



Washington State Medicaid Transformation Project (MTP) demonstration  
Section 1115 Waiver Quarterly Report (DY6 Q2)  
Demonstration Year: 6 (January 1 to December 31, 2022)  
Reporting Quarter: 2 (April 1 to June 30, 2022)

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# Introduction

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

Over the six-year MTP period, Washington will:

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

The state will accomplish these goals through these programs:

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

## Vision: a healthier Washington

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

# Quarterly report: April 1–June 30, 2022

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

## Summary of quarter accomplishments

- The state continued work on a longer-term MTP application for renewal, with submission to CMS anticipated during Q3 of 2022. HCA shared renewal concepts with CMS and completed tribal consultation, public hearings, and public comment.
- ACHs continued to distribute incentive funds to partnering providers through the financial executor (FE) portal. During the reporting period, ACHs distributed approximately \$14 million to partnering providers and organizations. The state distributed over \$92,000 in earned incentive funds to IHCPs in Q2 for achievement of IHCP-specific project milestones.
- As of June 30, 2022, nearly 13,300 clients have received services and supports from the MAC and TSOA programs. New enrollees in LTSS for this reporting period include 14 MAC dyads, 204 TSOA dyads, and 382 TSOA individuals.
- Within FCS, the total aggregate number of people enrolled in services as of June 30, 2022, included 4,505 in IPS and 7,482 in CSS. The total unduplicated number of enrollments at the end of this reporting period was 10,296.

## MTP-wide stakeholder engagement

During the reporting period, HCA prepared for the MTP waiver renewal formal public comment period, which took place May 12–June 13, 2022. In early May, the state [sent out an announcement](#) about the upcoming public comment period. Later that month and in early June, HCA [shared information](#) about the public hearings for the renewal, and reminded audiences to share feedback by June 13, 2022.

The state also updated the [MTP renewal page](#) to include information about the public hearings, how to share feedback during the public comment period, and resources. These resources included a draft application of the renewal and its appendices, an acronym glossary, and documents that described the programs that would continue, expand, and begin under the renewal.

The public comment period resulted in extensive feedback regarding the renewal. The overwhelming majority of comments were very supportive of the new and continuing waiver programs. Many of the comments will inform the final renewal application and others will be discussed during implementation. More information regarding tribal consultation and public comment will be summarized in Appendix H of the renewal application.

# Statewide activities and accountability

## Value-based purchasing (VBP)

HCA completed a series of strategy meetings to revisit VBP goals for 2022–2025, building on MTP and VBP priorities and focus areas. During these strategy meetings, staff also discussed the original purchasing goal of achieving 90 percent of state-financed health care in value-based payment arrangements by the end of 2021. In Q2 of demonstration year (DY) 6, HCA finalized a set of new purchasing goals and began sharing and vetting them internally.

## Paying for Value surveys

During the reporting period, HCA prepared for the launch of the annual [Paying for Value survey](#). This year, the state decided to conduct the plan/payer survey only. In previous years, HCA produced two surveys: the Paying for Value survey for plans/payers and the Paying for Value survey for providers.

HCA did not conduct the provider survey this year because other surveys (e.g., Integrated Care Assessment and Multi-payer Primary Care Transformation Model surveys) collect similar information, and HCA did not want to contribute to survey fatigue for providers. HCA will launch the Paying for Value survey for plans/payers on July 1, 2022. Results will be analyzed in Q4 and shared widely with partners, stakeholders, and the public.

## VBP Roadmap and Apple Health Appendix

The [VBP Roadmap](#) describes HCA's VBP goals, purchasing and delivery system transformation strategies, innovation successes to date, and efforts to accelerate the transition into value-based payment models. The Apple Health Appendix (appendix), in accordance with the STCs, describes how MTP supports providers and MCOs to move along the value-based care continuum. The roadmap establishes targets for VBP attainment and related Delivery System Reform Incentive Payment (DSRIP) incentives for MCOs and ACHs. HCA continues to refine the long-term strategic vision for VBP and plans to update the roadmap and appendix in Q3 or Q4.

## Validation of financial performance measures

HCA contracts with Myers and Stauffer LC (MSLC) to serve as the independent assessor (IA) for MTP. In this role, the IA functions as the third-party assessor of financial measures data submitted by MCOs as part of their contracts with HCA. HCA's contracts with the five MCOs establish parameters for the VBP assessment process. These parameters include the financial performance measures, the timelines under which MCOs must submit data, and the review process, which includes third-party validation. HCA met with MSLC in Q2 to begin the 2022 validation process.

## Statewide progress toward VBP targets

HCA sets annual VBP adoption targets for MCOs and ACH regions in alignment with HCA's state-financed purchasing goals. To track progress, HCA collects financial performance measure data from MCOs through the VBP validation process. This MCO data is reported in alignment with the nine ACH regions to track regional and statewide performance. In addition, HCA collects financial performance measure data from commercial and Medicare payers through an annual survey. HCA requires each MCO to respond to the annual survey to provide information and data on their non-Medicaid books of business in Washington State. HCA updated the survey template and will release the health plan survey in Q3 (as stated above in "Paying for Value surveys").

## Technical support and training

- No new activities in Q2.

## Upcoming activities

- HCA will continue refining the long-term VBP strategic vision and refine priorities for the waiver renewal period.
- MCOs will complete the VBP validation templates and work with the IA to address any questions in Q3. The IA will coordinate with HCA on the analysis and final reporting of MCO progress to-date.
- Health plans (including MCOs) will complete HCA's Paying for Value Survey by August 31, 2022 and HCA will analyze results in Q4.

- HCA will update the VBP roadmap and release a 2022 edition in early Q4.

## Integrated managed care (IMC) progress

In 2014, state legislation directed a transition to integrate the purchasing of medical and behavioral health services for Apple Health (Medicaid) clients through an IMC system no later than January 1, 2020. Below are IMC-related activities for Q2.

- Stabilizing the behavioral health provider network has continued to be a challenge due to the COVID-19 pandemic. However, significant behavioral health workforce gaps are now the bigger concern, and ACHs and MCOs continue to explore and implement strategies to mitigate these issues.
- Since April 2021, HCA has maintained focus in reviewing and monitoring behavioral health performance measures specific to clinical integration and bidirectional care, with the assistance of ACHs and MCOs around the state. In Q2, ongoing monitoring and collaboration continued to track these performance measures and advance improvements across the state.

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

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

The WA-ICA Workgroup and HCA previously introduced methodology to identify practice cohorts and developed an implementation schedule. The workgroup continued to develop a comprehensive set of strategies for outreach and engagement, including launching a dedicated website section on the [HCA site](#). During Q2 of 2022, the WA-ICA Workgroup continued to prepare for the launch of the integration assessment tool with the first cohort of practices, including conducting training webinars and distributing assessment guidance documents to prepare practices for completing the assessment.

Implementation of the WA-ICA will begin in Q3 of 2022 with engagement of an initial cohort of practices. Under the MTP 2.0 renewal, additional practices will use the tool to advance integration with new cohorts expected every six months through July 2024.

The [WA-ICA portal](#) is available on the Healthier Washington Collaboration Portal for providers and care teams. This portal provides access to the tools and contains support materials for orientation to the tool as well as additional resources for advancing integration.

The MTP application for renewal includes a request for funding to continue to support this work to advance bidirectional clinical integration. Funding will be used to support a centralized data management program; administrative costs to continue to support development work during 2023; and the training, coaching, and technical assistance provided to physical health and behavioral health practices.

Given the limited funding proposed in the renewal, there has been considerable discussion this quarter among the WA-ICA workgroup about how to best support practices. Discussion topics include ways to leverage the current work and expertise of MCOs and ACHs, as well as the feasibility of regional strategies to identify coaching/training/technical assistance needs. This work will continue into Q3 2022. The decision has been made to leverage current work and expertise, while still ensuring a standardized approach that includes shared language and tools to be outlined in coaching guidance documents.

The WA-ICA Workgroup continues to support alignment and adoption by other HCA payment and delivery models and initiatives.



## Health information technology (HIT)

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

1. Design
2. Implementation and operations
3. Assessment

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

- Electronic health records (EHRs)
- Mental Health Institutions for Mental Diseases (MH IMD) waiver
- SUD HIT Plan and Prescription Drug Monitoring Program (PDMP) enhancements
- Master Person Index (MPI)
- Provider directory
- Payment models and sources
- Data and governance
- Health information exchange (HIE) functionality
- Registries
- Clinical Data Repository (CDR)
- Tribal engagement

Q2 of 2022 focused on planning for several health IT-related initiatives, including the following:

- Nationally required 988 crisis call line and the related, more expansive state requirements for a Crisis Call Center Hub System and a Behavioral Health Integrated Referral System;
- Electronic Health Record as a Service (EHRaaS); and
- Electronic Consent Management Solution.

## Activities and successes

During Q2 of 2022, the Health IT team engaged in the following activities:

- The HCA Health IT team, in coordination with the Department of Health (DOH), supported implementation planning for the nationally required 988 crisis call system and the more expansive state requirements in E2SHB 1477 for a Crisis Call Center Hub System and the Behavioral Health Integrated Client Referral System. As summarized below, HCA engaged in activities to prepare for the implementation of the 988 crisis call line and develop the Technical and Operational Plan for the enhanced Crisis Call Center platform and Integrated Client Referral System required under E2SHB 1477:
  - HCA continued gathering information from the following sources in Washington State regarding the technology used and needed to respond to people in crisis:
    - Behavioral health crisis providers
    - Behavioral Health – Administrative Service Organizations
    - Regional crisis lines

- National Suicide Prevention Lifeline Services
- HCA identified the technical functional requirements required to meet federal and state law, including identifying the array of standards that would need to be supported by technology tools to enable interoperable information exchange and re-use.
- HCA identified document types that need to be standardized and interoperable to support the crisis call center platform and integrated client referral system, including mental health advance directives, assessments, and safety/crisis plans.
- HCA interviewed and participated in presentations from technology vendors that offer products that provide the functionality required under federal and state law, including:
  - Call center platforms (including telephony and record keeping systems)
  - Bed registries
  - Provider resource directories
  - Electronic health records
  - Closed loop referral tools
  - Care management/care coordination tools
  - Community information exchange (CIE)
- HCA participated in presentations regarding the relationship between and the infrastructure underlying 911 and 988 call lines; and participated in conversation with the State 911 Coordinator regarding work that would be needed to align these systems.
- HCA gave presentations to the Crisis Response Improvement Strategy (CRIS) Steering Committee, the Technical, Cross-System, Confidential Information Compliance and Coordination Subcommittee, and the 988 Tribal Subcommittee.
- HCA gathered information from Tribal partners regarding the technology tools and infrastructure needed to support crisis calls and response on behalf of tribal members.
- HCA continued gathering information from other states regarding their 988 implementation-related activities (e.g., Oregon, Illinois, and Maryland).
- The Washington State Legislature appropriated funds to HCA to consult with the Health and Human Services Enterprise Coalition, community-based organizations, health plans, ACHs, and safety net providers to determine the cost and implementation impacts of a statewide CIE.
- The Health IT team created a request for proposal (RFP) for the design and implementation of an electronic consent management (ECM) solution. The ECM solution will first initially focus on facilitating the exchange of SUD information, subject to 42 CFR Part 2. It is ultimately intended to be a generalized consent solution to address many future use cases.
- The Health and Human Services (HHS) Coalition MPI project continued with development of the MPI integration layer that provides the connection to the Verato MPI solution. Initial testing has begun, and the state's ProviderOne system will be the first system to connect, which is anticipated in the fall of 2022. The Coalition has approved the MPI operational governance model with launch of governance committees scheduled for August. DOH implemented the DOH Link ID Database that facilitates connection of DOH systems and registries.

