STATE OF WASHINGTON

October 25th, 2024

Dear Members of the Joint Select Committee on Health Care Oversight:

SUBJECT: Quarterly Report on the Medicaid Transformation Project

Pursuant to Senate Bill (SB) 5092, Sections 211 (2)(a)&(b), (3) and (4), enclosed please find two documents reporting on the activities, outcomes, financial status, and expenditures of the Medicaid Transformation Project (MTP). Washington State's Section 1115 Medicaid demonstration waiver. The first enclosure is a copy of our recently submitted report to the federal Centers for Medicare & Medicaid Services (CMS).

Under the terms of our agreement with CMS, the state is required to report quarterly on the activities and accomplishments of MTP. Within the report is a quarterly expenditure and FTE report covering three of five MTP initiatives. Given that the information contained in the report is the same as what we believe to be required under SB 5092, we respectfully suggest that the same report can fulfill both needs. However, please let us know if there is additional information you require.

The second enclosed document is a Medicaid Quality Improvement Program (MQIP) report, which is now included as a deliverable within our quarterly update. The MQIP report was required in the corresponding budget proviso.

If you have questions or require additional information, please do not hesitate to contact us.

Sincerely,

Susan E. Birch, MBA, BSN, RN
Director
Health Care Authority

Jilma Meneses
Secretary
Department of Social and Health Services

Enclosures

By email

cc: Senate Ways and Means Committee, leadership, and staff
Senate Health and Long-Term Care Committee, leadership, and staff
House Appropriations Committee, leadership, and staff
House Health Care and Wellness Committee, leadership, and staff
Joint Select Committee on Health Care Oversight, leadership, and staff
Senate and House, Democratic and Republican Caucus staff
Governor's Office, Senior Policy Advisors
Office of Financial Management, HCA Budget Assistants

Washington State Health Care Authority

Washington State Medicaid Transformation Project 2.0 (MTP 2.0) demonstration

Section 1115 Waiver Annual and Quarterly Report

Demonstration Year 8: July 01, 2023 – June 30, 2024

DY8 reporting period 4: April 1 through June 30, 2024

Washington State Health Care Authority

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Introduction

On June 30, 2023, the Centers for Medicare & Medicaid Services (CMS) approved Washington State's request for a Section 1115 Medicaid demonstration waiver, titled "Medicaid Transformation Project 2.0 (MTP 2.0)." 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 MTP 2.0 period, Washington will:

- Expand coverage and access to care, ensuring that people can get the care they need.
- Advance whole-person primary, preventive, and home-and community-based care.
- Accelerate care delivery and payment innovation focused on health-related social needs.

The state will accomplish these goals through these continuing or new programs:

- Long-Term Services and Supports (LTSS): Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) and Presumptive Eligibility (PE).
- Foundational Community Supports (FCS): Community Support Services (CSS) and Supported Employment – Individual Placement and Support (IPS).
- Substance use disorder (SUD) IMD[1] 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.
- Contingency Management (CM) for SUD treatment: evidence-based intervention for SUD.
- Continuous enrollment: Continuous Apple Health enrollment for children ages 0 through 5 and Apple Health postpartum coverage expansion.
- Reentry from a carceral setting: Services to individuals beginning up to 90 days prior to their expected release and continuing into their reentry to their communities.
- Health-related social needs (HRSN) services: Evidence-based, non-medical services that address social needs that affect health. HRSN services are coordinated in part by nine Community Hubs and one statewide Native Hub.

Vision: a healthier Washington

The Washington State Health Care Authority (HCA) is the lead agency for MTP 2.0, and many other 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.

[1] IMD stands for 'institution for mental diseases.' IMDs are hospitals, nursing facilities, or other institutions of more than 16 beds that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, which includes SUD. We acknowledge the term 'mental disease' may be harmful or stigmatizing. We use it in this context only to reflect the legal terminology used in statute.

Annual Report: Demonstration Year 8

In accordance with special terms and conditions (STC) 20.8 and 42 C.F.R. § 431.428, this report summarizes the activities and accomplishments for the eighth demonstration year of MTP (DY8). It documents accomplishments, project status, and operational updates and challenges.

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

Policy and administrative updates

MTP in DY8: MTP 2.0 approval

On June 30, 2023, the state received approval of its Section 1115 Medicaid demonstration waiver, titled "Medicaid Transformation Project 2.0 (MTP 2.0)." Over the MTP 2.0 period, there are continuing programs along with new programs. Some new programs to highlight are the justice-involved pre-release services and the Health-Related Social Needs (HRSN) services. During DY8, the state focused efforts in:

- Finalizing the Delivery System Reform Incentive Payment (DSRIP) program and MTP 1.0 programs that will not continue into MTP 2.0
- Submission of CMS deliverables per STC requirement
- Stakeholder and partner engagement on the planning and implementation of new programs

Annual Expenditures

Delivery System Reform Incentive Payment (DSRIP) program expenditures

During the period of July 1, 2023 – June 30, 2024, **all nine** Accountable Communities of Health (ACHs) earned nearly $64,817,023 in project incentives and integration incentives for demonstrating completion of required project and integration milestones during DY8, including the submission of implementation plans.

Table 1: DSRIP expenditures

	Q1 (July 1–September 30)	Q2 (October 1-December 31)	Q3 (January 1–March 31)	Q4 (April 1–June 30)	DY8 Total (July 1, 2023–June 30, 2024)	Funding source: Federal financial participation
Better Health Together	$0.0	$0.0	$0.0	$8,021,724	$8,021,724	$4,010,862
CHOICE	$0.0	$0.0	$0.0	$6,917,213	$6,917,213	$3,458,607
Elevate Health	$0.0	$0.0	$0.0	$5,364,236	$5,364,236	$2,682,118
Greater Health Now	$0.0	$0.0	$0.0	$10,460,610	$10,460,610	$5,230,305
HealthierHere	$0.0	$0.0	$0.0	$10,901,012	$10,901,012	$5,450,506
Thriving Together North Central Washington	$0.0	$0.0	$0.0	$4,077,056	$4,077,056	$2,038,528
North Sound	$0.0	$0.0	$0.0	$10,846,331	$10,846,331	$5,423,166
Olympic Community of Health	$0.0	$0.0	$0.0	$3,176,400	$3,176,400	$1,588,200
SWACH	$0.0	$0.0	$0.0	$5,052,441	$5,052,441	$2,526,221
Indian Health Care Providers	$0.0	$0.0	$0.0	0.0	0.0	

Table 2: LTSS and FCS service expenditures

	Q1 (July 1–September 30)	Q2 (October 1–December 31)	Q3 (January 1–March 31)	Q4 (April 1–June 30)	DY8 Total (July 1, 2023–June 30, 2024)
Tailored Supports for Older Adults (TSOA)	$3,523,276	$5,388,884	$5,755,443	$8,193,419	$22,861,021.89
Medicaid Alternative Care (MAC)	$117,757	$179,833	$227,905	$249,070	$774,565.22
MAC and TSOA not eligible	$73.92	$0	$0	$0	$73.92
FCS	$13,587,308	$8,710,047	$10,649,513	$11,666,519	$44,613,387.00

LTSS data annual summary

Table 3: beneficiary enrollment by program

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of June 30, 2024	346	2,067	4,140
Number of new enrollees in DY8 by program	155	1,056	1,678
Number of new person-centered service plans in DY8 by program*	80	395	655
Number of beneficiaries self-directing services under employer authority**	0	0	0

*New enrollees may not require a completed care plan if they are still in the care planning phase and services have yet to be authorized.

** The state has successfully implemented all necessary system enhancements for the Consumer Direct Employer for the MAC and TSOA programs. Effective 6/26/2024, MAC and TSOA participants have the option of self-directed services.

Table 4: Presumptive eligibility (PE) screenings through DY8, reporting period 4

Region	Screenings in process	Screenings finalized	Total screenings	Of finalized screenings, # ineligible for PE	Of finalized screenings, # eligible for PE	% of clients PE-eligible
1	18	90	108	8	82	91%
2	1	72	73	4	68	94%
3	14	29	43	0	29	100%
All	**33**	**191**	**224**	**12**	**179**	**95%**

Table 5: PE assessments through DY8, reporting period 4

Region	Full assessments created	Full assessments finalized	Days from PE Finalized to assessment finalized
1	58	45	6-173 days
2	53	42	7-62 days
3	17	17	5-153 days
All	**107**	**86**	

FCS data annual summary

Reports are available on MTP resources webpage.

Table 6: FCS client enrollment, DY8

Calendar month	Supported Employment – Individual Placement and Support (IPS)	Community Support Services (CSS)	CSS and IPS	Total aggregate enrollment
Jul-23	3,161	9,380	2,974	15,515
Aug-23	3,165	9,538	2,960	14,663
Sep-23	3,171	9,539	2,958	15,668
Oct-23	3,202	9,459	3,031	15,692
Nov-23	3,293	9,342	3,038	15,573
Dec-23	3,194	9,202	3,082	15,478
Jan-24	3,453	9,977	3,307	16,737
Feb-24	3,515	10,042	3,390	16,947
Mar-24	3,582	10,075	3,565	17,222
Apr-24	3,690	9,983	3,720	17,393
May-24	3,625	9,820	3,741	17,186
Jun-24	3,550	9,644	3,695	16,889

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.

