we implement MTP 2.0. We have identified several areas we commit to developing additional detail on to support community voice, transparency, and implementation accountability. Below are a few examples:

- ACH governance and decision-making.
- Community engagement mechanisms, including ACH community engagement practices.
- Real-time feedback from partners, providers, and those receiving services.
- Coordination with state agency leadership based on challenges and opportunities identified.
- Overall MTP accountability, monitoring, and reporting.

8. **A couple of commenters stated that ACHs and HCA should include communities of color in equity funding decisions.**

We appreciate the comment and agree that engaging communities is important. There is more work to do within the health equity investment program, and one of the key considerations will be authentic community voice tied to decision-making.

9. **One commenter asked what the working definitions of “equity” and “equitable” are regarding the MTP waiver.**

We appreciate the question. Our health equity language is based off Robert Wood Johnson Foundation’s definition of health equity. We believe health equity is a core value of the waiver and means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

10. **A couple of commenters noted appreciation that equity is an overarching theme but that there is a need to further clarify how equity is centered and advanced across all programs.**

We appreciate this feedback. The various waiver components, including TAHC/equity funding, re-entry, continuous enrollment, postpartum coverage, and FCS, address pronounced racial disparities. Racial equity and justice are explicit goals of these programs, alongside improving health and opportunity for all Apple Health enrollees.

11. **One commenter suggested to include reference to certified community behavioral health clinics (CCBHCs) in the waiver.**

We appreciate the comment. After further analysis, we believe specific reference to CCBHCs in the waiver is unnecessary. There is federal and state grant money to support CCBHCs, and the state is currently completing a research study on CCBHCs. We are also exploring the opportunity to involve CCBHCs in the WA-ICA program but don’t anticipate any barriers that require 1115 waiver flexibility.

12. **One commenter provided their concern about lack of providers to address needs in a timely manner as well as inconsistency across MCOs.**

We appreciate this feedback and will refer concerns related to network adequacy or access to the leads within the Medicaid Program. We are excited about the opportunity to increase partnership between MCOs, ACHs, and local providers and community organizations but understand there are challenges that need to be addressed related to workforce and capacity limitations.

13. **Several commenters suggested a greater focus on children, youth and families, mental health, and services in non-traditional settings, including services provided outside of school.**

We appreciate the focus on children, youth, and families and this aligns with HCA's intent to take a life stages approach under MTP 2.0, including renewal strategies like continuous enrollment, post-partum coverage, and HRS. The Community Hub model, FCS, and HRS offer an opportunity to better meet the needs of children, youth, and families by addressing unmet HRSN, such a nutrition and housing supports. It's important to remember that programs require justification tied to a waiver of federal requirements and also require legislative authorization.

14. **Several commenters suggested greater clarity regarding whole-person care, and greater emphasis on behavioral health integration, primary care, prevention, and the necessary technical assistance and capacity investments.**

We appreciate this comment and are making minor revisions within the application to clarify the meaning of whole-person care. We're also working to better highlight the importance of the state's ongoing effort with clinical integration, primary care supports, and related initiatives outside of MTP 2.0.

There are many programs and strategies outside of MTP 2.0 that HCA is leading or engaged in, including the agency's efforts to advance value-based whole-person care. That being said, we are pursuing the WA-ICA effort as proposed under MTP 2.0, which would bring in additional support and targeted investment for behavioral health and physical health providers under the renewal. In addition, the focus under MTP 2.0 on coverage expansion and care coordination provides many opportunities related to prevention and integration of services across the health system.

15. **A few commenters suggested the waiver should address low Medicaid rates and/or the need to add allowable codes, such as chronic care management.**

We appreciate the comment regarding Medicaid rates and billing codes. It doesn't appear this comment suggests a change to the MTP 2.0 application. Included programs require justification tied to a waiver of federal requirements and also require legislative authorization. For Medicaid rates and billing, we will continue to follow legislative direction and coordinate with staff internally to explore the opportunities to add allowable codes.

16. **One commenter asked about the CMS approval process, including how current programs and services would be impacted if approval does not occur by January 1, 2023.**

While the state hopes to have approval by the end of 2022, CMS has identified the possibility of a temporary extension for a period of time (e.g., six months) to continue existing programs and services while negotiations continue with MTP 2.0. This temporary extension concept is a common strategy to avoid disruption if a waiver renewal requires additional time for approval.