- HCA continues to work with the Apple and Google stores to publish the MyHealthButton App in the provider directory and patient directory Application Programming Interfaces (APIs). We currently have 136,455 providers listed in our provider directory.
- The state continues to work (i) on the funding for the EHRaaS (EHR as a Service) cloud-based EHR solution; and (ii) with the Washington State Office of the Chief Information Officer (OCIO) and Office of Financial Management (OFM) for licensing and Lead Organization services to implement the EHRaaS solution. In the meantime, HCA partnered with an EHR vendor to make available the EHR Lite. The EHR Lite is a technology tool that provides a limited set of functionalities compared to a certified EHR solution. Pending the availability of funds for the EHRaaS, the EHR Lite Pilot will be expanded to include Designated Crisis Responders (DCRs) and other organizations that would benefit from the use of this tool. HCA is also working with other Washington State Agencies to align the implementation to also meet the needs of other State Agencies that have shown interest in using the HCA EHRaaS instance.
- HCA continued participation and collaboration in the Steering Committee for the Washington Care Coordination Workgroup. The Care Coordination Workgroup, comprised of ACHs, MCOs, HCA, and Collective Medical (a technology vendor), hosted its first webinar of 2022 on Collective Medical 101 – Refresher Training.

## DSRIP program implementation accomplishments

### ACH project milestone achievement

#### Pay-for-reporting (P4R)

ACHs report on their MTP activities, project implementation, and progress on required milestones. This is outlined in the [Project Toolkit](#). P4R reports are submitted every six months. The most recent set of ACH P4R reports were submitted on April 8, 2022. After an independent assessment of performance by MSLC, it was determined that each ACH earned full credit for the report. The final set of ACH P4R reports under DSRIP are due on October 7, 2022.

#### Next steps

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

### Annual VBP milestone achievement by ACHs

ACHs help assess and support provider VBP readiness and practice transformation by connecting providers to training and resources. ACHs continue to use several strategies to support regional providers in the transition to VBP, including communication with providers regarding the opportunity to participate in the WA-ICA program in DY6 and throughout the MTP renewal period. WA-ICA provides a standardized assessment of integrated care to support behavioral health and physical health providers advance along the continuum of integration.

## Financial executor (FE) portal activity

ACHs continue to distribute incentive funds to partnering providers through the FE portal. During the reporting quarter, ACHs distributed more than \$13.7 million to 194 partnering providers and organizations in support of project planning and implementation activities. The state distributed \$92,176.00 in earned incentive funds to IHCPs in Q2 for achievement of IHCP-specific project milestones.

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

HCA will continue to monitor the FE portal to track distribution timing, categorization, and provider types receiving funding.

## DSRIP measurement activities

In May 2022, HCA announced that [ACHs earned full incentives](#) for their efforts in the semi-annual report for reporting period July–December 2021. [HCA's website](#) contains the work plan, report, and provider roster that each ACH submitted as part of this semi-annual reporting period.

In May 2022, HCA and the IA announced that ACHs earned incentives for their performance outcomes for DY4 in the following categories:

- Pay for performance
- Value-based purchasing
- High-performance pool

### Pay-for-performance (P4P)

DY4 was an unprecedented year due to COVID-19, which had significant impacts on DSRIP implementation and performance. Due to these impacts, CMS granted DY4 flexibility in P4P achievement value (AV) calculations. ACHs were able to use the best value from three performance components: 2020 regional performance, 2019 regional performance, or 2019 statewide performance. DY4 flexibility aided with mitigating COVID-19 performance variability.

### Value-based purchasing (P4P)

DY4 results show two out of nine ACHs earning 100 percent their VBP potential while eight ACHs improved over the prior year baseline.

### High-performance pool (HPP)

The HPP is derived from the unearned incentives from the VBP and P4P performance buckets. ACHs are assessed on 10 quality metrics that results in a competitive pool weighted by the 2017 Medicaid population counts by region. ACHs earned on average 35 percent of their potential DY4 incentives from the HPP.

## Statewide results

DY4 statewide results were submitted in the first quarter QPR in 2022. HCA anticipates having DY5 statewide results submitted to CMS by the end of 2022 or early 2023.

## DSRIP program stakeholder engagement activities

Below are some activities during this reporting period.

- HCA decided to discontinue the weekly COVID-19 email for ACHs. Although the public health emergency continues, much of the information included in the weekly email no longer pertained to COVID-19. However, the state continues to communicate with ACHs through various channels,

including sending emails, notifications, and announcements that may be of interest (and would have been included in the weekly email).

- As part of the formal public comment process for the MTP waiver renewal, ACHs helped gather feedback from their communities about the renewal. Many ACHs shared information and resources with their regions, and relayed feedback to the state.

## **DSRIP stakeholder concerns**

Q2 of 2022 included continued stakeholder engagement, in partnership with ACHs, to support public comment and finalizing the MTP renewal application ahead of submission to CMS. Stakeholders support the MTP renewal, but there is some concern regarding the transition of the DSRIP program and the funding that will no longer be available to support DSRIP activities specifically. HCA and ACHs continue to work with partners on the transition, including sustaining improvements and investments made through DSRIP funding. The state will summarize feedback, including concerns, received during the stakeholder engagement and public comment process. The process and comments will be documented in Appendix H of the MTP renewal application.

## **Upcoming DSRIP activities**

- HCA is chartering a task force to focus on the MTP renewal's TAHC program. The task force will include representatives from ACHs and MCOs and is anticipated to begin in Q3 of 2022.
- DY5 P4P data is now being compiled by HCA and DSHS data analytics teams. Performance workbooks are in development to be sent to the IA for DY5 AV computations beginning in Q3 of 2022. Payment for DY5 P4P is scheduled to go out in Q2 of 2023.

## **Tribal project implementation activities**

- Hosted two Roundtables and Consultation on the MTP renewal application.
- The state distributed \$92,176.00 in earned incentive funds to IHCPs in Q2 for achievement of IHCP-specific project milestones.

## **Tribal partner engagement timeline**

April 1: Met internally regarding workforce development, specifically on developing a State Plan Amendment (SPA) for reimbursement of Community Health Aides and Behavioral Health Aides (CHAs/BHAs)

April 4: met internally regarding Medicaid Transformation Project (MTP) renewal application

April 5: participated in discussion with CMS regarding MTP concept paper

April 5: participated in internal meeting reviewing in-lieu of services (ILOS)

April 5: met internally regarding CHA/BHA SPA

April 6: met internally to discuss MTP renewal budget

April 13: participated in the Tribal Partners Collaborative, hosted by Better Health Together

April 15: hosted external meetings regarding CHA/BHA SPA

April 18: participated in internal meeting on strategies to increase awareness and participation of Tribes and IHCPs in FCS

April 20: presented to HealthierHere's Indigenous Nations Committee of the MTP renewal

April 25: participated in the Northwest Washington Indian Health Board (NWWIHB) and North Sound Accountable Community of Health Tribal Alignment meeting

April 28: met internally to discuss MTP renewal budget

May 11: participated in the Tribal Partners Collaborative, hosted by Better Health Together

May 16: met internally regarding MTP renewal application

May 25: hosted first Roundtable regarding the MTP renewal application

May 26: participated in the public forum for the MTP renewal application

May 31: participated in the public forum for the MTP renewal application

June 2: met internally regarding a community information exchange (CIE)

June 7: participated in the public forum for the MTP renewal application

June 15: hosted second Roundtable regarding the MTP renewal application

June 29: hosted Consultation regarding the MTP renewal application

## LTSS implementation accomplishments

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

- As of June 30, 2022, more than 13,300 clients, in addition to their family caregivers, have received services and supports through the MAC and TSOA programs. The average caseload for the quarter is 4,636 clients.
- The service benefit package and eligibility criteria modifications request in the upcoming waiver renewal application were finalized.
- AL TSA facilitated two stakeholder meetings and participated in several HCA-facilitated stakeholder meetings to share details about the upcoming MTP waiver renewal application and process.

### Network adequacy for MAC and TSOA

Area Agencies on Aging (AAAs) across the state continue to face challenges with obtaining home care agency workers to meet clients' demand for in-home personal care and respite care services. AAAs are utilizing other waiver and community services to assist clients with their needs. AAAs continue to work on obtaining new contracts with a variety of providers including home care agencies not already contracted with them.

### Assessment and systems update

During the previous quarter, some technical issues were discovered with the Budget Management Tool, a system calculator designed to assist case workers tracking clients' monthly budget. These issues were fixed this quarter. AAA field staff tested the tool, and it will be released in July 2022.

Throughout this quarter, AL TSA worked with the contracted vendor for the case management system (GetCare) and the evidenced-based caregiver assessment vendor (TCARE, Inc.) to prepare for the implementation of the recently revised caregiver assessment (TCARE 5.0) used for MAC and TSOA dyads.