Table 7: 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	376,275	0	0	0	0	0	0	0	0
Feb-17	375,169	0	0	0	0	0	0	0	0
Mar-17	374,698	0	0	0	0	0	0	0	0
Apr-17	373,548	0	0	0	0	0	0	0	0
May-17	373,091	0	0	0	0	0	0	0	0
Jun-17	372,994	0	0	0	0	0	0	0	0
Jul-17	372,082	0	0	0	0	0	0	0	0
Aug-17	371,816	0	0	0	0	0	0	0	0
Sep-17	370,549	0	0	0	0	0	0	0	0
Oct-17	370,356	0	0	0	0	0	0	0	0
Nov-17	370,184	0	0	0	0	0	0	0	0
Dec-17	370,212	0	0	0	0	0	0	0	0
Jan-18	370,252	0	0	0	0	0	0	0	0
Feb-18	368,875	0	0	0	0	0	0	0	0
Mar-18	368,681	0	0	0	0	0	0	0	0
Apr-18	367,420	0	0	0	0	0	0	0	0
May-18	367,786	0	0	0	0	0	0	0	0

Jun-18	367,062	0	0	0	0	0	0	0	0
Jul-18	366,804	7	23	123	11	0	0	0	0
Aug-18	366,205	14	31	212	43	0	0	0	0
Sept-18	365,205	7	13	109	40	0	0	0	0
Oct-18	365,204	7	13	115	48	0	0	0	0
Nov-18	364,735	7	27	171	33	0	0	0	0
Dec-18	364,188	9	26	165	38	0	0	0	0
Jan-19	364,113	32	106	395	49	0	0	0	0
Feb-19	362,431	28	101	386	45	0	0	0	0
Mar-19	362,083	31	128	427	40	0	0	0	0
Apr-19	361,613	37	122	448	42	0	0	0	0
May-19	361,096	46	141	506	52	0	0	0	0
June-19	360,335	59	165	592	52	0	0	0	0
Jul-19	360,763	77	163	791	45	0	0	0	0
Aug-19	360,333	73	196	810	47	0	0	0	0
Sep-19	359,886	75	205	846	42	0	0	0	0
Oct-19	359,370	89	224	976	33	0	0	0	0
Nov-19	358,507	87	217	886	38	0	0	0	0
Dec-19	358,832	91	241	1074	44	0	0	0	0
Jan-20	359,278	78	188	1042	35	0	0	0	0
Feb-20	359,279	55	174	823	39	0	0	0	0
Mar-20	360,970	64	173	947	36	0	0	0	0
Apr-20	364,459	83	181	1148	16	0	0	0	0
May-20	366,908	58	220	817	17	0	0	0	0
Jun-20	369,704	74	232	1124	19	0	0	0	0
Jul-20	372,395	85	231	1256	19	0	0	0	0
Aug-20	375,226	51	203	870	29	0	0	0	0
Sep-20	377,447	67	205	1068	35	0	0	0	0
Oct-20	379,482	70	216	1220	22	0	0	0	0
Nov-20	380,391	36	188	755	18	0	0	0	0
Dec-20	381,872	47	209	863	24	47	22	60	6
Jan-21	383,045	43	222	843	25	2	2	13	6
Feb-21	383,144	26	87	294	15	107	38	173	7
Mar-21	384,472	22	82	309	14	109	38	171	6
Apr-21	385,781	20	73	286	13	108	38	172	4
May-21	386,965	32	86	311	22	111	39	171	4
Jun-21	388,018	20	31	163	20	111	38	168	3
Jul-21	389,585	26	101	375	18	109	38	168	5
Aug-21	391,578	20	92	320	15	107	38	173	4
Sep-21	392,961	18	80	313	15	111	38	173	6
Oct-21	394,255	17	78	261	15	110	39	171	5
Nov-21	396,145	15	77	293	12	111	39	170	6
Dec-21	396,729	8	40	214	12	112	38	171	5
Jan-22	398,301	4	13	88	8	107	36	178	4
Feb-22	399,578	36	179	649	10	78	21	144	2

Mar-22	401,110	40	176	657	20	77	21	144	2
April-22	403,256	41	182	663	15	82	21	140	4
May-22	404,662	44	197	732	14	86	21	141	3
Jun-22	406,868	46	194	746	24	84	22	142	6
Jul-22	408,935	43	195	787	14	83	22	144	3
Aug-22	411,688	79	259	1155	19	114	25	210	3
Sep-22	413,057	80	257	1161	20	116	23	211	3
Oct-22	415,013	80	260	1157	23	113	23	212	3
Nov-22	417,327	56	225	931	21	112	23	212	6
Dec-22	419,878	56	231	943	17	114	24	216	9
Jan-23	421,938	60	236	977	14	116	31	231	6
Feb-23	423,947	54	196	973	12	137	87	395	8
Mar-23	426,637	57	200	985	16	137	91	402	7
April-23	427,853	55	200	1004	17	137	90	410	8
May-23	427,892	84	291	1122	10	140	92	417	8
Jun-23	420,057	88	289	1122	17	133	94	419	5
Jul-23	411,585	94	315	1422	11	132	96	421	6
Aug-23	401,791	89	305	1425	11	132	89	416	7
Sep-23	399,768	91	309	1430	18	133	88	413	10
Oct-23	399,063	93	316	1465	19	134	89	415	9
Nov-23	398,240	74	288	1219	14	136	89	407	8
Dec-23	396,659	73	294	1219	19	139	85	395	4
Jan-24	394,628	77	303	1253	11	139	82	388	0
Feb-24	392,814	67	261	1100	14	72	60	185	1
March-24		66	262	1076	4	72	58	183	1
April-24		63	259	1025	0	72	57	173	0
May-24									
June-24									
Total	32,965,387	3601	12303	53433	1659	4,382	2,005	9,718	203

Table 8: Member months eligible to receive services (Presumptive Eligibility, Post-Partum, Continuous Enrollment for Children)

Calendar month	Presumptive Eligibility	CE Post-Partum Individuals	CE Children Disabled	CE Children Non-Disabled
Apr-23	0	0	2,663	254,888
May-23	0	0	2,624	254,776
Jun-23	0	0	2,610	253,331
Jul-23	0	563	2,610	252,404
Aug-23	0	545	2,457	252,417
Sep-23	0	548	2,441	253,965
Oct-23	0	571	2,430	254,304
Nov-23	0	592	2,433	254,627
Dec-23	4	624	2,389	254,631

Jan-24	9	640	2,385	254,191
Feb-24	20	622	2,359	253,622
Mar-24	23	620	2,338	251,771
Apr-24	28	635	2,352	254,311
May-24	23	591	2,352	252,328
Jun-24	20	545	2,327	249,605
Total	127	7,096	36,770	3,801,171

Maintenance of Effort (MOE) update

Foundational Community Supports Transitional Assistance Program (FCS TAP):

FCS TAP offers funding to FCS supportive housing (SH) enrollees as they take steps to achieve short- and long- term housing goals.

FCS-SH enrollees must be making housing transitions to access FCS TAP funding. FCS-SH enrollees can use TAP funding with a maximum spending amount of $5,000 per 12-month period. Funding is to cover such items as:

- IDs and other documentation (ID card, birth certificates, Social Security cards)
- Application fees (rental applications, background check, credit check)
- Transitional housing fees (associated with entering certain housing)
- Moving expenses (moving rental and supplies)
- Home essentials and sustainability items (small appliances, mattresses, cleaning supplies, light furnishings)
- Items in arrears (utilities, rental, storage)

TAP is fully funded by general fund state dollars.

Housing and Essential Needs (HEN)

The Housing and Essential Needs (HEN) program provides funding to local governments and homeless service providers to help individuals referred by the Department of Social and Health Services (DSHS) with:

- Time-limited rent assistance
- Services connected to housing stability
- Limited essential needs items, such as personal hygiene and transportation

Eligible participants have a disability, are low income, and are experiencing homelessness or are at-risk of becoming homeless. HEN is fully funded by general-fund state dollars.

Table 9 details the baseline and spending during state fiscal year (SFY) 2023 (July 1, 2022–June 30, 2023) and SFY2024 (July 1, 2023–June 30, 2024).

Table 9: MOE Program baseline funding and expenditures, SFY23 and SFY24

MOE Program	Baseline	SFY23 expenditures	SFY24 expenditures*
TAP	$3,055,670	$3,095,591	$3,000,379
HEN	$48,736,141	$60,191,611	$47,801,058

*The baseline was not met in SFY24 for these programs, given that the period ended June 30, 2024, and services are still being paid. HCA will provide updated spending in a future monitoring report.

MTP evaluation

The state worked with Oregon Health and Science University Center for Health System Effectiveness (OHSU-CSHE) as the Independent External Evaluator (IEE) during DY8 to craft and submit the MTP 2.0 Evaluation Design for consideration to CMS. The design was submitted for final approval in June of 2024. The evaluation design includes qualitative and quantitative evaluation methodologies of all programmatic initiatives. While the evaluation design is under review with CMS, the state is working to identify the data needed for OHSU to complete their evaluation activities.

State legislative developments

The Washington State Legislature's 2024 session ran from January 8 to March 7, 2024. The operating budget provided continued spending authority for MTP. At the request of the Legislature, the state presented MTP updates to multiple legislative committees during 2024.

The legislature continues to be interested in options to strengthen the FCS program.

MTP Public Forum

On December 12, 2023, HCA hosted the annual MTP Public Forum to provide an update to the public on our programs and share next steps for MTP. In addition to an overview of MTP and the MTP 2.0 renewal, the presentation included the 2023 successes and challenges for these MTP services:

- Aging and Long-Term Support Administration (ALTSA)
    - Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)
    - Long-term services and supports (LTSS) presumptive eligibility (PE)
    - FCS, including supported employment and supportive housing
- Continuous eligibility for kids 0-6
- Health-related social needs (HRSN)
- Native Hub
- Postpartum coverage expansion
- Reentry from a carceral setting
- Substance use disorder (SUD) and mental health

Attendees had an opportunity to ask questions and share their input during the forum. Watch the **forum recording** and **view the slide deck**.