Continuous Apple Health enrollment for children

17. Several commenters expressed support for continuous enrollment for children.

We appreciate the support and agree this program will improve continuity of coverage and access to important care and services for eligible children.

18. One commenter suggested the need for a clear transition plan for children turning seven to ensure continuity of coverage.

Under an approved waiver, expanding medical coverage will allow all Medicaid-enrolled children in Washington with family incomes below 215 percent of the FPL to remain enrolled in Medicaid until age six. This FPL standard will significantly reduce the possibility of extending coverage to children who could become income-ineligible for Apple Health. This includes reducing the possibility of an ineligibility determination. That said, we agree it will be important to work with families who experience an ineligibility determination for children turning seven.

Re-entry coverage for continuity of care

19. A couple of commenters provided their concerns on utilizing resources and suggested that community health centers (CHCs) should be leveraged as a resource to assist in providing Medicaid coverage and access services for the reentry population.

We appreciate sharing the suggestion. Each facility sets up differently how they transition services. We will share this comment with the statutory re-entry workgroup that is reviewing and working on the improvement of this process. Anyone interested in learning more or joining the workgroup can contact us at HCAreentryworkgroup@hca.wa.gov.

20. One commenter had a question about the expansion of language to include the 30-day delay aligned with legislative direction.

We appreciate the feedback and have taken into consideration updating the waiver draft. The language will be updated to clarify that the 30-day re-entry and pre-release policy will be consistent with requirement in Senate Bill 5304 (2021) and House Bill 1348 (2021).

21. One commenter had a question about the expansion of language to include state hospitals.

We appreciate the feedback and have updated the waiver draft to align with legislative direction under Senate Bill 5304 and House Bill 1348 (2021). The waiver request will include re-entry to support continuity of care for individuals confined in a state hospital or IMD.

22. One commenter had a question whether it is a state or federal rule to stop Medicaid when incarcerated.

We appreciate the inquiry. It is a federal rule that federal financial participation of Medicaid cannot be leveraged while an individual is incarcerated.

23. **One commenter asked about reviewing the implementation role of MCOs in the services to the reentry population.**

We appreciate the concern and feedback. We will share this comment with the re-entry workgroup that is reviewing and working on the improvement of this process. Anyone interested in learning more or joining a workgroup, please contact us at HCAreentryworkgroup@hca.wa.gov.

24. **A couple of commenters asked whether the re-entry program requires a freedom of choice waiver.**

We appreciate the question and feedback. We have taken the input into consideration and updated the waiver language to add a freedom of choice waiver for the reentry program.

Apple Health postpartum coverage expansion

25. **One commenter asked if the program request is similar to Maternity Support Services and if coverage expansion requires CMS approval.**

We appreciate the inquiry. This request does not include an expansion of Maternity Support Services but will be an expansion of full categorically needy coverage. The agency would require Washington State legislative and CMS approval to explore the expansion of Maternity Support Services through a SPA.

26. **Many commenters provided their support for the expanded postpartum coverage program.**

We appreciate the feedback and support for this program.

SUD and MH IMD supports for people receiving SUD and mental health treatment

27. **A few commenters suggested an increase of funding for specific strategies, such as opiate harm reduction and the Better Prescribing Better Treatment (BPBT) program.**

We appreciate the suggestion and are always exploring ways to support efforts to curb opioid misuse and reduce harm. MTP 2.0 includes continuation of SUD-related IMD services that allow the state to utilize federal funds participation in IMD settings that would be excluded if the 1115 waiver was not in place.

Dedicated waiver funding for additional programs, such as the BPBT program or syringe exchange programs, are not included in the waiver. However, the state will continue to explore ways to support these programs. The IMD provisions in the waiver are specifically related to allowing individuals to be treated at facilities with the IMD designation, contrary to current federal standards. This opens more treatment opportunities for Medicaid enrollees across the state. Early engagement and harm reduction are also critical parts of our SUD/OD strategy.

LTSS, including MAC and TSOA

28. **A couple of commenters suggested increasing the TSOA eligibility criteria.**

We have taken the feedback into consideration and plan to submit a proposed TSOA income and resource standards, including annual updates for the standards, to CMS in the waiver. The application will include a request for an increase in the income criteria for TSOA applicants. This will not impact the requests for additional services for the MAC and TSOA benefit package or the new LTSS enhancements.