## Staff training

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

- April 20, 2022: MTD GetCare User Manual Overview and Q&A session
- May 18, 2022: Those Rascally RACs and Other Errors (CARE, P1, ACES)
- June 15, 2022: Rascally RAC/Error Office Hours (Q&A Session)

Q3 webinars:

- July 20, 2022: TCARE 5.0 (Caregiver Assessment) and Budget Management Tool training
- August 17, 2022: TCARE 5.0 Office Hours (Q&A Session)
- September 21, 2022: What's Gained, What's Lost (helping applicants/clients decide what program is the best fit for them)
- October 19, 2022: Estate Recovery Overview

## Data and reporting

**Table 1: beneficiary enrollment by program**

	MAC dyads	TSOA dyads	TSOA individuals
<b>LTSS beneficiaries by program as of June 30, 2022</b>	227	1409	3432
<b>Number of new enrollees in quarter by program</b>	26	204	382
<b>Number of new person-centered service plans in quarter by program</b>	14*	73**	160***
<b>Number of beneficiaries self-directing services under employer authority</b>	0	0	0

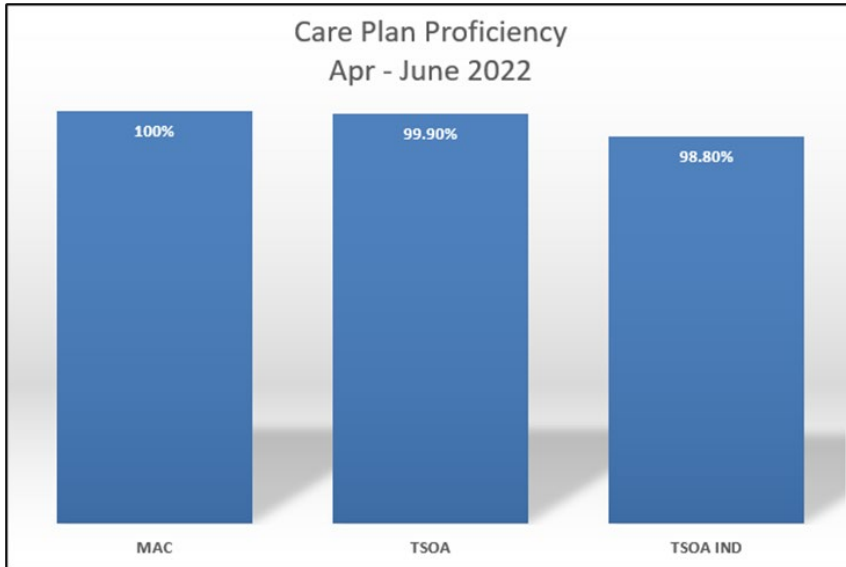
\* 12 of the new enrollees do not require a care plan because they are still in the care planning phase and services have yet to be authorized.

\*\* 130 of the new enrollees do not require a care plan because they are still in the care planning phase and services have yet to be authorized.

\*\*\*220 of the new enrollees do not require a care plan because they are still in the care planning phase and services have yet to be authorized.

The state will begin using individual providers after the Consumer Directed Employer is fully implemented for the 1915c and 1915k programs.

**Figure 1: care plan proficiency**



The state is proud to report the AAAs continued proficiency in timely completion of care plans for new enrollees.

## Tribal engagement

DSHS AL TSA met with several tribes this quarter to discuss Medicaid services and Initiative 2 and 3 of the MTP.

- April: AL TSA, along with Economic Services Administration, Department of Vocational Rehabilitation and Division of Child Support, shared MAC, TSOA, and LTSS brochures and information
- May: AL TSA Tribal Affairs shared LTSS brochures and LTC/MAC/TSOA application packets with the Port Gamble S'Klallam.
- June:
  - AL TSA program managers were invited to Indian Policy Advisory Committee to present on MAC and TSOA. Information and discussion engaged with tribal leaders, tribal representatives, and partners.
  - Recognizing a need to broaden marketing and outreach materials that are culturally appropriate, AL TSA negotiated a contract to increase materials for use in multiple programs, including respite, kinship care and MAC/TSOA. Marketing materials are now being completed by copywriters.

Several Tribal roundtables were held this quarter to discuss the 1115 waiver renewal application:

- May 25, 2022 Round Table #1 – Tribal Compliance and Operations Workgroup (TCOW)
- June 9, 2022 Round Table #2 – Governors Indian Health Advisory Council (GIHAC)
- June 15, 2022 Round Table #3 – Waiver Review which occurred during the Tribal Centric Behavioral Health Advisory Board (TCBHAB)

The state continues to be under a declared state of emergency. It has impacted all aspects of state, local, and tribal government operations.



## Outreach and engagement

Two outreach projects led by HCS program management include the creation of placemats and a tribal video. The placemats provide information about family caregiver programs and are intended to be used at congregate meal sites and other venues such as hospital cafeterias, senior housing dining, etc.

The placemats were finalized and made available for AAAs to order and use in their communities. Another Tribal video is being produced. Tribal communities have been asked if there are any caregiver/care receiver pairs who may be interested in being interviewed. These interviews are expected to begin in August 2022.

**Table 2: outreach and engagement activities by AAA**

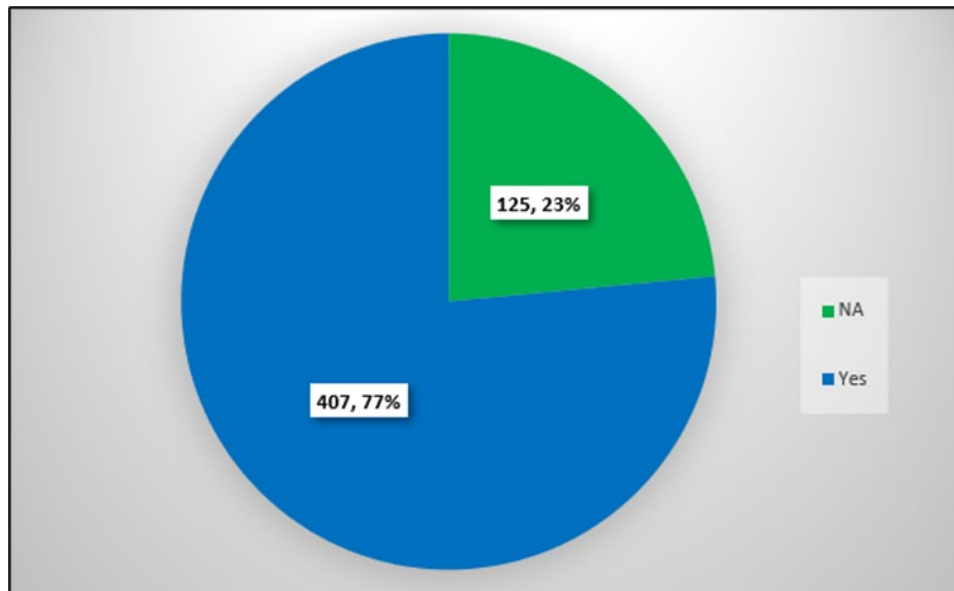
	April	May	June
	Number of events held		
Community presentations and information sharing	44	74	37

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

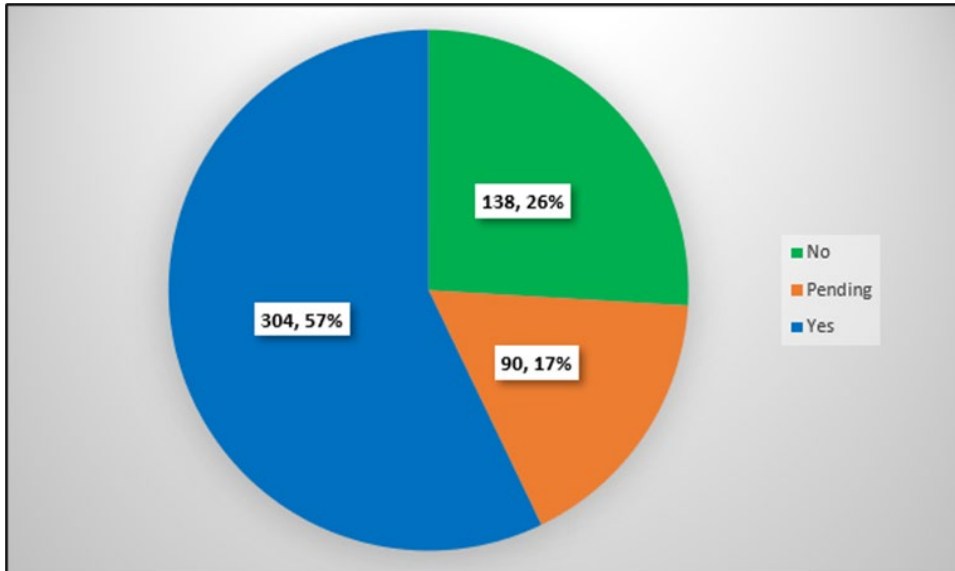
## Quality assurance

Below are results of the quarterly presumptive eligibility (PE) quality assurance review.

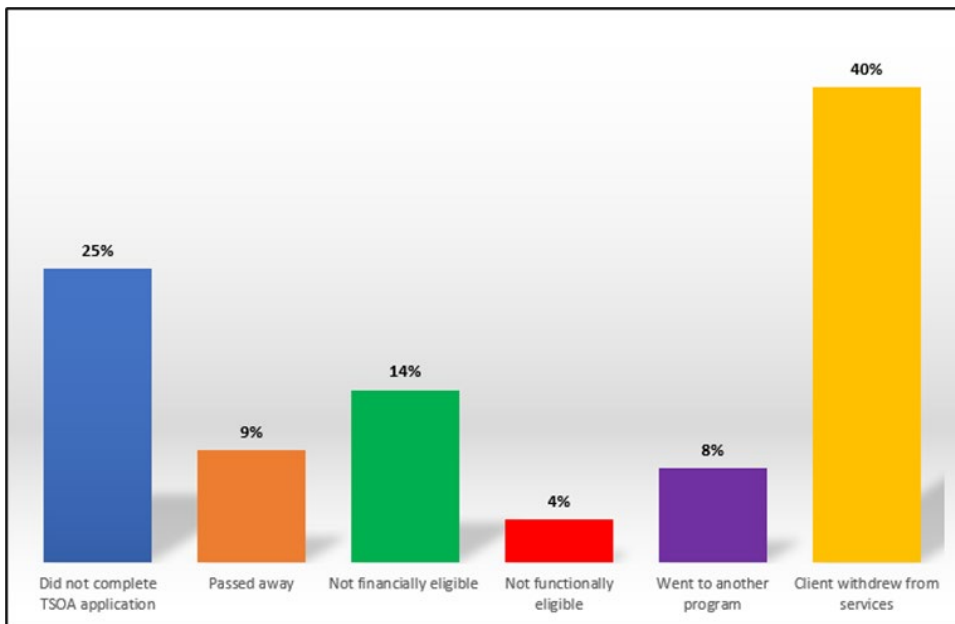
**Figure 2: Question 1: was the client appropriately determined to be nursing facility level of care eligible for PE?**