Summary of public comments received during DY8

The following public comments were received during DY8, organized by program:

DSRIP program public comments

Quarter 1:

- Stakeholders and partners asked questions on the CMS approval of MTP 2.0. Questions focused on the development and implementation process for the new programs of MTP 2.0.

Quarter 2:

- No MTP stakeholder concerns were reported.

Quarter 3:

- No MTP stakeholder concerns were reported.

Quarter 4:

- No MTP stakeholder concerns were reported.

LTSS program public comments

MAC and TSOA Programs

Quarter 1

- The modified Washington Administrative Code (WAC) related to new MAC and TSOA services (Pest Eradication, Specialized Deep Cleaning, and Community Choice Guiding Services as well as the expansion of Nurse Delegation) requested in the 1115 waiver renewal (MTP 2.0) as well as the expanded definition for transportation to include accessing community resources (requested in the January 2021 amendment) became permanent during quarter one. No public comments were identified in the rule making process.

Quarter 2

- Statewide there continues to be a shortage of paid in -home care providers for respite and personal care services, so alternative services and providers are being explored to act as a bridge when personal care or respite workers are in short supply. Continued utilization of other services in the MTP service benefits package to meet participants needs. These include but are not limited to, home delivered meals, personal emergency response systems, adult day care, and environmental modifications. The DSHS Home and Community Services (HCS) anticipates improvements in this area after the recent implementation of a workforce development team. In addition, MAC and TSOA programs have started the implementation of the consumer directed employer vendor to utilize individual providers who will provide personal care and respite care services.

Quarter 3

- Statewide open forum meeting for contracted Community Choice Guide providers to discuss the implementation of community choice guiding services for the MAC and TSOA programs.

Quarter 4

- The MAC and TSOA programs successfully implemented all necessary system enhancements for the Consumer Direct Employer. Effective 6/26/2024, MAC and TSOA participants have the option of self-directed services.

LTSS PE

Quarter 1

- No public comments or community partner concerns noted during this quarter.

Quarter 2

- The implementation of LTSS PE, phase 1, began December 4, 2023. Coordination with the Washington State Hospital Association (WSHA) continues as it related to LTSS PE discharge referrals. Refinement of tracking and metrics continued. Collaboration began with home care agencies to provide in-home caregivers to LTSS PE participants. No public comments or stakeholder concerns noted during this quarter.

Quarter 3

- No public comments or community partner concerns were noted during this quarter.

Quarter 4

- No public comments or community partner concerns were noted during this quarter.

FCS program public comments

Quarter 1

- None

Quarter 2

- HCA received feedback from a group of providers regarding potential improvements to the program including feedback around provider rates, payment methodologies, and clarification around client eligibility.

Quarter 3

- None

Quarter 4

- HCA received dozens of comments related to the budget and operations of the program when new enrollments to the program were waitlisted. HCA also received input from other key stakeholders including other state agencies and legislators.

Quarterly report: April 1 – June 30, 2024

This quarterly report summarizes MTP activities from the third reporting period of MTP 2.0: April 1 through June 30, 2024. It details MTP implementation, including stakeholder education and engagement, planning and implementation, and development of policies and procedures, and continues the demonstration reporting as "demonstration year 8" (DY8).

Summary of quarter accomplishments

- ACHs continue to distribute incentive funds to partnering providers through the FE portal. During the reporting quarter, ACHs distributed approximately $36 million to partnering providers and organizations.
- The final MTP 1.0 DSRIP payments for Indian health care providers (IHCPs) were distributed. As such, there are no activities to report for this quarter.
- As of June 30, 2024, more than 17,700 clients, in addition to their family caregivers, have received services and supports through the MAC and TSOA programs. The average caseload for the quarter was 4,236 clients. New enrollees for LTSS for this quarter reporting period includes 43 MAC dyads, 280 TSOA dyads, and 455 TSOA individuals.
- Within FCS, the total aggregate number of people enrolled in services at the end of DY8 reporting period 4 includes 7,245 in IPS and 13,339 in CSS. The total unduplicated number of enrollments at the end of this quarter reporting period is 3,695.

MTP 2.0-wide stakeholder engagement

During the reporting quarter, HCA continued its stakeholder engagement efforts, mostly focused on MTP 2.0's Reentry Demonstration Initiative (Reentry Initiative).

Reentry Initiative engagement

This quarter, HCA announced via a **press release** and a **GovDelivery announcement** that Washington carceral facilities—including state prisons, city and county jails, Tribal jails, and youth correctional facilities—were invited to participate in the Reentry Initiative. Carceral facilities were also invited to participate via **letter from Dr. Charrissa Fotinos**, HCA's Medicaid and Behavioral Health Medical Director.

In addition, HCA and some of our partners hosted a Q&A webinar for carceral facilities about the Reentry Initiative. About 120 people attended. The presentation provided an overview of the initiative and MTP 2.0, the goals of the initiative, requirements for carceral facilities to participate, and timelines and funding. At the end of the presentation, we answered many thoughtful questions from attendees. View the **presentation slide deck** and watch a **recording of the webinar**.

Following the webinar, HCA held two virtual office hours to answer outstanding questions and to aid facilities with the Intent to Participate letter required to initiate participation in the program.

- Watch the **May 13 office hours recording**
- Watch the **May 24 office hours recording**

This quarter, HCA also created or updated:

- **Reentry Initiative overview document**
- **Reentry FAQ**
- **Reentry webpage on hca.wa.gov**. We will continue to build out this page as we develop more products and guidance for facilities.
- GovDelivery list topic specifically for the Reentry Initiative. **Sign up to receive our announcements**.

To learn more, visit the **Reentry Initiative implementation accomplishments section** in this report.

Other opportunities in Medicaid

On May 7, HCA sent out a GovDelivery announcement after our state was selected to participate in the Center for Health Care Strategies (CHCS) **Medicaid Health-Related Social Needs Implementation Learning Series**. This learning series will help states work on health-related social needs initiatives. **Read the full announcement**.

Learning Symposium

Although HCA no longer holds a formal learning symposium once per year, HCA ensures ongoing opportunities for collaboration and shared learning among the nine ACHS and HCA staff. Weekly conference calls with ACH leadership provide a venue for updates from HCA, plus a forum for ACHs to provide feedback and share information with each other. In addition, quarterly calls with each ACH allow for more detailed, region-specific discussion.

State activities and accountability

Integrated managed care (IMC) progress

There are no updates to report for this quarter. Per CMS guidance on monitoring reporting requirements, the IMC progress will not be included in the quarterly and annual progress reports moving forward.

Health information technology (Health IT)

The Health IT Operational Plan is composed of actionable deliverables to advance the Health IT goals and vision articulated in the **Health IT Strategic Roadmap**. This work supports MTP in Washington State. The Health IT Roadmap and Operational Plan focuses on three phases of MTP work: design, implementation and operations, and assessment. The activities for the 2023 Health IT Operational Plan include 42 deliverables and tasks in these areas:

- Health Care Management and Coordination System (HCMACS) Crisis Call Center and Related Activities: 988/E2SHB 1477
- Electronic Consent
- Mental health (MH) IMD Waiver Health IT tasks

Activities and successes

The Health IT team spent much of the reporting period continuing its focus on advancing multi-year initiatives involving Health IT. During the past quarter, the state:

Crisis Call and Response Services

HCA's Health IT team, in coordination with the Department of Health (DOH), continued implementation planning for the nationally required 988 crisis call system and Washington State's more expansive requirements for a Crisis Call Center Hub System and the Behavioral Health Integrated Client Referral System (BHICRS) outlined in House Bill 1477 (E2SHB 1477). Requirements for geolocation and geo-routing were approved to be included, but not activated by project sponsors.

The BHICRS work required in E2SHB 1477 has been organized by workstreams and leads/subject matter experts (SMEs) are being identified for each workstream.

HCA and DOH staff are discussing options for the future 988 system's bed registry. DOH owns an existing system called WaHealth, and HCA staff have analyzed systems used by other states via a 2021 National Association of State Mental Health Program Directors (NASMHPD) report. HCA staff have also spoken directly to several states about their experience and current state of bed registry, including Arizona, Georgia, Indiana, and Rhode Island. Outreach and information gathering with other states has been ongoing.

HCA received a NASMHPD Transformation Transfer Initiative (TTI) award to be used for gathering information from providers, first responders, payers, and persons with lived experience to identify opportunities, barriers, and options to increase provider awareness of and use of bed registry and referral tools and make available information from a bed registry to persons with lived experience.

- HCA contracted with a vendor, BerryDunn, to complete this work.
- HCA received additional funds in a supplemental award from NASMHPD to gather information specific to providers' technology needs/barriers/concerns regarding bed registry and referral tools.
- HCA and BerryDunn have completed the BerryDunn-hosted Discovery Sessions and web surveys for this work and have begun the process of consolidating and analyzing the results.

HCA and DOH staff began preparations for the planned Request for Proposal (RFP). A decision was made for a single RFP, with DOH as the chief steward.

- Requirements for the future RFP have been developed and reviewed by project staff, Tribes, and other partners. The requirements are being sorted into a phased approach and labeled accordingly. Minimum Viable Product (MVP) is being identified within the requirements.
- A cross-agency team has developed a set of user stories spanning the life of several types of 988 calls for review. A decision is needed whether to include user stories in the RFP, and to what capacity. Inclusion of user stories in the feasibility study, requested by CMS and WATech, is also under discussion.

The HCA-initiated 988 State Affinity Workgroup (SAW) continues to convene monthly. It is now facilitated by representatives from NASMHPD. The 988 SAW is a multi-state forum to discuss 988 implementation.

HCA HIT has hired additional staff, including an IT Business Analyst and a 988 Business Change Manager. Recruitment continues for other positions.