29. One commenter asked to define whole-person primary, preventive, and home and community-based care.

We appreciate the feedback to provide clarification. This language reflects the second goal within MTP 2.0 and is meant to encompass several concepts. The language helps address whole-person care (including physical and behavioral health), primary and preventive care, and home and community-based care. Home and community-based care means providing services and supports to individuals in a community setting that is not considered "institutional," such as a hospital or nursing facility.

30. One commenter asked about the benefit amount for the MAC and TSOA programs, access of services available for enrolled clients, and availability of culturally appropriate services.

We appreciate the feedback regarding MAC and TSOA programs. In response to the questions about amount and type of services available, enrollees have access to a budget amount that can be used to purchase a variety of services. If an enrollee chooses to use the entire budget for an in-home care provider, they can receive about 20 hours of service per month.

If an enrollee's needs cannot be met within the program limits, they can ask for an exception to the rule for additional hours or can apply for a traditional program. This includes Community First Choice or COPES which may provide a larger service package.

Enrollees looking for a service or provider that is culturally relevant to them should consult with their case manager. We agree that culturally appropriate services are a critical part of ensuring the waiver serves all communities and will take the feedback into consideration during the implementation phase of the waiver. All services and providers in MAC and TSOA must have the criteria approved by CMS in the waiver application.

31. One commenter recommends exploring a quasi-New Freedom model for the purchasing of goods and service.

We appreciate the recommendation of using a financial management service vendor like the model used in New Freedom waiver. Currently, it is not financially feasible to utilize this model for MAC and TSOA services.

32. One commenter provided support for presumptive eligibility for LTSS eligibility screening.

We appreciate the feedback on LTSS enhancements proposed in the waiver and believe that the use of presumptive eligibility for LTSS applicants will allow for more timely delivery of services. The LTSS enhancement can also address the institutional bias that exists today for Medicaid enrollees who choose to receive services in their community.

WA-ICA

33. **Many commenters expressed overall support for the WA-ICA effort and the work led by the workgroup that worked to select the WA-ICA tool for standardized assessment.**

Thank you for your support and for recognizing the important work of the WA-ICA workgroup that received input from providers, MCOs, ACHs and state agency staff.

34. **A few commenters suggested a focus on adequate measurement within WA-ICA, including quality metrics, provider payments, and services that address whole-person care.**

Thank you for the feedback. We will share this comment regarding the measurement framework with the WA-ICA leads for consideration as we continue to implement the new assessment tool.

35. **A few commenters suggested more capacity funding is needed to support integrated care, along with a focus on provider organizations that have yet to embark on integrated care implementation.**

We appreciate this feedback regarding support for providers who are either early in integrated care implementation or not yet working on integration. The WA-ICA is meant to support providers from all points along the integrated care continuum. We will continue to explore use of targeted incentives to best support provider engagement and advancement in integrated care, recognizing that some providers haven't yet begun efforts to integrate.

36. **One commenter asked about the ACH role related to WA-ICA.**

We appreciate this question and will continue to work on the implementation plan for WA-ICA. We will continue to explore a potential ACH role to support provider engagement, reporting, and incentive payment. HCA is interested in streamlining WA-ICA supports where it makes sense, such as centralized data analysis and deployment of practice coaching supports.

TAHC

37. **Several commenters expressed support for Community Hubs, community-based workforce, and aligning community-based care coordination to avoid duplication.**

We appreciate the support for the Community Hub and community-based workforce strategies within the application. We agree the Community Hub model is an additional opportunity to reinforce existing programs and support community organizations while bringing together disparate programs and establishing new referral partnerships to avoid duplication and gaps.

38. **Several commenters recommended further partnership between MCOs, ACHs and providers, including more emphasis on the MCO role in community-based care coordination.**

We agree there is a significant opportunity for partnership. We will continue to engage and convene the various stakeholders to move toward further collaboration between MCOs, ACHs, and providers. The emphasis on clinical care coordination among MCOs was meant to reinforce non-clinical focus of the Community Hub model and the need for greater support for community-based workforce and HRS. We will continue to evaluate existing capacities and how to address gaps while avoiding duplication.

39. **Several commenters expressed support for SDOH and health equity focus, including emphasis on HRS (e.g., medically tailored meals).**

We appreciate the support and believe this work to address health equity and unmet HRSN is critical.