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



**Figure 4: Question 2b: if “No” to question #2a, why?**



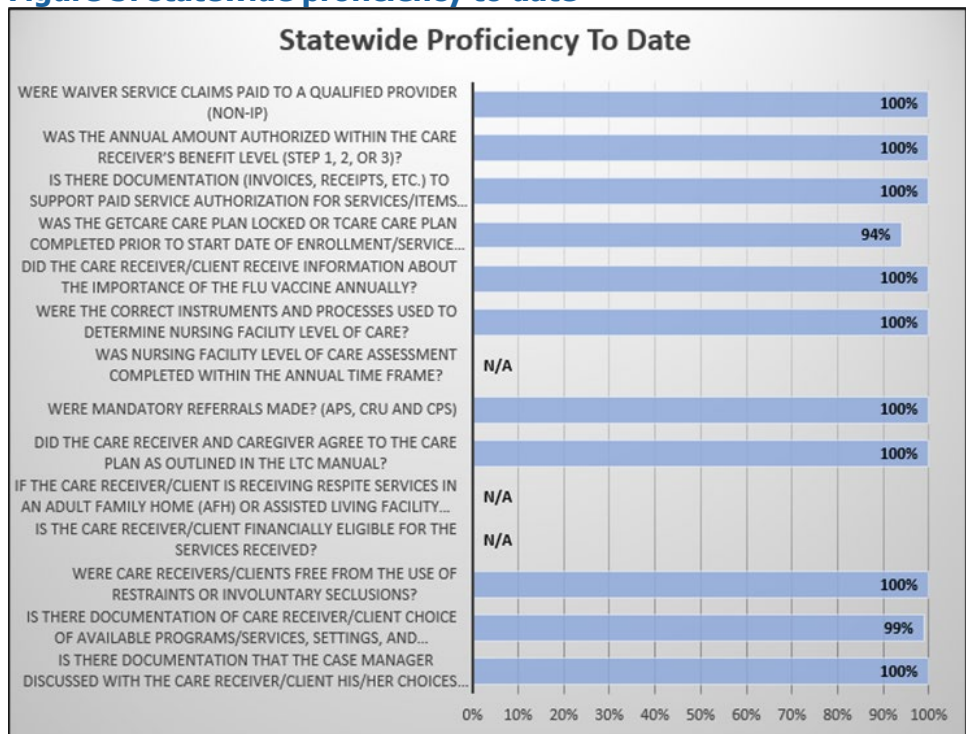
Note: These percentages represent the “No” population in the previous table (26 percent). For example, the 14 percent of PE clients found to be not financially eligible are 14 percent of the 26 percent illustrated in the Table for Question 2a.

## 2022 quality assurance results to date

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

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

**Figure 5: statewide proficiency to date**



## State rulemaking

AL TSA continued the rule making process this quarter to modify Washington Administrative Code (WAC) related to the upcoming release of TCARE 5.0, the evidence-based caregiver assessment tool used for MAC and TSOA dyads. Notice of rulemaking was posted in the Washington State Register (WSR 22-15-025). The public review and comment period ends on August 23, 2022, after the public hearing.

## Upcoming activities

- Begin rulemaking process for prospective program changes related to the 1115 renewal application to be submitted to CMS in July 2022.
- Release of the newly revised caregiver assessment tool, TCARE 5.0 in Q3 2022.
- Continue design and development of interfaces between GetCare, the MTD case management system and the system used by CDWA, the consumer directed employer for individual providers.
- Begin policy and procedure discussions with the thirteen AAAs regarding potential changes to MAC and TSOA programs as part of the renewal process.

## LTSS stakeholder concerns

No general stakeholder concerns were noted this quarter. AL TSA and HCA did receive feedback this quarter related to the 1115 waiver renewal public comment process. Overall, the information received was positive and supportive of the new and continuing programs that assist Washington’s aging population and their families.

# FCS implementation accomplishments

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

- Total aggregate number of people enrolled in FCS services at the end of DY6 Q2:
  - CSS: 7,482
  - IPS: 4,808
- There were 171 providers under contract with Amerigroup at the end of DY6 Q2, representing 465 sites throughout the state.

**Note:** CSS and IPS enrollment totals include 1,994 participants enrolled in both programs. The total unduplicated number of enrollments at the end of this reporting period was 10,296.

## Network adequacy for FCS

**Table 3: FCS provider network development**

FCS service type	April		May		June	
	Contracts	Service locations	Contracts	Service locations	Contracts	Service locations
<b>Supported Employment – Individual Placement Support (IPS)</b>	37	76	36	75	36	75
<b>Community Support Services (CSS)</b>	19	45	19	45	19	45
<b>CSS and IPS</b>	116	345	116	345	116	345
<b>Total</b>	<b>172</b>	<b>466</b>	<b>171</b>	<b>465</b>	<b>171</b>	<b>465</b>

- The FCS provider network remained largely the same during Q2 but anticipates growth during Q3 upon the completion of the first Medicaid Academy (a program developed in partnership with Corporation for Supportive Housing) that will bring new providers to the network.

## Client enrollment

**Table 4: FCS client enrollment**

	April	May	June
<b>Supported Employment – Individual Placement and Support (IPS)</b>	2,652	2,675	2,814
<b>Community Support Services (CSS)</b>	5,060	5,204	5,488
<b>CSS and IPS</b>	1,913	1,903	1,994
<b>Total aggregate enrollment</b>	<b>9,625</b>	<b>9,782</b>	<b>10,296</b>

Data source: RDA administrative reports

**Table 5: FCS client risk profile**

		Met HUD homeless criteria	Avg. PRISM risk score	Serious mental illness
<b>April</b>	IPS	582 (13%)	.95	3,169 (69%)
	CSS	1,505 (22%)	1.26	4,511 (65%)
<b>May</b>	IPS	582 (13%)	.95	3,158 (69%)
	CSS	1,542 (22%)	1.27	4,556 (64%)
<b>June</b>	IPS	592 (12%)	.88	2,575 (54%)
	CSS	1,647 (22%)	1.12	3,655 (49%)

HUD = Housing and Urban Development

**PRISM** = Predictive Risk Intelligence System (Risk ≥ 1.5 identifies top 10 percent of high-cost Medicaid adults; Risk ≥ 1.0 identifies top 19 percent of high-cost Medicaid adults)

**Table 6: FCS client risk profile, continued**

		Medicaid only enrollees*	MH treatment need	SUD treatment need	Co-occurring MH + SUD treatment needs flags
<b>April</b>	IPS	3,838	3,551 (93%)	2,328 (61%)	2,218 (58%)
	CSS	5,778	5,278 (91%)	4,256 (74%)	3,981 (69%)
<b>May</b>	IPS	3,833	3,532 (92%)	2,284 (60%)	2,174 (57%)
	CSS	5,871	5,342 (91%)	4,276 (73%)	3,994 (68%)
<b>June</b>	IPS	4,012	3,672 (92%)	2,372 (59%)	2,250 (56%)
	CSS	6,188	5,588 (90%)	4,472 (72%)	4,158 (67%)

Data source: RDA administrative reports

\*Does not include individuals who are dual-enrolled.

**Table 7: FCS client service utilization**

		Medicaid only enrollees*	Long-term Services and Supports	Mental health services	SUD services (received in last 12 months)	Care + MH or SUD services
<b>April</b>	IPS	3,838	386 (10%)	2,807 (73%)	1,454 (38%)	324 (8%)
	CSS	5,778	635 (11%)	3,834 (66%)	2,582 (45%)	521 (9%)
<b>May</b>	IPS	3,833	410 (11%)	2,760 (72%)	1,409 (37%)	342 (9%)
	CSS	5,871	641 (11%)	3,802 (65%)	2,536 (43%)	519 (9%)
<b>June</b>	IPS	4,012	442 (11%)	2,826 (70%)	1,446 (36%)	364 (9%)
	CSS	6,188	668 (11%)	3,869 (63%)	2,618 (42%)	529 (9%)

(Aging CARE assessment in last 15 months)

Data source: RDA administrative reports

\*Does not include individuals who are dual-enrolled.

**Table 8: FCS client Medicaid eligibility**

		CN blind/disabled (Medicaid only & full dual eligible)	CN aged (Medicaid only & full dual eligible)	CN family & pregnant woman	ACA expansion adults (nonadults presumptive)	Adults (nonadults presumptive) ACA expansion adults (SSI presumptive)	CN & CHIP children
<b>April</b>	IPS	1,344 (29%)	93 (2%)	479 (10%)	2,041 (45%)	479 (10%)	129 (3%)
	CSS	2,282 (33%)	350 (5%)	820 (12%)	2,401 (34%)	1,041 (15%)	79 (1%)
<b>May</b>	IPS	1,366 (30%)	101 (2%)	492 (11%)	1,991 (43%)	489 (11%)	139 (3%)
	CSS	2,319 (33%)	356 (5%)	865 (12%)	2,390 (34%)	1,101 (15%)	76 (1%)
<b>June</b>	IPS	1,461 (30%)	109 (2%)	514 (11%)	2,066 (43%)	518 (11%)	140 (3%)
	CSS	2,427 (32%)	381 (5%)	923 (12%)	2,504 (33%)	1,166 (16%)	81 (1%)

ACA = Affordable Care Act

CHIP = Children's Health Insurance Program

CN = categorically needy

Data source: RDA administrative reports

## Quality assurance and monitoring activity

FCS staff continued to work with the TPA to monitor the implementation of FCS during Q2. No major concerns or issues were identified, and the TPA reported no grievances or appeals during the quarter. The cumulative enrollment increased month-over-month in each program, after seeing slight decreases at the end of DY5.

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

FCS training staff completed eight fidelity reviews of contracted FCS providers, five for IPS service providers, and three for CSS service providers. These reviews were completed virtually or hybrid over two or more days with a review team of HCA staff and FCS providers. The FCS training staff are also bringing on fidelity reviewers from other state agencies such as the Division of Vocational Rehabilitation to facilitate more cross-system collaboration.

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

## Other FCS program activity

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

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

FCS staff attended and presented at the annual Housing First Partners Conference in Seattle, the International IPS Learning Community Annual Meeting in Detroit, and the virtual Washington Behavioral Healthcare Conference in Q2.

The FCS Transition Assistance Program (TAP) launched May 2 to provide state-funded support to CSS enrollees with behavioral health treatment needs who are making housing transitions. The FCS TAP fund is administered by the TPA, and enrollees may access funds for up to one year during their enrollment in FCS services. FCS CSS providers draw upon the fund to assist CSS enrollees to take steps to achieve their individualized housing goals. As of June 30, 2022, 86 unique CSS enrollees have benefited from this new funding, and FCS staff are excited by the potential impact of this funding.