HCA has delivered recommendations for the future role of Regional Crisis Lines (RCLs) to the sponsors for approval and approved. Work is paused until next steps are identified.

- A new dispatch process will be created after the announcement of the RCL-988 alignment. This process will streamline the way teams are currently dispatched while maintaining regional control over their teams.

HCA and DOH submitted a white paper and Planning Advanced Planning Document (PAPD) to Centers for Medicaid Services (CMS) for their review and approval. This is for the purpose of securing an enhanced federal match funding for technology related to/utilized for the 988 project.

- The white paper was submitted and reviewed by CMS in Q4 of 2023.
- The PAPD was submitted in Q4 2023 and is currently under review by CMS. A Request for Additional Information (RAI) was submitted to HCA and DOH in Q1 of 2024 and was reviewed and answered by Washington.
- Multiple rounds of questions from CMS have been received and answered, with the latest Washington answers to be submitted the week of April 22, 2024.
- A second RAI was submitted to HCA and DOH in Q2 of 2024, and answers were reviewed and submitted by Washington along with an updated PAPD.

SB 6251 created regional crisis protocols that Behavioral Health – Administrative Services Organizations (BH-ASO) can adopt by January. The protocols will cover things like information sharing, 911-988 hand offs, and facility placement among many other priorities for the BH-ASOs. These protocols will be updated with changes to the crisis system or at least every three years.

WA contracted with a vendor, Public Knowledge (PK), to complete Quality Assurance for the 988 project. PK conducted a Readiness Assessment of the project and is attending meetings and holding interviews with project staff. The Readiness Assessment has been finalized and submitted, and interviews are ongoing. PK also submits monthly status reports for review and commentary to the project sponsors.

Electronic Consent Management (ECM)

The ECM solution will initially focus on managing consents governing the exchange of SUD information, subject to 42 CFR Part 2, and will ultimately be a generalized consent solution to address many future use cases. In Q2, the ECM solution vendor completed all System Integration Testing (SIT), user acceptance testing (UAT) and Accessibility/508 compliance testing and CodeSmart (the prime vendor) signed off on the system. Representatives from five provider organizations participated in the UAT sessions. The prime vendor has completed their SOC2 Type I certification/final report, but the subcontractor Midato Health is still working on their certifications. Penetration Testing (PEN) testing, audit and remediation work are expected to be complete in early August. The Expanded Solution discovery document was also completed and accepted by HCA.

HCA, in collaboration with the vendors, is finalizing a provider onboarding diagram, checklist, intake form, standard communications and agendas to complete those sessions as soon as possible. We have had leadership kickoff calls with the three providers in the initial cohort of users and will now schedule follow-up work sessions. Vendor continued updating training materials and will record a webinar for future use. HCA has now updated a standard Part 2 consent form under the guidance of the agency Privacy Officer. This is compliant with the Feb 8, 2024, new Final Rule published by Health and Human Service Coalition (HHS Coalition) and will be available in the ECM solution as an option for providers to use versus their current forms. HCA continues outreach with providers and other influencers in the behavioral health/SUD community to identify possible system user candidates. The first cohort of providers will start using the system on August 13, 2024.

Provider Directory Application Programming Interface (API)

MyHealthButton continues to be published in the Google and Apple application stores. A new application, BWell Connected Health is requesting to be connected to the Fast Healthcare Interoperability Resources (FHIR) server. Their connection is currently going through the HCA review process. HCA currently has 171,533 providers listed in the provider directory as of June 30, 2024.

Master Person Index (MPI)

The HHS Coalition MPI project has established the MPI solution and connected its second system in 2023. The MPI team continues to enhance the solution, building reporting, notification, and performance enhancements to allow the solution to meet the HHS Coalition's needs in the coming years. The project is preparing to connect a number of HHS Coalition systems in the coming months, including Healthplanfinder, ACES and the state's immunization registry between now and June 2025.

HCMACS Program (formerly EHR as a Service)

The Department of Enterprise Services (DES) convenience contract for HCMACS vendors continues working through finalizing contracts. The HCMACS program will have the opportunity to select a vendor from this convenience contract once contracts have been signed. The program has entered into preliminary conversations with a vendor from this list to explore timeline, scope, and cost in preparation for development of a statement of work.

A candidate for the Executive Program Director role has been interviewed and selected. A job offer has been extended and a start date of July 2024 has been announced. Job descriptions are being developed for the other high priority program positions.

Funds that had been allocated for the program in Fiscal Year 2024 (FY24; July 1, 2023 through June 30, 2024) have been moved to FY25 (July 1, 2024–June 30, 2025). Contracting and procurement of the HCMACS system vendor is now scheduled to occur in FY25, with corresponding impacts to program timeline. Implementation activities are scheduled to kick off around Q4 of calendar year (CY) 2025, with the first implementation group going live in Q3 of CY2026.

Development of the RFP for the System Integrator (SI) to support the implementation is underway. The vendor has been engaged and workgroups are meeting to define requirements and determine the operating model. The RFP for the SI is expected to be released in Q4 CY2024.

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 final **ACH P4R report** was submitted on October 7, 2022. Per CMS guidance on monitoring reporting requirements, the P4R progress will not be included in the quarterly and annual progress reports moving forward.

Pay for performance (P4P)

HCA and the Independent Assessor are actively working on P4P results, achievement values, and the statewide accountability report. Because of the at-risk DSRIP funding, the statewide accountability report must be approved by CMS prior to the Independent Assessor finalizing regional P4P results.

Statewide Accountability Report

HCA submitted the statewide accountability report to CMS in Q4 of 2023.

Next steps

The final P4P and High Performance Pool (HPP) payments have been administered to the nine ACHs in the second quarter of 2024.

HCA and ACHs continue to partner on the transition from DSRIP to the programs approved under MTP 2.0, including nine Community Hubs and one statewide Native Hub to support and deliver HRSN services. HCA continues to convene a task force that includes representatives from managed care organizations (MCOs), ACHs, DOH, DSHS, and HCA to discuss roles and partnership opportunities to support the hub model and HRSN services implementation.

Conversations during this reporting period focused on approving readiness criteria for the community hubs, appropriate reporting for HRSN infrastructure payments, and contract updates.

Annual value-based purchasing (VBP) milestone achievement by ACHs

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

In Q2 of 2024, ACHs helped spread the word about the Paying for Value Survey for providers. The ACHs' formal responsibilities related to VBP will be phased out with the sunsetting of DSRIP performance accountability.

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 **$36,473,642 to 44** partnering providers and organizations in support of project planning and implementation activities.

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.

Tribal project implementation activities

Last quarter, the Tribal Liaison for Medicaid Transformation finished visits regarding MTP 2.0, which led to the distribution of the final MTP 1.0 DSRIP payments. As such, there are no activities to report here.

LTSS implementation accomplishments

This section summarizes development and implementation activities for LTSS programs from April 1 through June 30, 2024.

MAC and TSOA

As of June 30, 2024, more than 17,700 clients, in addition to their family caregivers, have received services and supports through the MAC and TSOA programs. The average caseload for the quarter was 4,236 clients.

The ALTSA continues with the 2024 annual quality assurance cycle.

Expansion under 1115 demonstration waiver renewal, MTP 2.0, to further develop innovative projects, activities, and services for MTP participants was successfully implemented.

Expansion Highlights:

- Utilizing the updated TSOA income eligibility criteria (400 percent of the federal benefit rate), 66 new participants in the expanded eligibility tier accessed TSOA services this quarter.
- Utilizing the updated resource standard (six months of the current private nursing facility rate), 13 additional participants in the expanded eligibility tier accessed TSOA services this quarter.
- Policy and procedure development for the expanded definition of Transportation service for the MAC and TSOA benefits package expansion was implemented.
- Care Receivers have begun utilizing MTP 2.0 additional services including Pest Eradication, Specialized Deep Cleaning, and Community Choice Guiding Services.

LTSS PE

- LTSS PE continues to gain momentum in Phase 1. As of June 30, 2024, approximately 200 clients pursued services through PE, and approximately 95 percent went to in-home services after full functional and financial eligibility were determined.
- With the anticipation of widening the door to LTSS PE in Phase 2, discussions continue with management, regional staff and the Area on Aging Agency (AAA) around staffing needs, caseload sizes, case sharing, training, tracking data, and potential barriers. Phase 2 will remove the criteria of discharging from an acute care hospital or diverting from a psychiatric hospital.
- Efforts continue around how to integrate LTSS PE through the AAAs, to encompass the “no wrong door” philosophy.

Network adequacy for MAC and TSOA

AAAs continue to monitor already established contracts and continue executing additional contracts in relation to the MTP 2.0 additional services (Pest Eradication, Specialized Deep Cleaning and Community Choice Guide services). After recent policy and contract enhancements, AAAs are also working on increasing the provider network for non-medical Transportation vendors.

Statewide there continues to be a shortage of paid in-home care providers for respite and personal care services, so alternative services and providers are being explored to act as a bridge when personal care or respite workers are in short supply. Continued utilization of other services in the MTP service benefits package to meet participants needs include but are not limited to, home delivered meals, personal emergency response systems, adult day care, and environmental modifications.

Consumer Directed Employer (CDE) implementation occurred in June 2024. Consumer Direct Care of Washington (CDWA) is the contracted CDE provider for Washington state. With the implementation of CDWA, MAC and TSOA participants now have a self-directed care model option when choosing their personal or respite care provider.

Assessment and systems update

MAC and TSOA

RTZ Systems, GetCare' s administrator, completed the interface between the GetCare case management system and CDWA's provider management system. This interface allows case managers to send and receive required documents, as part of the referral process, to CDWA. The interface will also allow CDWA to send pertinent case management notifications.