40. **Several commenters expressed support for continued ACH role in convening, working across sectors and communities, etc.**

We agree ACHs have provided a lot of value to communities and organizations across the state. They will play an important role to continue advancing health equity, engaging communities, and bringing together different sectors and programs.

41. **One commenter expressed interest in expanding the HRS menu to include a broader array of services and/or provide regional flexibility. Examples include childcare, GED support, translation services, etc.**

While we recognize the value of HRS as a vehicle to address additional unmet HRSN, HCA remains focused on an HRS menu that fits the ILOS criteria of medically appropriate and cost-effective alternatives. After further analysis of current and newly proposed HRS, HCA adjusted the menu to remove services that are likely to fall outside of the ILOS construct.

In addition, we consolidated several originally proposed and newly suggested services within other domains. For example, transportation and legal supports have been moved into housing navigation, along with the addition of childcare and language access support, to show where these services can be offered with related strategies to implement medically appropriate alternative services (ILOS).

42. **A few commenters questioned whether HRS will result in siloed payment apart from IMC or if HRS will only address high costs.**

We appreciate the opportunity to clarify the intent. The goal with HRS is to leverage the managed care system and further the use of ILOS authority to offer new services and/or expanded access to existing services. HCA will work with MCOs, ACHs, and others to ensure payment is structured to leverage current MCO and ACH capacities to reduce the burden on providers, CBOs, and Medicaid enrollees.

43. **Several commenters highlighted the importance of not disrupting existing payment arrangements and avoiding duplication with existing programs and capacity, including MCOs, primary care, and CHCs.**

We appreciate this emphasis and agree that non-duplication is important. We believe the Community Hub model will support non-duplication by bringing together different resource and referral processes to support continuity and increased information exchange and access between organizations. ACHs and Community Hubs will not replace existing capacity, and we recognize community-based workforce is and should be placed in multiple settings. The goal is to address capacity and payment gaps where they exist, while leveraging existing relationships and strengths among MCOs and ACHs.

44. **Several commenters suggested a focus on sustainable Community Hub and workforce funding, including use of Medicaid funding and capacity for expanded workforce.**

We appreciate the focus on sustainability and agree it will be important to explore sustainable funding strategies, including permanent Medicaid payment strategies. We are exploring strategies to phase in other Medicaid funding during the renewal period to support long-term community-based workforce payment.

45. **One commenter expressed a concern that SDOH screening and referral mechanisms will be met with increased data needs without corresponding resources and services, including the need for more housing investments.**

We appreciate the caution and need to balance screening and data collection with increased access to required services and supports. We believe the Community Hub, FCS program, and HRS all offer reinforcement to ensure increased payment for services. This includes housing supports and investments. It is also worth noting that the Washington State Legislature recently passed House Bill 1866 (2022) to establish the Apple Health and Homes program. This program will address issues contributing to homelessness, including the lack of affordable housing.

46. **One commenter suggested local health jurisdiction access to Medicaid data related to WA-ICA and programs addressing HRSN to support surveillance, evaluation, assessment, etc.**

HCA will explore the possibility of data-sharing as we get closer to implementation and later evaluation. It is important to note that MTP 2.0 will require a holistic evaluation design, along with other performance assessment and reporting requirements.

47. **Several commenters highlighted the importance of MCO partnership with ACHs, addressing varied ACH capacity and avoiding duplication of MCO functions.**

HCA will continue to work with ACHs and MCOs to develop a close partnership and build upon the strengths of each organization and avoid duplication. We believe it is also important to recognize gaps that exist in terms of community capacity, community-based workforce, and availability of HRS. The partnership between ACHs and MCOs to implement the proposed strategies represents an incredible opportunity to address health equity and unmet HRSN.

48. **A few commenters asked for more information on what is included as HRS, including whether this addresses housing, medical respite, etc.**

The HRS menu is included within the renewal application as appendix A and includes many important proposed services, including housing supports and medical respite.

49. **A few commenters asked for more information on Tribal funding and Tribal relationships with ACHs.**

Tribal funding will be provided through the Native Hub and equity investments. This will ensure an equivalent investment for Tribes and IHCPs, as for ACHs and their communities. HCA is currently evaluating Tribal engagement and collaboration under MTP and will revisit the current policy that addresses engagement and collaboration under MTP 2.0, including ACH expectations and opportunities for HCA to support this partnership.