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

The first of two six-week Medicaid Academies was offered to potential and current FCS providers in Q2 and will be offered again in Q4. These Academies are targeted to executive leads, fiscal/finance leads, programmatic leads, and quality improvement leads within their agencies. Information presented will

primarily benefit agencies that are not yet set up as Medicaid billers and agencies that have experienced issues when billing to Medicaid.

## Upcoming activities

- The FCS program staff is growing thanks to significant investment by the state legislature during the 2022 legislative session. This includes one FTE (state-funded) to help support the development and implementation of new projects and initiatives, with a specific focus on quality improvement and project management. HCA anticipates the hiring of this position mid Q3.
- FCS staff continue to meet weekly with the Department of Commerce on the planning and development of two programs:
  - Apple Health and Homes, a partnership between the Department of Commerce, DSHS, and the HCA focused on creating permanent supportive housing units for CSS-eligible individuals.
  - The expansion of the Housing and Essential Needs (HEN) program to create a bridge period of up to nine months of additional rental support for IPS-enrolled individuals. Roughly 30 percent of IPS enrollees have a referral for and receive assistance from the HEN program.
- FCS staff will present at several conferences in the Q3, including the Washington State Conference on Ending Homelessness and the Peer Pathways conference.

## FCS program stakeholder engagement activities

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

**Table 9: FCS program stakeholder engagement activities**

	April	May	June
	Number of events held		
<b>Training and assistance provided to individual organizations</b>	68	32	51
<b>Community and regional presentations and training events</b>	10	6	7
<b>Informational webinars</b>	13	16	8
<b>Stakeholder engagement meetings</b>	16	22	25
<b>Total activities</b>	<b>107</b>	<b>76</b>	<b>91</b>

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

Q2 topics included:

- Combating compassion fatigue and burnout
- Maximizing your investment in supervision
- Motivational tools to achieve wellness in supportive housing
- Using social media to find employment

- Best practices in job coaching
- Housing types: providing the full menu of options
- FCS TAP info sessions
- Racial trauma-informed services
- Skills to strengthen executive functioning
- Golden thread of documentation series
- Housing skills assessment and training for supportive housing tenants
- Permanent supportive housing fidelity: flexible, voluntary services
- Think people who are homeless can't work? Surprising reasons why that is not the case

### **FCS stakeholder concerns**

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

## **SUD IMD waiver implementation accomplishments**

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

This section summarizes SUD IMD waiver development and implementation activities from April 1 through June 30, 2022.

- The second-year funding from the Washington State Project to Prevent Prescription Drug/Opioid Overdose (WA-PDO) was released. WA-PDO reaches adults who use opioids, lay person and community members who may be the first responders at an opioid overdose event. Core interventions include stakeholder engagement, opioid overdose prevention and response training, and naloxone distribution.

### **Implementation plan**

In accordance with the amended STCs, the state is required to submit an implementation plan for the SUD IMD waiver, incorporating six key milestones outlined by CMS. At present all milestones of the SUD amendment are in alignment with CMS expectations.

### **SUD HIT plan requirements**

During Q2 2022:

- HCA continued to coordinate internally and with DOH to support implementation planning for the nationally required 988 crisis- call system and enhanced Crisis Call Center Hub System and Behavioral Health Integrated Client Referral System required under state law (E2SBH 1477). The



Crisis Call Center Hub System and Behavioral Health Integrated Client Referral System includes a focus on persons with SUD and MH needs. The technology systems and tools that are being considered include tools to support crisis call response and dispatch, and behavioral health referral and follow-up.

- The Health IT Team developed an RFP for the design and implementation of an electronic consent management (ECM) solution. The first use case that this solution will focus on is the exchange of SUD information subject to 42 CFR Part 2.

## Evaluation design

- No updates to report.

## Monitoring protocol

- No changes to report.

## Upcoming activities

- Awaiting additional input from Edward Michael.

# MH IMD waiver implementation accomplishments

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

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

- Work continued on integrating Health Information Technology, see below.

## Implementation plan

- No updates to report this quarter.

## MH HIT plan requirements

During Q2 2022:

- The state legislature appropriated approximately \$1.5 million in state general funds solely for the use of health IT and evaluations to support MTP as it relates to IMDs.
- HCA started planning for use of the funds appropriated by the state legislature for the health IT tasks in support of the MH IMD waiver. One topic that emerged from work sessions related to the enhanced Crisis Call System and Integrated Client Referral System is standardization and interoperability of mental health advance directives. HCA started identifying standards that could be used to support the interoperable exchange and re-use of mental health advance directives. As planning for this (and other) projects proceed, the state may submit to CMS an amended 2022 Health IT Operational Plan to identify the tasks more clearly for which funds will be used.
- HCA staff started discussions regarding MCO contract language that could require inpatient psychiatric hospitals and units that have interoperable HIT to create and send admission, discharge, and transfer summaries using HIT standards on behalf of persons admitted/transferred to or discharged from these institutions.

## Evaluation design

- Work continued on finalizing the evaluation design.

## Monitoring protocol

- The state received approval for its monitoring protocol in April.

## Upcoming activities

- HCA continues work to expand non-IMD residential treatment facilities and will be hosting open houses and online forums to respond to public concerns as the process continues.

## Quarterly expenditures

The following table reflects quarterly expenditures for DSRIP, LTSS, and FCS during DY6 (2022). MCOs earned \$8,000,000 and ACHs earned \$2,022,044 for VBP incentives.

**Table 10: DSRIP expenditures**

	Q1	Q2	Q3	Q4	DY6 Total	Funding source
	January 1– March 31	April 1– June 30	July 1– September 30	October 1– December 31	January 1– December 31	Federal financial participation
<b>Better Health Together</b>	\$0	\$9,103,699				\$4,551,850
<b>Cascade Pacific Action Alliance</b>	\$0	\$9,462,549				\$4,731,275
<b>Elevate Health</b>	\$0	\$12,361,357				\$6,180,679
<b>Greater Columbia</b>	\$0	\$11,373,483				\$5,686,742
<b>HealthierHere</b>	\$0	\$19,146,935				\$9,573,468
<b>North Central</b>	\$0	\$5,344,126				\$2,672,063
<b>North Sound</b>	\$0	\$12,980,082				\$6,490,041
<b>Olympic Community of Health</b>	\$0	\$4,219,193				\$2,109,597
<b>SWACH</b>	\$0	\$5,803,354				\$2,901,677
<b>Indian Health Care Providers</b>	\$0	\$939,500				\$479,750

**Table 11: MCO-VBP expenditures**

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

**Table 12: LTSS and FCS service expenditures**

	Q1	Q2	Q3	Q4	DY6 Total
	January 1– March 31	April 1– June 30	July 1– September 30	October 1– December 31	January 1– December 31
<b>Tailored Supports for Older Adults (TSOA)</b>	\$1,759,393	\$7,049,254			\$8,808,647
<b>Medicaid Alternative Care (MAC)</b>	\$50,791	\$201,047			\$251,838
<b>MAC and TSOA not eligible</b>	\$0	\$281			\$281
<b>FCS</b>	\$3,047,246	\$6,125,131			\$9,172,377

## Financial and budget neutrality development issues

### Financial

Below are the counts of member months eligible to receive services under MTP. Member months for non-expansion adults are updated retrospectively, based on the current caseload forecast council (CFC) medical caseload data. Actual caseload data for non-expansion adults is available through February 2022. March 2022 through June 2022 member months for non-expansion adults are forecasted caseload figures from CFC.

**Table 13: member months eligible to receive services**

Calendar month	Non-expansion adults only	SUD Medicaid disabled	SUD Medicaid non-disabled	SUD newly eligible	SUD AI/AN	SMI Medicaid Disabled IMD	SMI Medicaid non-disabled IMD	SMI Newly eligible IMD	SMI AI/AN
Jan-17	376,306								
Feb-17	375,203								
Mar-17	374,732								
Apr-17	373,586								
May-17	373,130								
Jun-17	373,035								
Jul-17	372,123								
Aug-17	371,857								
Sep-17	370,592								
Oct-17	370,397								
Nov-17	370,226								
Dec-17	370,254								
Jan-18	370,293								
Feb-18	368,920								
Mar-18	368,729								
Apr-18	367,469								
May-18	367,834								
Jun-18	367,114								
Jul-18	366,857	5	19	91	10				
Aug-18	366,259	8	17	95	44				

<b>Sept-18</b>	365,263	4	19	80	44				
<b>Oct-18</b>	365,261	4	22	93	47				
<b>Nov-18</b>	364,796	3	27	93	34				
<b>Dec-18</b>	364,248	4	17	96	23				
<b>Jan-19</b>	364,172	34	133	411	37				
<b>Feb-19</b>	362,492	31	115	391	40				
<b>Mar-19</b>	362,146	42	144	398	45				
<b>Apr-19</b>	361,676	56	136	473	38				
<b>May-19</b>	361,161	43	125	483	49				
<b>June-19</b>	360,398	65	150	573	54				
<b>Jul-19</b>	360,807	65	197	676	55				
<b>Aug-19</b>	360,346	66	243	744	49				
<b>Sep-19</b>	359,870	75	214	779	44				
<b>Oct-19</b>	359,325	73	237	884	36				
<b>Nov-19</b>	358,421	81	190	812	44				
<b>Dec-19</b>	358,717	58	213	940	51				
<b>Jan-20</b>	359,131	32	129	531	44				
<b>Feb-20</b>	359,037	24	125	478	44				
<b>Mac-20</b>	360,711	33	133	484	45				
<b>Apr-20</b>	364,165	42	109	383	21				
<b>May-20</b>	366,570	25	97	376	29				
<b>Jun-20</b>	369,316	46	157	553	46				
<b>Jul-20</b>	371,996	25	84	335	32				
<b>Aug-20</b>	374,838	51	218	711	38				
<b>Sep-20</b>	377,059	65	208	680	46				
<b>Oct-20</b>	379,079	26	93	373	42				
<b>Nov-20</b>	379,992	28	87	378	25				
<b>Dec-20</b>	381,478	40	100	444	24	0	0	8	2
<b>Jan-21</b>	382,631	16	59	222	31	1	1	188	11
<b>Feb-21</b>	382,670	25	89	297	18	0	0	206	11
<b>Mar-21</b>	383,991	21	85	317	25	1	0	230	13
<b>Apr-21</b>	385,307	25	96	368	14	0	2	190	18
<b>May-21</b>	386,488	31	85	313	26	1	2	201	17
<b>Jun-21</b>	387,544	17	32	157	20	0	3	204	18
<b>Jul-21</b>	389,140	25	102	367	19	271	178	602	19
<b>Aug-21</b>	391,186	19	90	320	20	249	175	562	19
<b>Sep-21</b>	392,634	16	85	322	15	239	177	602	17
<b>Oct-21</b>	393,961	16	81	270	11	255	198	616	18
<b>Nov-21</b>	395,830	14	77	294	14	247	223	605	13
<b>Dec-21</b>	396,419	6	44	214	13	237	220	618	3
<b>Jan-22</b>	397,966	1	12	64	5	237	232	615	0
<b>Feb-22</b>	399,238	15	94	352	6	218	247	592	0
<b>Mar-22</b>	400,224	18	112	394	3	232	227	658	0
<b>April-22</b>	402,053	20	99	329	0	186	146	391	0
<b>May-22</b>	403,123								
<b>Jun-22</b>	405,203								
<b>Total</b>	24,722,996	1,439	5,000	18,438	1,420	2,374	2,031	7,088	179

## Budget neutrality

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

## Designated state health programs (DSHP)

- Myers and Stauffer has completed the independent audit to validate the accuracy of DSHP claims for CY2020. Attached is a [final report](#) issued by Myers & Stauffer.
- HCA has continued to contract with Myers & Stauffer to perform an independent audit based on agreed-upon procedures to validate the accuracy of DSHP claims reported on the CMS-64 for CY2021. Expected completion of the review is June 30, 2023.