Expected future system updates include:

- Improvements to the person-centered care planning tools.
- Reduced processing time of recipient aid categories through the system interfaces.
- Streamlining Voter's Registration assistance process.
- Implementation of a view option in GetCare for care receiver's eligibility status from WA State's payments system, ProviderOne.

LTSS Presumptive Eligibility

During this quarter the following CARE enhancements were completed:

- LTSS PE Financial Screen now includes Income and Resource Limits.
- Electronic Signature functionality for LTSS PE Approval and Care Plan.

Future CARE enhancements that are being explored are:

- Increase detail of Caregiver instructions in the PE care plan.
- Pursuing voice signature functionality to the LTSS PE Approval and Care Plan forms.
- Collateral contacts to print on the LTSS PE Care Plan.
- Disabling Dynamic functionality for LTSS PE assessment.
- Maintain ability to access and edit the LTSS PE Care Plan section after the LTSS PE assessment has been completed.
- Continuing to address the need for case sharing between HCS and the AAA's and how that will look/function for both HCS and the AAA's.

Staff training

MAC and TSOA

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

- April 2024: Open Office Hours, Compare and Contrast Family Caregiver Support Program (FCSP) vs. MAC and TSOA
- May 2024: CDWA Training – Getting Started (Overview of person-centered care planning discussions with care receivers and caregivers as well as review of implementation policy and procedures)
- June 2024: CDWA Systems and Functional Training (Overview of system enhancement, referral process, and interface connections)

LTSS PE

Informal Q&A meetings occur routinely statewide to address individual questions or concerns as they arise. Training materials, fact sheets, guides and workflows have been posted on a shared Teams channel for ongoing reference.

Data and reporting

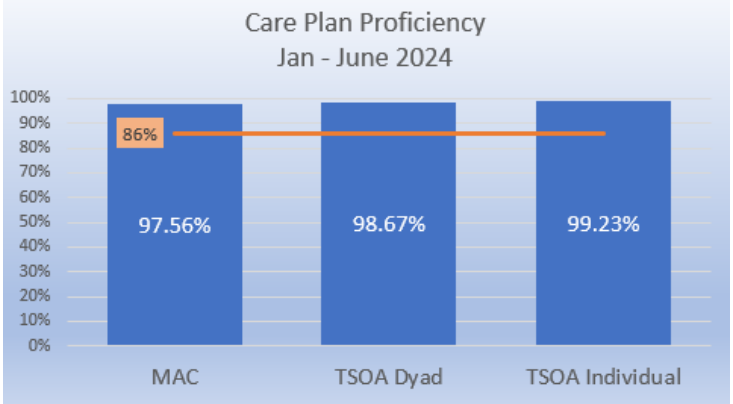
MAC and TSOA

Table 10: beneficiary enrollment by program

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of June 30, 2024	253	1,394	3,035
Number of new enrollees in quarter by program	43	280	455
Number of new person-centered service plans in quarter by program	22	104	176
Number of new enrollees who do not require a care plan because they are still in the care planning phase and services have yet to be authorized	21	175	277
Number of beneficiaries self-directing services under employer authority*	0	0	0

*The state has successfully implemented all necessary system enhancements for CDE for the MAC and TSOA programs. Effective June 26, 2024, MAC and TSOA participants have the option of self-directed services.

Figure 1: statewide care plan proficiency to date



Note: The 86 percent line represents the CMS proficiency expectation.

The AAAs compliance with timely completion of care plans for enrollees continues to exceed proficiency.

LTSS Presumptive Eligibility

See **Tables 4 and 5** for LTSS PE assessment and screening data. Numbers reflect all PE participants through the end of this quarter. There has been a steady rise in participants, with a significant percentage moving on to in-home services.

Tribal engagement

ALTSA met with several tribes to discuss Medicaid services, MAC, TSOA and FCS from April 1–June 30, 2024.

- April: Tribal Affairs met with Nooksack Tribe to discuss Tribal Health Homes, Money Follows the Person Tribal Initiative (MFP-TI) and unpaid caregiver programs including the MAC and TSOA programs.
- May: Tribal Affairs worked with Nooksack Tribe to develop MFP-TI contract that supports the Health Home program and research for unpaid caregiver programs that support their community, including the MAC and TSOA programs.
- June: MAC and TSOA programs were presented at the Spring Summit on June 11, 2024. Colville, Lummi, Kalispel, Quinault, Spokane, Yakama, Skokomish, Squaxin Island, and Port Gamble S'Klallam tribes were in attendance.

ALTSA's Tribal Affairs team continues building relationships with Tribal nations while sharing services supported by MFP-TI including the MAC and TSOA programs. Tribal Affairs has participated in meetings with ALTSA headquarters (HQ) program managers to increase culturally responsive materials regarding the MAC and TSOA programs for outreach relevant to Tribal nations. MAC and TSOA, as well as other programs, for unpaid caregivers continue to be a focus when working with Tribal partners. Tribal Affairs is partnering with MAC and TSOA program managers in a number of ways including developing materials that provide concise and pertinent information for Tribal nations as well as collaborating and providing feedback to MAC and TSOA program managers to increase utilization of these programs for Tribal nations.

Tribal engagement for LTSS PE is scheduled for a future date.

Outreach and engagement

MAC and TSOA

ALTSA's MAC and TSOA Program Manager continues to seek indigenous volunteers to participate in interviews for the Caregivers Program video.

In conjunction with a department wide rebranding refresh, ALTSA HQ staff will continue to collaborate with the AAAs on updating outreach materials and brainstorming ideas for new publications to engage community members.

Table 11: number of outreach and engagement activities held by Area Agencies on Aging

	April	May	June
Community presentations and information sharing	94	59	57

There was an increase in overall outreach and engagement activities though the volume and type of outreach activities continues to fluctuate.

LTSS Presumptive Eligibility

As LTSS PE is being implemented statewide through HCS, the AAAs are getting exposure to this service through resource materials, routine meetings and shared trainings. At this time, collaboration has begun around expanding LTSS PE to the AAAs as Phase 2 approaches. The details are in the beginning stage but will progress through the next quarter.

Quality assurance

MAC and TSOA

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?

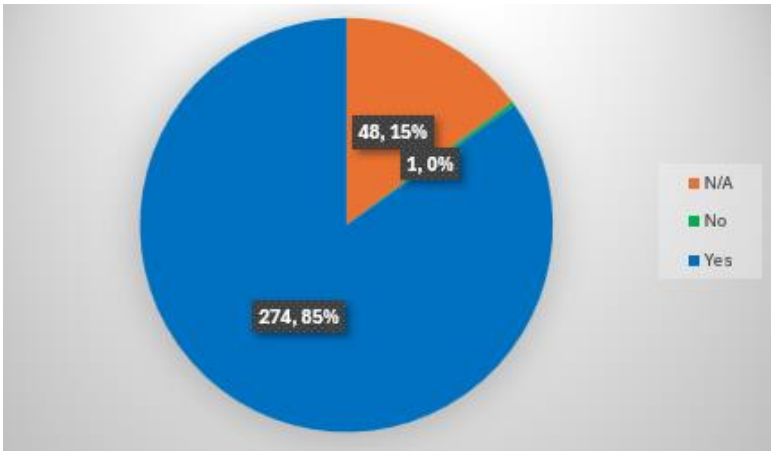


Figure 3: Question 2a: did the client remain eligible after the PE period?

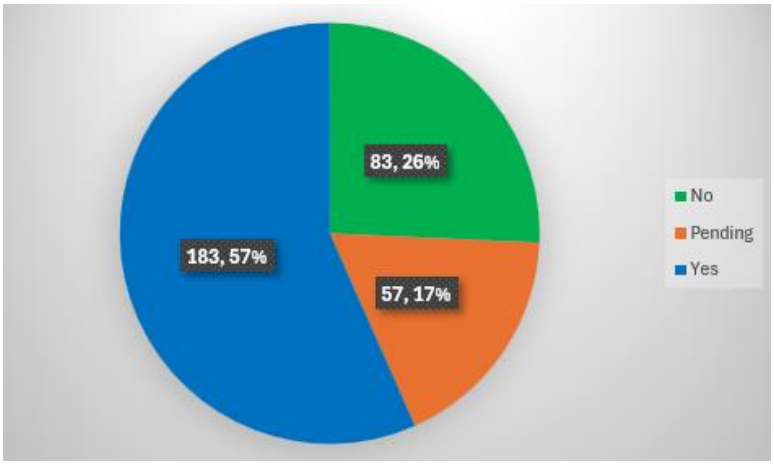
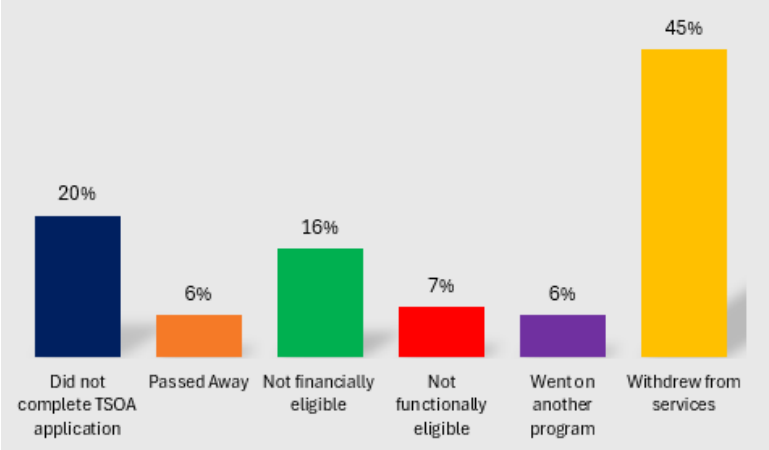


Figure 4: Question 2b: if "No" to question #2a, why?