50. **A few commenters highlighted the importance of building on existing ACH capacity and successes, including core ACH functions, and the need for consistent transparency, engagement, and balanced decision-making.**

We appreciate the recognition of core ACH functions and the value ACHs provide across the state. HCA continues to discuss challenges and opportunities to inform potential adjustments under MTP 2.0. This includes priorities like community engagement, transparent decision-making, Tribal collaboration, etc.

51. **A few commenters suggested that capacity and sustainability of CBOs will depend on uptake of HRS payments, and that upfront funding and capacity building is required for HRS to be successful.**

We appreciate the emphasis on HRS uptake (implementation and payment for HRS) because the services are optional to MCOs and Apple Health enrollees. Capacity investments are proposed under MTP 2.0 through the Community Hub model, along with related opportunities to address infrastructure through equity investments. HCA will work with MCOs and ACHs to identify performance goals, partnership opportunities, and implementation plans related to Community Hubs and HRS.

52. **One commenter suggested Community Hubs will need training and curricula for community-based workforce.**

Thank you for the suggestion. We will bring this topic forward as we work with ACHs on standards for the Community Hub model, including criteria and/or curricula for community-based workforce. We agree this is an important consideration but have also explored a balanced approach, with community-based workforce defined broadly and not being overly restrictive.

FCS

53. **A couple of commenters suggested extending the FCS enrollment period from six months to 12 months.**

We appreciate the feedback and have taken the input into consideration to extend the enrollment for supportive housing services to 12 months, per legislative alignment. House Bill 1866 (2022) (Apple Health and Homes) directs FCS to provide 12-month authorization for supportive housing services, effective 2023.

We are currently evaluating the potential impact and assessing the increases to program budget needs for pursuing a similar change with supported employment services. Service authorizations may be re-authorized for as long as an individual has the need for services.

54. **A couple of commenters suggested extending supported employment services to 12 months.**

We appreciate the feedback. We will need to conduct additional analysis to assess the financial implications of extending the service authorization. We intend on pursuing this and other analyses during the upcoming rate study and into the upcoming year. We remain dedicated to improving access and reducing barriers to receiving services and remind all stakeholders that

any FCS enrollee can be reauthorized for as long as the services are needed, regardless of the length of the authorization period.

55. A few commenters asked about the implementation and coordination of the Apple Health and Homes legislation.

We appreciate the question regarding coordination and alignment. HCA, DSHS, and the Department of Commerce are in the early stages of developing the policies around the implementation of Apple Health and Homes, which provides permanent supportive housing units to FCS-enrolled individuals. We will be extending our services authorization for supportive housing services to 12 months, in alignment with this legislation. We will share more information in the upcoming months as the program is further developed.

56. A couple of commenters suggested a restructure of rates and benefits.

We appreciate the feedback and are pursuing a rate study to evaluate the adequacy of the program's reimbursement rates and understand the potential impact of other payment methods. We are planning to review FCS housing and employment rates and the FFS payment methodology this year and next. At this time, supportive housing service units are only available in two types of billing procedure codes: a per diem or per month rate. For the purposes of tracking program budget and engagement, the per diem rate gives us the most granular data possible to assess how FCS services are being accessed.

57. A couple of commenters suggested an improvement to eligibility determination.

We share the concerns for improvement on determining eligibility. We will take this feedback into consideration as we explore ways to streamline and ensure easy access to eligibility determination services as we continue to implement the program.

58. One commenter suggested expanding provision of coverage of FCS to all managed care organizations.

We appreciate this input. Leading up to the renewal period, we sought national technical assistance from the Technical Assistance Collaborative (TAC) on this topic. It was strongly recommended to maintain a third-party administrator (TPA) to administer the FCS benefit moving into the renewal period while we analyze and weigh different sustainability options for the program.

59. A few commenters noted concerns about agency startup costs, training, and retention.

HCA offers free technical assistance (TA) and training that helps support providers in implementing and providing FCS services successfully. This includes much of the onboarding trainings to understand supportive housing services. These trainings include documentation training, infrastructure, providing intentional services, case management skills, billable services, fidelity, landlord outreach and engagement, etc.