# Overall MTP development and issues

## Operational/policy issues

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

## Consumer issues

The state has not experienced any major consumer issues for DSRIP, FCS, LTSS, or the SUD and MH IMD waivers during this reporting period, other than general inquiries about benefits available through MTP. Significant public comment was received during the MTP renewal public comment period, including input from consumers. Feedback will be summarized within Appendix H of the MTP renewal application.

## MTP evaluation

The MTP Independent External Evaluator's (IEE) quarterly rapid cycle report was delivered on June 6, 2022, in compliance with the contracted deliverable timeline. This report covers April 1, 2022 through June 30, 2022. It presents findings regarding Washington State's Medicaid system performance through March 2021, including key performance indicators in ten measurement domains as well as an examination of equity and disparities among specific populations within measurement domains.

### Quantitative analysis of Medicaid data:

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

### Qualitative analysis:

- The qualitative team continued to analyze previously collected qualitative data; these ongoing analyses will be documented in the final evaluation report.
- The qualitative team completed Round 4 ACH Key Informant Interviews (final round) with the executive director, CEO, or other leader from each ACH. During interviews, ACH leaders were asked to reflect on their prior work and share their plans for sustainability.
- The qualitative team completed data management activities (e.g., transcription and developing a qualitative database for Round 4 interviews) and began analyzing these data which will be documented in the final evaluation report.
- The survey team administered the survey to all hospitals and practices that responded to the survey in 2019. We emailed the survey on February 22, 2022 with six weekly or bi-monthly follow up reminders to complete the survey as needed. The response rates were 37.9 percent for hospitals (33 of 87 total) and 45.5 percent of practices (41 of 90 that completed the survey in 2019).

## Key findings (extracted from the IEE's fourteenth rapid cycle report):

- The performance measures in this report include data from the first full year of the COVID-19 pandemic in the state. Rates of care received in Emergency Departments dropped by 15.5 percent and care in acute hospital settings dropped by 10.7 percent. The state also observed declining rates of preventive screenings, oral health care, and access to primary care for adults. These decreases likely represent combined challenges to access as well as behavioral changes in seeking care during this period.
- In contrast, some measures of health care access and quality improved during this measurement period. Access to substance use disorder treatment improved along with types of care that can be delivered virtually, such as medication management for mental health and chronic conditions.
- Finally, the state continues to see some notable inequities in health care access and quality among the subpopulations examined in this report. American Indian/Alaska Native members experienced markedly worse access to well-child visits, cancer screenings, and care related to chronic conditions. Black members were less likely to receive follow-up care after an emergency department visit for alcohol or other drug use, less likely to receive appropriate treatment for an opioid use disorder, and more likely to be prescribed opioids compared with other groups. Members with an SMI were more likely to be arrested and to experience homelessness.

## Summary of changes in Medicaid system performance through December 2020

### **Better**

- Visits to the Emergency Department and acute hospital care continued a sharp downward trajectory first observed at the onset of the COVID-19 pandemic. While these shifts are in the desired direction, the timing suggests these decreases in utilization likely reflect pandemic-related behavioral changes in the population or barriers to care. Rates of care obtained in these settings varied widely among members of different racial and ethnic groups. However, individuals with an SMI received care in the emergency department at a rate three times higher than the statewide average.
- Rates of concurrent prescriptions of opioids and sedatives showed an encouraging, albeit subtle, downward trend over the last quarter, while other measures for OUD treatment remained relatively flat.

### **Mixed**

- A negative trajectory for primary and preventive care appeared to have leveled off for children ages 3 to 21 from the previous measurement period, though, these measures were still down 9.4 percent compared to the previous year.
- Access to oral health care for periodontal exams also improved this quarter but remained 12 percent lower on average than the previous year. Other measures within this domain continued a downward trend.
- Changes in outcomes related to social determinants of health were small during this period, with employment continuing a downward trend, while rates of arrest improved slightly. Members with an SMI continued to experience markedly worse outcomes for all measures in this domain.
- The state continued to see mixed outcomes related to mental health care and care for people with chronic conditions. In both these domains, measures related to medication management improved, while access to in-person care declined.

- Most measures of access to SUD care improved during this period, though SUD treatment penetration continued to decline slightly.

### **Worse**

- Most outcomes related to prevention and wellness worsened during this period. Screening rates for breast, cervical and colorectal cancer as well as screening for chlamydia continued to decline. Colorectal cancer screening for American Indian/Alaska Native populations dropped from 35 percent to 29.8 percent over the last quarter.

### **Upcoming IEE activities:**

- The survey team will provide descriptive information to the qualitative team to help select interviewees and complete analysis of the survey responses. The qualitative team will review those results and develop a sampling plan to maximize coverage of key variables. The team will then develop tailored interview guides for each participant.
- The qualitative team will continue to analyze the Round 4 ACH interviews and will meet regularly to discuss emerging findings.
- The qualitative team completed key informant interviews with representatives from AL TSA, HCA, Amerigroup, and provider organizations in early 2022. Using an inductive analytic approach, they are continuing to analyze FCS related data and refine findings that will be shared in the September Rapid Cycle Report.

## **Summary of additional resources, enclosures, and attachments**

### **Additional resources**

To learn more about Washington’s MTP, [visit the HCA website](#). Receive notifications about MTP-related activities, new materials, and other information through HCA’s [email subscription list](#).

### **Summary of attachments**

- Attachment A: [state contacts](#)
- Attachment B: [Financial Executor Portal Dashboard, Q2 2022](#)
- Attachment C: [1115 SUD Demonstration Monitoring Workbook – Part A](#)
- Attachment D: [1115 SUD Demonstration Monitoring Report – Part B](#)
- Attachment E: [1115 SMI/SED Demonstration Monitoring Workbook – Part A](#)
- Attachment F: [1115 SMI/SED Demonstration Monitoring Report – Part B](#)

# Attachment A: state contacts

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

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

**For mail delivery, use the following address:**

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



# Attachment B: Financial Executor Portal Dashboard, Q2 2022

[View this table on the HCA website](#), which shows all funds earned and distributed through the FE portal through June 30, 2022.

# Attachment C: 1115 SUD Demonstration Monitoring Workbook – Part A

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

# Attachment D: 1115 SUD Demonstration Monitoring Report – Part B

## 1. Title page for the state’s SUD demonstration or SUD components of broader demonstration

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

## 2. Executive summary

- For the most part metric trends continued stable, with decreases noted in follow up rates following emergency department visits for mental illness and average length of stays in IMDs. Slight downward trends continue in this measurement period for Medicaid beneficiaries with SUD diagnosis both monthly and annually, as well as beneficiaries treated in an IMD for SUD. This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on these measures is unknown. Any changes in trends should be treated with caution.

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

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
1.2 Assessment of Need and Qualification for SUD Services			
1.2.1 Metric Trends			
<input checked="" type="checkbox"/> <b>The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.</b>	<p>The monthly number of Medicaid beneficiaries with an SUD diagnosis has fluctuated slightly and continues to be trending downward slightly in more recent months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.</p>	04/01/2019 – 06/30/2019	#3: Medicaid beneficiaries with SUD diagnosis (monthly)
	<p>The annual number of Medicaid beneficiaries with an SUD diagnosis has also trended downward slightly, including Medicaid beneficiaries with an OUD diagnosis. However, given the potential impact on access to services during the ongoing COVID-19 pandemic, it is unclear whether this is a true decrease in the prevalence of SUD and OUD. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.</p>	07/01/2018 – 06/30/2019	#4: Medicaid beneficiaries with SUD diagnosis (annual)
	<p>There has been a decrease in the number of Medicaid beneficiaries treated in an IMD for SUD from the previous year. However, this decrease may be a result of the impact of the ongoing COVID-19 pandemic and should be interpreted with caution. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.</p>	07/01/2018 – 06/30/2019	#5: Medicaid beneficiaries treated in an IMD for SUD
<input type="checkbox"/> <b>The state has no metrics trends to report for this reporting topic.</b>			

<b>1.2.2 Implementation Update</b>			
<p><b>Compared to the demonstration design and operational details, the state expects to make the following changes to:</b></p> <p><input type="checkbox"/> i) The target population(s) of the demonstration.</p> <p><input type="checkbox"/> ii) The clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration.</p>			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The state expects to make other program changes that may affect metrics related to assessment of need and qualification for SUD services.			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<b>2.2 Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)</b>			
<b>2.2.1 Metric Trends</b>			
<input checked="" type="checkbox"/> The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1.	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received any SUD treatment has fluctuated slightly and continues to be trending downward slightly in more recent months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#6: Any SUD Treatment
	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received SBIRT has fluctuated slightly but has remained fairly stable. <a href="#">Research</a> within the state has highlighted some barriers to billing for SBIRT, including but not limited to staff turnover and uncertainty around reimbursement. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#7: Early Intervention