LTSS Presumptive Eligibility

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

Figure 5: Question 1a: Did the client remain eligible for in-home services after the Presumptive Eligibility period?

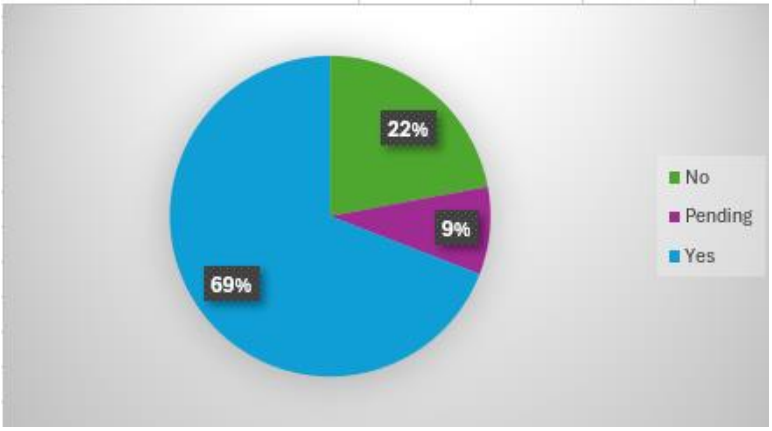


Figure 6: Question 1b: If "No" to question 1a, why?

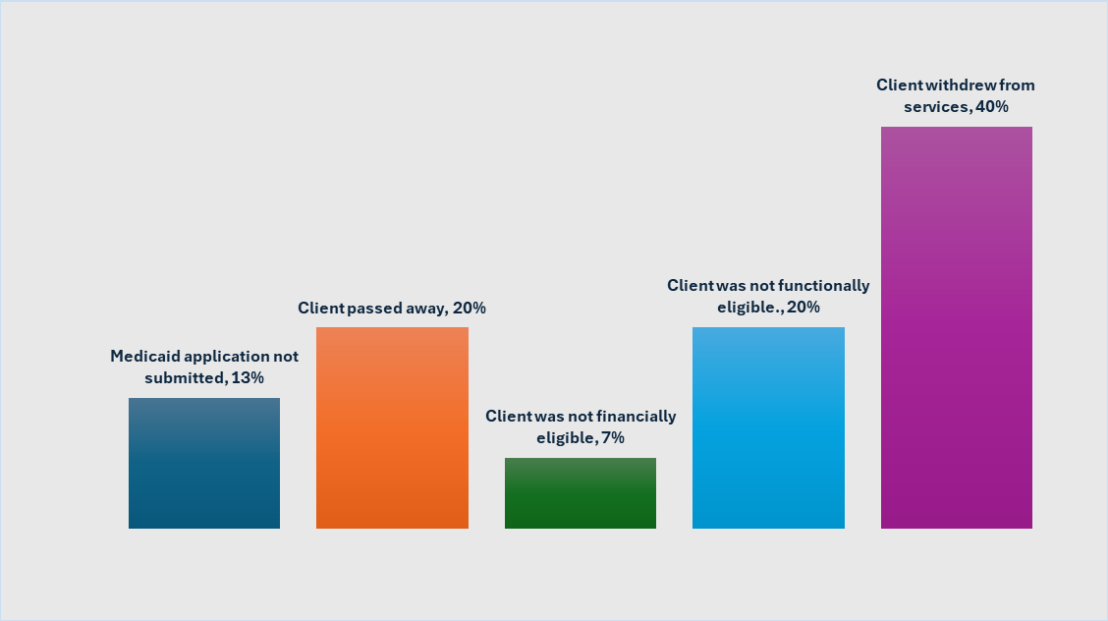
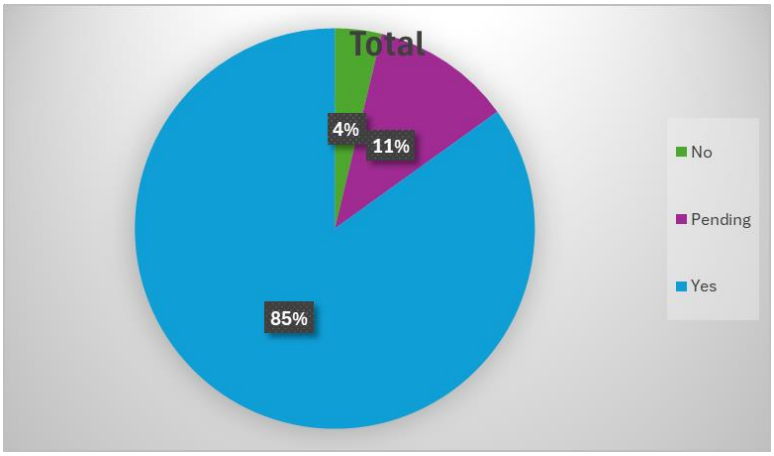


Figure 7: Question 2a: Did level of care remain the same from PE assessment to full CARE assessment?

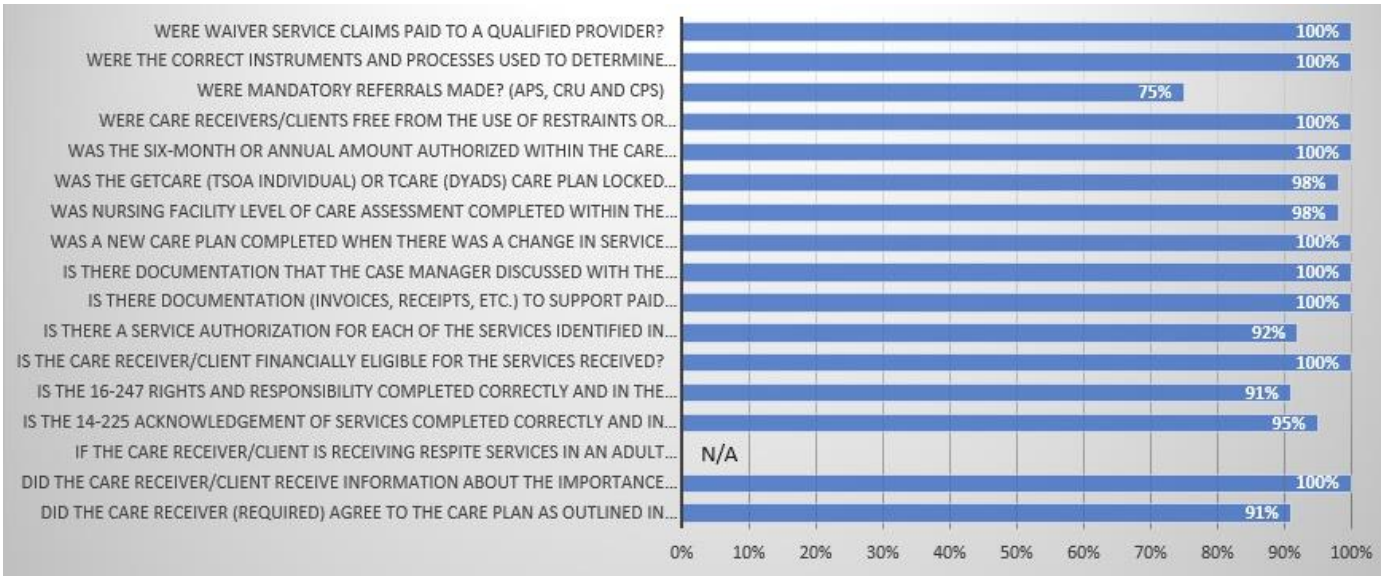
Note: Only applies to those who went onto in-home services



2024 quality assurance results to date

MAC and TSOA

Figure 9: statewide proficiency to date



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

State rulemaking

MAC and TSOA

No state rulemaking specific to MAC and TSOA occurred during this quarter.

LTSS Presumptive Eligibility

No state rulemaking specific to LTSS PE occurred during this quarter.

Upcoming activities

MAC and TSOA

Continue monitoring system infrastructure and referral processes regarding the recent implementation of the Consumer Direct Employer – self-directed care model.

LTSS Presumptive Eligibility

LTSS PE Phase 2 is approaching. Continuing efforts to coordinate with the regions in preparation for additional PE applicants.

Integrate LTSS PE through the AAAs, to encompass the "no wrong door" philosophy.

LTSS stakeholder concerns

MAC and TSOA

There are no community partner concerns to report this quarter.

LTSS Presumptive Eligibility

There are no community partner concerns to report this quarter.

FCS implementation accomplishments

FCS 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, 2024. Key accomplishments for the quarter include:

Total aggregate number of people enrolled in FCS services at the end of this reporting period:

- CSS: 13,339
- IPS: 7,245

There were 221 providers under contract with Wellpoint at the end of the reporting period, representing 548 sites throughout the state.

Note: CSS and IPS enrollment totals include 16,889 participants enrolled in both programs. The total unduplicated number of enrollments at the end of this reporting period was 3,695.

Network adequacy for FCS

Table 12: FCS provider network development

	April		May		June	
FCS service type	Contracts	Service locations	Contracts	Service locations	Contracts	Service locations
Supported Employment – Individual Placement Support (IPS)	37	76	37	77	37	77
Community Support Services (CSS)	28	65	28	65	28	65
CSS and IPS	161	395	165	401	165	401
Total	226	536	230	543	230	543

The FCS provider network saw some growth in early Q8 with new providers joining the network as part of the state-funded Apple Health and Homes initiative that aims to connect FCS CSS enrollees with state-funded rental assistance.