60. One commenter suggested greater engagement with Apple Health members in initiative development.

FCS offers the opportunity for participants of services to engage in our advisory council that meets quarterly to have their voice heard in the development of the program. Also, as part of our FCS evidence-based practices, we encourage partners to create formal feedback loops to ensure participant voices are included in the provision of the program.

61. A few commenters suggested reimbursement for pre-tenancy and tenancy sustaining support services.

FCS is designed as intentional support services to help individuals find and maintain housing and employment. Through the program, FCS staff engage with participants in the program. This includes what we call “collateral” services (services that are not face-to-face but on behalf of an individual).

These services include coordination of care to external partners, landlord outreach and engagement, and job development on behalf of an individual. This allows the provider to bill for work to help support an individual in those pre-tenancy and tenancy sustaining services.

62. One commenter suggested inclusion of clubhouse services to preserve the programs fidelity and allow them to function in a way that is congruent with clubhouse culture and accreditation standards.

HCA strongly encourages clubhouses to become providers in the FCS network to receive funding for these services. Because FCS is not designed to be a standalone service, HCA also encourages strong collaboration between FCS and clubhouses to design a program that fits the needs of each clubhouse. It’s also worth noting that certain clubhouse programs or services may align with the proposed HRS to be implemented by MCOs.

63. One commenter suggested broader roll out of pathways tool.

To date, from the perspective of the evidence-based practice of Permanent Supportive Housing, pathways has posed challenges to fidelity to the model in its lack of ability to provide Golden Thread of Medicaid documentation. HCA encourages all providers to attend Golden Thread trainings and utilize additional technical assistance to ensure proper Medicaid documentation. This is to ensure agencies are prepared for if/when an audit may occur. Related to the Community Hub model, HCA will continue to work with ACHs and partners to understand success factors that should be replicated and/or standardized, including the potential use of a common tool or framework.

64. One commenter asked about which FCS rules need agreement from the federal government vs. rules that have flexibility and can change regardless of the final renewal terms.

The MTP special terms and conditions, which include the protocol for FCS, identify the key elements that require authority/approval to change or amend. Any changes to the program that increase the overall budget will also require rationale and budget expenditure authority at the state legislative and federal levels.

65. A few commenters asked about providing transitional housing costs, as this continues to be a gap in the current housing continuum.

The FCS program launched the Transition Assistance Program (TAP) in May 2022, which provides short-term rental assistance (first/last month's rent, security deposits, basic home goods, etc.) for eligible enrollees. We aim to build upon that with our request to CMS for the authority to pay for one-time transition costs (covering similar expenses as TAP), targeting individuals with a history of homelessness and inpatient treatment.

We aim to demonstrate the impact of paying for these transitions to reduce rates of returns to homelessness and need for high-cost inpatient treatment services. The state has also made a significant investment in permanent supportive housing units through House Bill 1866, which we are currently developing with the Department of Commerce. This adds another housing option for eligible individuals.

- 66. One commenter requested clarification on the new, one-time transition funds for individuals who are exiting behavioral health treatment and have a documented history of homelessness. This person also asked for clarification on the management of these funds and whether they will be administered by MCOs or the third-party administrator.**

It has not yet been determined how these funds will be distributed on behalf of FCS participants. Currently, TAP is in its early stages and being implemented outside of the billing process established under the waiver.

We have not negotiated with CMS yet, so we don't have a plan on how to administer the new, one-time transition funds. Until we have a plan in place with CMS, we encourage each MCO in Washington to engage with FCS and the TPA in our quarterly advisory council meetings where these topics can be covered in a public forum.

- 67. Many commenters provided their support for the continuation of the FCS program, including the enhancements under MTP 2.0**

We appreciate the feedback and support for the FCS program. We are excited to continue this important program and to implement the requested updates to expand eligibility and enhance services.

Tribal-specific

- 68. One commenter expressed concern about the relationship between ACHs and tribes, including the need for direct contracting and funding for Tribes, rather than through ACHs.**

We appreciate this comment and recognize the importance of dedicated tribal funding within the 1115 waiver and honoring the government-to-government relationship. It's important to note that tribal equity investments and Native Hub investments will go directly to Tribes, not through ACHs.

HCA is looking at our partnership with Tribes and how we can deepen those relationships in MTP 2.0. HCA's goal is to support Tribes through direct funding while also encouraging participation in ACH efforts through improved communication and engagement approaches.