	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received outpatient SUD treatment has fluctuated slightly and continues to be trending downward slightly in more recent months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#8: Outpatient Services
	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received residential and inpatient SUD treatment has fluctuated slightly continues to be trending downward slightly in more recent months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#10: Residential and Inpatient Services
	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received withdrawal management SUD treatment has fluctuated slightly and continues to be trending downward slightly in more recent months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#11: Withdrawal Management
	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received MAT SUD treatment has fluctuated slightly and continues to be trending downward slightly in more recent months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#12: Medication Assisted Treatment
	There has been a decrease in the average length of stay from the previous year. However, this decrease may be a result of the impact of the ongoing COVID-19 pandemic and should be interpreted with caution. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of	07/01/2018 – 06/30/2019	#36: Average Length of Stay in IMDs

	these services is unknown. Any changes in trends should be interpreted with caution.		
<input type="checkbox"/> The state has no metrics trends to report for this reporting topic.			
2.2.2 Implementation Update			
<p>Compared to the demonstration design and operational details, the state expects to make the following changes to:</p> <p><input type="checkbox"/> i) Planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g., outpatient services, intensive outpatient services, medication assisted treatment, services in intensive residential and inpatient settings, medically supervised withdrawal management).</p> <p><input type="checkbox"/> ii) SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and medication assisted treatment services provided to individuals in IMDs.</p>			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The state expects to make other program changes that may affect metrics related to Milestone 1.			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
3.2 Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)			
3.2.1 Metric Trends			
<input type="checkbox"/> The state reports the following metric trends, including all changes (+ or -)			



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

greater than 2 percent related to Milestone 3.			
<input checked="" type="checkbox"/> The state has no trends to report for this reporting topic.			
<input type="checkbox"/> The state is not reporting metrics related to Milestone 3.			
4.2.2 Implementation Update			
<p>Compared to the demonstration design and operational details, the state expects to make the following changes to:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> i) Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards.</li> <li><input type="checkbox"/> ii) State review process for residential treatment providers' compliance with qualifications standards.</li> <li><input type="checkbox"/> iii) Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site.</li> </ul>			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The state expects to make other program changes that may affect metrics related to Milestone 3.			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The state is not reporting metrics related to Milestone 3.			

<b>5.2 Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)</b>			
<b>5.2.1 Metric Trends</b>			
<input checked="" type="checkbox"/> <b>The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4.</b>	SUD provider capacity has remained fairly stable despite the COVID-19 pandemic. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	07/01/2018 – 06/30/2019	#13: SUD provider availability
	SUD provider capacity – MAT has remained fairly stable despite the COVID-19 pandemic. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	07/01/2018 – 06/30/2019	#14: SUD provider availability – MAT
<input type="checkbox"/> <b>The state has no trends to report for this reporting topic.</b>			
<b>5.2.2 Implementation Update</b>			
<b>Compared to the demonstration design and operational details, the state expects to make the following changes to:</b>			
<input type="checkbox"/> <b>Planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care.</b>			
<input checked="" type="checkbox"/> <b>The state has no implementation update to report for this reporting topic.</b>			
<input type="checkbox"/> <b>The state expects to make other program changes that may affect metrics related to Milestone 4.</b>			
<input checked="" type="checkbox"/> <b>The state has no implementation update to report for this reporting topic.</b>			
<b>6.2 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)</b>			
<b>6.2.1 Metric Trends</b>			
<input type="checkbox"/> <b>The state reports the following metric trends, including all changes (+ or -)</b>			

<p><b>greater than 2 percent related to Milestone 5.</b></p>			
<p><b>☒ The state has no trends to report for this reporting topic.</b></p>	<p>Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state anticipated reporting this metric next quarter.</p>	<p>01/01/2017 – 12/31/2017</p>	<p>#15: Initiation and Engagement of Alcohol and Other Drug Treatment</p>
	<p>Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state anticipated reporting this metric next quarter.</p>	<p>01/01/2018 – 12/31/2018</p>	<p>#18: Use of Opioids at High Dosage in Persons without Cancer (modified by State)</p>
	<p>Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state anticipated reporting this metric next quarter.</p>	<p>01/01/2018 – 12/31/2018</p>	<p>#21: Concurrent Use of Opioids and Benzodiazepines (modified by State)</p>
	<p>Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state anticipated reporting this metric next quarter.</p>	<p>01/01/2018 – 12/31/2018</p>	<p>#22: Continuity of Pharmacotherapy for Opioid Use Disorder (modified by State)</p>

6.2.2 Implementation Update			
<p><b>Compared to the demonstration design and operational details, the state expects to make the following changes to:</b></p> <p><input type="checkbox"/> i) Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD.</p> <p><input type="checkbox"/> ii) Expansion of coverage for and access to naloxone.</p>			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The state expects to make other program changes that may affect metrics related to Milestone 5.			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
7.2 Improved Care Coordination and Transitions between Levels of Care (Milestone 6)			
7.2.1 Metric Trends			
<input checked="" type="checkbox"/> The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 6.	Follow-up rates have remained stable at both 7 days and 30 days despite the disruption due to the COVID-19 pandemic. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2017 – 12/31/2017	#17(1): Follow-Up after Emergency Department Visit for Alcohol or Other Drug Dependence
	Follow-up rates have decreased at both 7 days and 30 days. It is unclear whether this is due to the disruption of the COVID-19 pandemic or due to other causes. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2017 – 12/31/2017	#17(2): Follow-Up after Emergency Department Visit for

			Mental Illness
<input type="checkbox"/> The state has no trends to report for this reporting topic.			
7.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: <input type="checkbox"/> Implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports.			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The state expects to make other program changes that may affect metrics related to Milestone 6.			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
8.2 SUD Health Information Technology (Health IT)			
8.2.1 Metric Trends			
<input checked="" type="checkbox"/> The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its Health IT metrics.	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2017 – 06/30/2018	Q1: PDMP Statewide Fatal Drug Overdoses – All, All Opioids, Heroin, Prescription Opioids (excluding synthetic opioids), Synthetic Opioids (not

			Methadone)
	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	Q2: Substance Use Disorder Treatment Penetration Rate
	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	Q3: Foundational Community Supports Beneficiaries with Inpatient or Residential SUD Services
<input type="checkbox"/> The state has no trends to report for this reporting topic.			
8.2.2 Implementation Update			
<p><b>Compared to the demonstration design and operational details, the state expects to make the following changes to:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> i) How health IT is being used to slow down the rate of growth of individuals identified with SUD.</li> <li><input type="checkbox"/> ii) How health IT is being used to treat effectively individuals identified with SUD.</li> <li><input type="checkbox"/> iii) How health IT is being used to effectively monitor “recovery” supports and services for individuals identified with SUD.</li> </ul>			

<input type="checkbox"/> iv) Other aspects of the state’s plan to develop the health IT infrastructure/capabilities at the state, delivery system, health plan/MCO, and individual provider levels. <input type="checkbox"/> v) Other aspects of the state’s health IT implementation milestones. <input type="checkbox"/> vi) The timeline for achieving health IT implementation milestones. <input type="checkbox"/> vii) Planned activities to increase use and functionality of the state’s prescription drug monitoring program.			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The state expects to make other program changes that may affect metrics related to Health IT.			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			
9.2 Other SUD-Related Metrics			
9.2.1 Metric Trends			
<input checked="" type="checkbox"/> The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to other SUD-related metrics.	The rate of emergency department utilization for SUD has remained relatively stable over the last 6 months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#23: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries
	The rate of inpatient stays for SUD has remained relatively stable over the last 6 months. Note: This measurement period occurred during the COVID-19	04/01/2019 – 06/30/2019	#24: Inpatient Stays for



	pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.		SUD per 1,000 Medicaid Beneficiaries
	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#25: Readmissions Among Beneficiaries with SUD
	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2017 – 06/30/2018	#26: Overdose Deaths (count)
	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2017 – 06/30/2018	#27: Overdose Deaths (Rate)
	Access to Preventive/Ambulatory Health Services has remained stable over the last year. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2017 – 12/31/2017	#40: Access to Preventive /Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD.
<input type="checkbox"/> <b>The state has no trends to report for this reporting topic.</b>			
9.2.2 Implementation Update			
<input type="checkbox"/> <b>The state expects to make other program changes that may affect metrics related to other SUD-related metrics.</b>			

<input checked="" type="checkbox"/> <b>The state has no implementation update to report for this reporting topic.</b>			
10.2 Budget Neutrality			
10.2.1 Current status and analysis			
<input type="checkbox"/> <b>If the SUD component is part of a broader demonstration, the state should provide an analysis of the SUD-related budget neutrality and an analysis of budget neutrality. Describe the status of budget neutrality and an analysis of the budget neutrality to date.</b>			
10.2.2 Implementation Update			
<input type="checkbox"/> <b>The state expects to make other program changes that may affect budget neutrality</b>			
<input checked="" type="checkbox"/> <b>The state has no implementation update to report for this reporting topic.</b>			
11.1 SUD-Related Demonstration Operations and Policy			
11.1.1 Considerations			
<input type="checkbox"/> <b>States should highlight significant SUD (or if broader demonstration, then SUD-related) demonstration operations or policy considerations that could positively or negatively affect beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.</b>			

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

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

13.1 Other Demonstration Reporting			
13.1.1 General Reporting Requirements			
<input type="checkbox"/> The state reports changes in its implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol.			
<input checked="" type="checkbox"/> The state has no updates on general requirements to report for this reporting topic.			
<input type="checkbox"/> The state anticipates the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes.			
<input checked="" type="checkbox"/> The state has no updates on general requirements to report for this reporting topic.			
<p>Compared to the demonstration design and operational details, the state expects to make the following changes to:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> i) The schedule for completing and submitting monitoring reports.</li> <li><input type="checkbox"/> ii) The content or completeness of submitted reports and/or future reports.</li> </ul>			
<input checked="" type="checkbox"/> The state has no updates on general requirements to report for this reporting topic.			
<input type="checkbox"/> The state identified real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation			

<input checked="" type="checkbox"/> <b>The state has no updates on general requirements to report for this reporting topic.</b>			
13.1.2 Post-Award Public Forum			
<input type="checkbox"/> <b>If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual report.</b>			
<input checked="" type="checkbox"/> <b>No post-award public forum was held during this reporting period and this is not an annual report, so the state has no post-award public forum update to report for this topic.</b>			
14.1 Notable State Achievements and/or Innovations			
14.1 Narrative Information			
<input type="checkbox"/> <b>Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD (or if broader demonstration, then SUD related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable</b>			

<b>terms, e.g., number of impacted beneficiaries.</b>			
<input checked="" type="checkbox"/> <b>The state has no notable achievements or innovations to report for this reporting topic.</b>			

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

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

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

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

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

- Per discussions with CMS, the reporting of the SMI monitoring protocol is delayed for this quarter to incorporate CMS recommendations for reporting.