Table 13: FCS client enrollment, DY8 reporting period 4

	April	May	June
Supported Employment – Individual Placement and Support (IPS)	3,690	3,625	3,550
Community Support Services (CSS)	9,983	9,820	9,644
CSS and IPS	3,720	3,741	3,695
Total aggregate enrollment	17,393	17,186	16,889

Data source: RDA administrative reports

Table 14: FCS client risk profile

		Met HUD homeless criteria	Avg. PRISM risk score	Serious mental illness
April	IPS	853 (12%)	1.05	5,050 (68%)
	CSS	2,829 (21%)	1.29	8,685 (63%)

May	IPS	881 (12%)	1.05	5,005 (68%)
	CSS	2,850 (21%)	1.28	8,609 (63%)
June	IPS	881 (12%)	1.07	5,002 (69%)
	CSS	2,833 (21%)	1.29	8,591 (64%)

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 15: FCS client risk profile continued

		Medicaid only enrollees*	MH treatment need	SUD treatment need	Co-occurring MH + SUD treatment needs flags
April	IPS	6,393	5,785 (90%)	3,925 (61%)	3,628 (57%)
	CSS	11,799	10,500 (89%)	8,290 (70%)	7,543 (64%)
May	IPS	6,348	5,744 (90%)	3,879 (61%)	3,581 (56%)
	CSS	11,668	10,377 (89%)	8,165 (70%)	7,424 (64%)
June	IPS	6,245	5,629 (90%)	3,791 (61%)	3,491 (56%)
	CSS	11,450	10,149 (89%)	7,942 (69%)	7,208 (63%)

Data source: RDA administrative reports

*Does not include individuals who are dual enrolled.

Table 16: 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
April	IPS	6,393	800 (13%)	4,562 (71%)	2,695 (42%)	684 (11%)
	CSS	11,799	1,061 (9%)	7,584 (64%)	5,196 (44%)	890 (8%)
May	IPS	6,348	819 (13%)	4,480 (71%)	2,659 (42%)	695 (11%)
	CSS	11,668	1,083 (9%)	7,432 (64%)	5,115 (44%)	902 (8%)
June	IPS	6,245	804 (13%)	4,327 (69%)	2,570 (41%)	670 (11%)
	CSS	11,450	1,077 (9%)	7,130 (62%)	4,896 (43%)	888 (8%)

(Aging CARE assessment in last 15 months)

(Aging CARE assessment in last 15 months)

Data source: RDA administrative reports

*Does not include individuals who are dual-enrolled.

Table 17: 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
April	IPS	1,957 (26%)	191 (3%)	869 (12%)	3,188 (43%)	982 (13%)	172 (2%)
	CSS	3,678 (27%)	760 (6%)	1,789 (13%)	4,885 (36%)	2,430 (18%)	105 (1%)
May	IPS	1,967 (27%)	191 (3%)	854 (12%)	3,133 (43%)	998 (14%)	170 (2%)
	CSS	3,670 (27%)	754 (6%)	1,761 (13%)	4,810 (35%)	2,405 (18%)	104 (1%)
June	IPS	1,954 (27%)	193 (3%)	854 (12%)	3,080 (43%)	950 (13%)	158 (2%)
	CSS	3,643 (27%)	760 (6%)	1,729 (13%)	4,712 (35%)	2,333 (17%)	96 (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 collaborated with the third-part administrator (TPA) to oversee FCS. No significant concerns or problems were identified, and the TPA has confirmed the absence of any grievances or appeals throughout this period.

FCS staff continued work to identify processes to decrease the need for reconnecting enrollees who experience changes in their Medicaid coverage. FCS is not an entitlement benefit, and enrollment is accomplished through a manual process requiring weekly workflows to enroll and re-enroll (or reconnect) eligible individuals to the program. The reconnection process necessitates conducting a historical eligibility screening to identify gaps in coverage that may have occurred due to changes in Medicaid type, incarceration, or other modifications in the ProviderOne database that automatically disconnect an individual from FCS. The FCS team at HCA and the TPA have identified a potential solution and are currently working on a pilot project to meet this need.

The FCS team conducted two more virtual comprehensive fidelity reviewer trainings, which were divided into two sessions. One two-part training centered on supported employment, while the other training was dedicated to supportive housing. The purpose of the training events was to equip FCS providers and potential reviewers with knowledge about the evidence-based practices; ultimately, enhancing the quality of the services they offer.

The training aimed to prepare agency staff for their active participation in review panels while also raising their knowledge of fidelity measurement. The fidelity reviews adopt a collaborative learning approach. In Q4 DY8, the FCS team conducted 17 formal reviews on FCS programs. Each of these agencies voluntarily participanted and each review team consists of at least two other peer agencies. All in all, the learning collaborative to increase quality services is continuing to grow.

Additionally, this year FCS providers can receive incentives through Substance Abuse and Mental Health Services Administration (SAMHSA) block grant funds if they choose to become reviewers or host a review. This quarter, nine agencies were awarded with up to $25,000 to enhance and/or increase sustainability of their program. Each awardee was required to participate in several trainings related to program implementation and evidence-based practice fidelity as well as working with the FCS trainers to develop a formal sustainability plan for their program.

All of these engagements intend to create and maintain high quaility service delivery by investing in foundational knowledge and supportive guidance regarding evidence based practice fidelity adherence.

Other FCS program activity

Effective April 22, 2024, HCA implemented a temporary pause to new FCS program enrollments due to projected budgetary overspend and to preserve the services of existing program participants. Growth in the program exceeded previously projected enrollment forecast in the end of DY7 and early DY8. The program will maintain a waitlist for new enrollments to be managed on a first-come, first-served basis as space becomes available in the program.

A number of concerns were raised regarding participants who are “inactive” in the program, or not engaged in services. Historically, the program has only disenrolled individuals who did not reauthorize for services or who specifically requested to be disenrolled. FCS providers assess it to be overly burdensome to carry inactive participants on their caseload. As a result, HCA worked to establish a process by which providers could disenroll participants who are no longer engaged in services after demonstrating their due diligence in four separate attempts to engage in services with an individual.

HCA continues to maintain an ongoing monthly workgroup with the ALTSA team and DSHS’s Research and Data Analysis (RDA) staff. The workgroup meets to develop, discuss, and adopt key policies and practices necessary for the continued operation, improvement, and long-term success of the FCS program.

Additionally, the group continues to hold bi-monthly meetings with providers, coordinated by King County, the most populous county in Washington State. Recently, Spokane County also initiated a similar space for providers. These meetings offer FCS providers in the county the opportunity to share experiences, exchange ideas, and learn from one another about effective practices when administering FCS benefits.

In partnership with the DSHS’s Division of Vocational Rehabilitation (DVR), HCA actively engages in a quarterly workgroup. This workgroup's primary goal is to improve consistency, foster collaboration, and optimize employment outcomes for DVR customers with behavioral health conditions who are receiving supported employment services through the DVR Supported Employment program and FCS. In Q4, this group is focusing on increasing confidence in supported employment programs and retaining employment specialists.

FCS provided a funding opportunity, referred to as Glidepath, which is intended to provide formal benefit planning and employment services. Multiple agencies were awarded contracts and will support identified regions. These funds are intended to partner with Housing and Essential Needs program to provide up to nine months of additional rental assistance as a bridge period for IPS-enrolled individuals who would otherwise be financially unsupported due to increasing income through employment.

Lastly, the FCS team is rolling out the Apple Health and Homes (AHAH) program which is having it’s first lottery for awardees of the benefit. AHAH is a benefit to FCS enrolled clients. AHAH provides project or tenant based rental subsidies to eligible enrollees.

Upcoming activities

Supportive Housing Institute: Based on provider feedback, a series of nine training courses aiming to increase tenant engagement, clarify roles and responsibilities, and increase the state’s housing inventory will be offered in 2024, in addition to the FCS team's traditional Supportive Housing Institute in 2025.

The FCS team continued to maintain regular meetings with the Department of Commerce (COM) to discuss the planning and development of two programs. These programs include the collaboration of COM, DSHS, and HCA to establish permanent supportive housing units for CSS-eligible individuals under the name "Apple Health and Homes."

FCS program stakeholder engagement activities

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

A significant portion of the stakeholder engagement activities during this quarter were related to the temporary pause to new enrollments. The FCS program staff held monthly meetings with providers and other key stakeholders to solicit feedback related to the pause and how the waitlist will be managed.

Table 18: Number of FCS program stakeholder engagement activities held

	April	May	June
Training and assistance provided to individual organizations	104	98	73
Community and regional presentations and training events	9	5	7
Informational webinars	12	20	9
Stakeholder engagement meetings	3	11	6
Total activities	128	134	95

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.

During this reporting period, topics included:

- Stages of Change/Motivational Interviewing
- Re-Integration Services and Employment
- Leadership Expectations and Best Practices
- FCS 101
- Work-Works! The part you plan in the intersection of collaboration recovery and employment
- Psychosis consultation/training
- Discussion of Contracting process, Medicaid, and billable services
- Supporting workers experiencing primary and secondary trauma

FCS stakeholder concerns

The FCS team has been receiving feedback about the challenges faced by providers who are new to billing Medicaid when submitting claims as well as the FCS enrollment pause. In response, HCA is offering additional one-on-one technical assistance, a series of pre-recorded budget webinars to support providers in adopting best practices and aligning with other Medicaid billing processes. The FCS team additionally developed a New Provider Orientation presentation to assist these agencies with the intricacies of billing FCS services.

FCS is maintaining a commonly asked questions document available to the public explaining specific details related to the enrollment pause. Primary questions are related to timeline expectations and ensuring low likelihood of another future pause. FCS supervisor shares updates at each monthly Question and Answer meeting as well as one-on-one with providers.

FCS agencies have been actively providing feedback and insights on FCS services. Providers share, at a minimum, during a quarterly Advisory Council meeting. Some of the issues that were raised were the need to increase understanding about systems used to verify eligibility of enrollees, examining reasons for application denials, and decreasing confusion through updating provider facing documents. To keep constituents informed, the FCS team regularly provides updates and opportunities during the quarterly Advisory Council meetings, as well as hosts webinars with specific and relevant information.