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

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

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

## **2. Executive Summary**

- Per discussions with CMS, the reporting of the SMI monitoring protocol is delayed for this quarter to incorporate CMS recommendations for reporting.

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

Per discussions with CMS, the reporting of the SMI monitoring protocol is delayed for this quarter to incorporate CMS recommendations for reporting.

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
<b>1.2 Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings (Milestone 1)</b>			
<b>1.2.1 Metric Trends</b>			
<input type="checkbox"/> The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1.			
<input type="checkbox"/> The state has no metrics trends to report for this reporting topic.			
<b>1.2.2 Implementation Update</b>			
<p>Compared to the demonstration design and operational details, the state expects to make the following changes to:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> i) The licensure or accreditation processes for participating hospitals and residential settings</li> <li><input type="checkbox"/> ii) The oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state’s licensing or certification and accreditation requirements</li> <li><input type="checkbox"/> iii) The utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay</li> </ul>			

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

<p>coordinate with housing services providers</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> iii) State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers within 72 hours post discharge</li> <li><input type="checkbox"/> iv) Strategies to prevent or decrease the lengths of stay in EDs among beneficiaries with SMI or SED (e.g., through the use of peers and psychiatric consultants in EDs to help with discharge and referral to treatment providers)</li> <li><input type="checkbox"/> v) Other State requirements/policies to improve care coordination and connections to community based care</li> </ul>			
<input type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The state expects to make other program changes that may affect metrics related to Milestone 2.			
<input type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<b>3.2 Access to Continuum of Care, Including Crisis Stabilization (Milestone 3)</b>			
<b>3.2.1 Metric Trends</b>			
<input type="checkbox"/> The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 3.			
<input type="checkbox"/> The state has no trends to report for this reporting topic.			
<b>3.2.2 Implementation Update</b>			
<p>Compared to the demonstration design and operational details, the state expects to make the following changes to:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> i) State requirement that providers use an evidenced-based, publicly available patient assessment tool to determine appropriate level of care and length of stay</li> </ul>			

<input type="checkbox"/> ii) Other state requirements/policies to improve access to a full continuum of care including crisis stabilization			
<input type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The state expects to make other program changes that may affect metrics related to Milestone 3.			
<input type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<b>4.2 Earlier Identification and Engagement in Treatment, Including Through Increased Integration (Milestone 4)</b>			
<b>4.2.1 Metric Trends</b>			
<input type="checkbox"/> The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4.			
<input type="checkbox"/> The state has no trends to report for this reporting topic.			
<b>4.2.2 Implementation Update</b>			
<p>Compared to the demonstration design and operational details, the state expects to make the following changes to:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> i) Strategies for identifying and engaging beneficiaries in treatment sooner (e.g., with supported education and employment)</li> <li><input type="checkbox"/> ii) Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment</li> <li><input type="checkbox"/> iii) Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED</li> <li><input type="checkbox"/> iv) Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people</li> </ul>			
<input type="checkbox"/> The state has no implementation update to report for this reporting topic.			

<input type="checkbox"/> The state expects to make other program changes that may affect metrics related to Milestone 4.			
<input type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<b>5.2 SMI/SED Health Information Technology (Health IT)</b>			
<b>5.2.1 Metric Trends</b>			
<input type="checkbox"/> The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its health IT metrics.			
<input type="checkbox"/> The state has no trends to report for this reporting topic.			
<b>5.2.2 Implementation Update</b>			
<p>Compared to the demonstration design and operational details, the state expects to make the following changes to:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> i) The three statements of assurance made in the state’s health IT plan</li> <li><input type="checkbox"/> ii) Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider and/or physician/mental health provider to community based supports</li> <li><input type="checkbox"/> iii) Electronic care plans and medical records</li> <li><input type="checkbox"/> iv) Individual consent being electronically captured and made accessible to patients and all members of the care team</li> <li><input type="checkbox"/> v) Intake, assessment, and screening tools being part of a structured data capture process so that this information is interoperable with the rest of the health IT ecosystem</li> <li><input type="checkbox"/> vi) Telehealth technologies supporting</li> </ul>			

collaborative care by facilitating broader availability of integrated mental health care and primary care <input type="checkbox"/> vii) Alerting/analytics <input type="checkbox"/> viii) Identity management			
<input type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The state expects to make the following program changes that may affect metrics related to health IT.			
<input type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<b>6.2 Other SMI/SED-Related Metrics</b>			
<b>6.2.1 Metric Trends</b>			
<input type="checkbox"/> The state reports the following metric trends, including all changes (+ or -) greater than two 2 percent related to other SMI/SED-related metrics.			
<input type="checkbox"/> The state has no trends to report for this reporting topic.			
<b>6.2.2 Implementation Update</b>			
<input type="checkbox"/> The state expects to make the following program changes that may affect other SMI/SED-related metrics.			
<input type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<b>7.1 Annual Assessment of the Availability of Mental Health Providers</b>			
<b>7.1.1 Description Of Changes To Baseline Conditions And Practices</b>			
<input type="checkbox"/> Describe and explain any changes in the mental health service needs (for example, prevalence and distribution of SMI/SED) of Medicaid beneficiaries with SMI/SED compared to those described in the Initial Assessment of Availability of Mental Health Services. Recommended word count is 500 words or less.			
<input type="checkbox"/> This is not an annual report, therefore the state has no update to report for this reporting topic.			



<input type="checkbox"/> Describe and explain any changes to the organization of the state’s Medicaid behavioral health service delivery system compared to those described in the Initial Assessment of Availability of Mental Health Services. Recommended word count is 500 words or less.			
<input type="checkbox"/> This is not an annual report, therefore the state has no update to report for this reporting topic.			
<input type="checkbox"/> Describe and explain any changes in the availability of mental health services for Medicaid beneficiaries with SMI/SED in the state compared to those described in the Initial Assessment of Availability of Mental Health Services. At minimum, explain any changes across the state in the availability of the following services: inpatient mental health services; outpatient and community-based services; crisis behavioral health services; and care coordination and care transition planning. Recommended word count is 500 words or less.			
<input type="checkbox"/> This is not an annual report, therefore the state has no update to report for this reporting topic.			
<input type="checkbox"/> Describe and explain any changes in gaps the state identified in the availability of mental health services or service capacity while completing the Availability Assessment compared to those described in the Initial Assessment of Availability of Mental Health Services. Recommended word count is 500 words or less.			
<input type="checkbox"/> This is not an annual report, therefore the state has no update to report for this reporting topic.			
<b>7.1.2 Implementation Update</b>			
<input type="checkbox"/> Compared to the demonstration design and operational details, the state expects to make the following changes to:			

<input type="checkbox"/> i) The state’s strategy to conduct annual assessments of the availability of mental health providers across the state and updates on steps taken to increase availability <input type="checkbox"/> ii) Strategies to improve state tracking of availability of inpatient and crisis stabilization beds			
<input type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<b>8.1 SMI/SED Financing Plan</b>			
<b>8.1.1 Implementation Update</b>			
<p>Compared to the demonstration design and operational details, the state expects to make the following changes to:</p> <input type="checkbox"/> i) Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, and observation/assessment centers, with a coordinated community crisis response that involves law enforcement and other first responders <input type="checkbox"/> ii) Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model			
<input type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<b>9.2 Budget Neutrality</b>			
<b>9.2.1 Current Status and Analysis</b>			
<input type="checkbox"/> If the SMI/SED component is part of a broader demonstration, the state should provide an analysis of the SMI/SED-related budget neutrality and an analysis of budget			

neutrality as a whole. Describe the current status of budget neutrality and an analysis of the budget neutrality to date.			
<b>9.2.2 Implementation Update</b>			
<input type="checkbox"/> The state expects to make the following program changes that may affect budget neutrality.			
<input type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<b>10.1 SMI/SED-Related Demonstration Operations and Policy</b>			
<b>10.1.1 Considerations</b>			
<input type="checkbox"/> States should highlight significant SMI/SED (or if broader demonstration, then SMI/SED-related) demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SMI/SED demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.			
<input type="checkbox"/> The state has no related considerations to report for this topic.			
<b>10.1.2 Implementation Update</b>			
<input type="checkbox"/> The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities.			
<input type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The state is working on other initiatives related to SMI/SED.			

<input type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<input type="checkbox"/> The initiatives described above are related to the SMI/SED demonstration as described (States should note similarities and differences from the SMI/SED demonstration).			
<input type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<p>Compared to the demonstration design and operational details, the state expects to make the following changes to:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> i) How the delivery system operates under the demonstration (e.g. through the managed care system or fee for service)</li> <li><input type="checkbox"/> ii) Delivery models affecting demonstration participants (e.g. Accountable Care Organizations, Patient Centered Medical Homes)</li> <li><input type="checkbox"/> iii) Partners involved in service delivery</li> <li><input type="checkbox"/> iv) The state Medicaid agency's Memorandum of Understanding (MOU) or other agreement with its mental health services agency</li> </ul>			
<input type="checkbox"/> The state has no implementation update to report for this reporting topic.			
<b>11 SMI/SED Demonstration Evaluation Update</b>			
<b>11.1. Narrative Information</b>			
<input type="checkbox"/> Provide updates on SMI/SED evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. See report template instructions for more details.			
<input type="checkbox"/> The state has no SMI/SED demonstration evaluation update to report.			

<input type="checkbox"/> Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.			
<input type="checkbox"/> The state has no SMI/SED demonstration evaluation update to report.			
<input type="checkbox"/> List anticipated evaluation-related deliverables related to this demonstration and their due dates.			
<input type="checkbox"/> The state has no SMI/SED demonstration evaluation update to report.			
<b>12.1 Other Demonstration Reporting</b>			
<b>12.1.1 General Reporting Requirements</b>			
<input type="checkbox"/> The state reports changes in its implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol.			
<input type="checkbox"/> The state has no updates on general requirements to report for this topic.			
<input type="checkbox"/> The state anticipates the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes.			
<input type="checkbox"/> The state has no updates on general requirements to report for this topic.			
<input type="checkbox"/> The state identified real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation.			
<input type="checkbox"/> The state has no updates on general requirements to report for this topic.			
Compared to the demonstration design and operational details, the state expects to make the following changes to:  <input type="checkbox"/> i) The schedule for completing and submitting monitoring reports			

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

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

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

*("HEDIS®") measures that are owned and copyrighted by the National Committee for Quality Assurance ("NCQA"). NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications.*

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*Calculated measure results, based on the adjusted HEDIS specifications, may be called only "Uncertified, Unaudited HEDIS rates."*

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