SUD IMD waiver implementation accomplishments

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

This section summarizes SUD IMD waiver development and implementation activities from April 1 through June 30, 2024. Accomplishments for this reporting period include:

Some related legislative changes were passed this year in 2SSB 6228 (laws of 2024) and became effective on June 6, 2024. This law will:

- Prohibit inpatient SUD providers from refusing to readmit a patient who left against medical advice.
- Prohibit insurance carriers from considering patient length of abstinence when determining admission criteria for inpatient treatment.
- Require inpatient SUD treatment agencies to report to DOH when they kick a patient out of treatment and why. Patient forced discharges are a rampant problem.
- Prohibit insurance carriers from considering patient length of stay in treatment in determining continued need for care. This is intended to stop the practice of insurance carriers discharging all patients after 28 days, when some need more care than that, particularly in the era of fentanyl.
- Require all behavioral health agencies to provide patients with education about and access to medication treatment options for opioid use disorder (OUD) and alcohol use disorder (AUD). Only 1 in 3 patients with OUD has access to treatment medications and only 1 in 10 patients with AUD has access to treatment medications.
- Allow hospitals to bill for long-acting injectable buprenorphine (Suboxone)
- Require training for emergency department social workers on how to use Ricky's Law, the state's involuntary treatment system for patients with substance use disorder. Hospitals are frequently not summoning designated crisis responders to evaluate patients in substance use crisis, resulting in one-half of Ricky's Law beds sitting empty.
- Prohibit insurance carriers from requiring utilization review prior to 14 days of inpatient care and no more frequent than every 7 days. This is to reduce administrative burden on providers.
- Create a patient shared decision making tool for use in primary care, emergency departments, and behavioral health settings regarding treatment medications for alcohol use disorder.

Implementation plan

There are no updates to report for this reporting period.

SUD Health IT plan requirements

There are no updates to report for this reporting period.

Evaluation design

There are no updates to report for this reporting period.

Monitoring protocol

There are no updates to report for this reporting period.

Upcoming activities

ScalaNW.org is set to debut this summer. ScalaNW is an online resource that offers 24/7 live clinical support to hospitals and emergency rooms looking to provide patients with medications for opioid use disorder (MOUD). Hospitals that enroll in the hotline, which is offered in partnership with the University of Washington Psychiatry Consultation Line, will also

have access to 24/7 follow-up appointment scheduling supported by the Washington Recovery Helpline and offered to patients before they are discharged from the emergency department.

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) and 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, 2024.

In April, the Crisis Response Improvement Strategy Committee (CRIS Committee) focused on rural community behavioral health crisis response and the needs of rural residents and legislative developments including E2SB 6251 (laws of 2024) which supports community based crisis teams that are part of an emergency medical services agency, a fire service agency, a public health agency, a medical facility, a nonprofit crisis response provider, or a city or county government entity, other than a law enforcement agency, that provides the on-site community-based interventions of a mobile rapid response crisis team for individuals who are experiencing a behavioral health crisis.

In May, the CRIS lived experience committee met and discussed the Mental Health Crisis Call Diversion Initiative (MHCCDI), Olympic Heritage Behavioral Health, and Washington Speaks.

In June, the CRIS provided updates on the new 988 awareness campaign, focused on crisis services for youth, ways to ensure that 911 and 988 systems cooperate, and data collection.

According to Vibrant Emotional Health, the national 988 administrator, Washington's 988 crisis centers answered 8,307 calls, 3,310 texts, and 1,154 chats statewide in June 2024. In addition, there were 508 calls answered by the Native and Strong Lifeline in May 2024. New legislation passed during the 2024 legislative session (E2SB 6251) requires text and chat services to be offered through the Native and Strong Lifeline to the same extent as the general 988 Lifeline.

Washington State maintained answer rates above 91 percent for all 988 contacts. Phone contacts maintained a 91 percent answer rate for calls, 99 percent answer rate for texts, and 99 percent answer rate for chats. The overall call answer rate in Washington meets the national performance benchmark

Implementation plan

No updates at this time.

MH Health IT plan requirements

Activities on MH Health IT can be found in the Health Information IT section of this report.

Evaluation design

No updates to report at this time.

Monitoring protocol

No updates to report at this time.

Upcoming activities

Rulemaking

Designated 988 Contact Hubs - DOH is in the process of developing rules for DOH designation of 988 Contact Hubs based on input from community and Tribal listening sessions and workshops in 2022 and 2023. DOH again circulated the draft rules to interested parties in May 2024 and has completed its final pre-hearing feedback collection period. Work on the proposed rules (CR-102 rules) package continues, with the public hearing anticipated in August 2024. Final rules will be effective on January 1, 2025.

Legislation passed during the 2023 legislative session (2SSB 5120), requires that DOH establish rules to license or certify 23-hour Crisis Relief Centers (CRC). Information about this rulemaking process is available on the DOH's Behavioral Health Agency rulemaking webpage. On June 5, 2024, DOH held a public hearing with draft rules.

Legislation passed in 2023 (2SSB 5555) establishes certified peer support specialists and certified peer specialist trainees as new health professions. These new peer credentials must be available by July 1, 2025. The **Peer Specialist Rules in Progress webpage** includes information about the rulemaking process, including draft Peer Specialist rules.

Mobile Crisis Endorsement Standards - HCA initiated the rulemaking process to establish the mobile crisis endorsement standards for Community-Based Crisis Teams and Mobile Rapid Response Crisis Teams, as required under HB 1134 (2023) (see CR-101). HCA sought CRIS feedback through external review in June. The agency is also working with Tribes to establish Mobile Rapid Response Crisis Team standards specific to Tribal teams. To review the proposed rules, visit **Behavioral Health and Recovery Rulemaking | Washington State Health Care Authority**.

Contingency Management for SUD treatment implementation accomplishments

On July 1, 2023, Washington State received approval of its 1115 waiver (MTP 2.0) for new programs including Contingency Management. Contingency Management is an evidence-based behavioral intervention for stimulant use disorder. It provides incentives to individuals contingent upon objective evidence of the target behavior, such as a negative urine drug test, to increase the likelihood of these behaviors, which are essential components and outcomes of effective treatment.

This section summarizes the Contingency Management program development and implementation activities from April 1 through June 30, 2024.

Implementation progress

This quarter focused on finalizing the development of the Selection Survey, now called the Contingency Management (CM) interest and readiness tool. The Contingency Management (CM) interest and readiness tool was sent out to prospective participants via GovDelivery announcement. The survey responses are currently being received and gathered from prospective facilities for review at upcoming CM workgroup meetings.

Upcoming activities

Through a series of Contingency Management workgroup meetings, we anticipate completing the site selection process in the upcoming months. The selection will be based on the responses provided on the Contingency Management (CM) interest and readiness tool.

The CM workgroup will continue to work on the development of the Goods and Services Requests (GSRs) needed to develop the billing A-19 process. This process will be continuous until the necessary contracts for CM are executed.

We will continue to meet with the Contingency Management working group team and will meet with Washington State tribal representation to coordinate efforts for Contingency Management within the Washington Tribal community.

Continuous Enrollment implementation accomplishments

On July 1, 2023, Washington State received approval of its 1115 waiver (MTP 2.0) for new programs:

- The **Continuous Apple Health enrollment for children, ages 0 through 5,** program provides continued benefits for eligible children, ages 0 through the end of the month in which they turn 6 years old.
- The **Apple Health Postpartum coverage expansion** program provides continued benefits for individuals from the end of pregnancy through 12 months postpartum (for targeted individuals not covered by the SPA).

This section summarizes the Continuous Enrollment programs development and implementation activities from April 1 through June 30, 2024. Enrollment numbers are referenced in **Table 8**.

Continuous Apple Health enrollment for children, ages 0 through 5

Implementation progress

Since the approval date in April 2023, the state has provided continuous coverage for children on Medicaid, ages 0 through 5. Initially, the state utilized a manual process to ensure continuous coverage, reinstating benefits for any children under the age of six who may have lost coverage under the yearly redetermination process.

Full system support to provide continuous eligibility through automatic annual renewals was implemented in March 2024.

Upcoming activities

The state continues to outreach to families on continuous Apple Health enrollment.

Apple Health Postpartum coverage expansion

Implementation progress

The state implemented postpartum extension coverage in June 2022 under the American Rescue Plan Act (ARPA) and with state plan approval, Washington provides full coverage to those who were on Medicaid or Children's Health Insurance Program (CHIP) during their pregnancy. With waiver approval, Washington State is authorized to provide coverage to those who were not previously enrolled in Medicaid or CHIP during their pregnancy with income up to 193 percent of the federal poverty line until 12 months after their pregnancy ends.

Upcoming activities

By July 2024, the state will add this coverage group into managed care to be consistent with the other postpartum programs in Washington.

Reentry from a carceral setting implementation accomplishments

On July 1, 2023, Washington State received approval of its 1115 waiver (MTP 2.0) for new programs. The Reentry Demonstration Initiative (Reentry Initiative) provides individuals pre-release services up to 90 days prior to the expected date of release to their communities. This section summarizes the program development and implementation activities from April 1 through June 30, 2024.

Implementation progress

HCA sent an official invitation to all carceral facilities (Facilities) to support Washington's Reentry Initiative. Facilities will go-live with one of three cohorts, based on a facility's readiness. Participation in the reentry initiative is based on Facilities meeting the following milestones:

1) Submit an Intent to participate form indicating the facility's intent to participate and participation cohort. In the Intent to Participate form, participating facilities will also choose which cohort they will go-live with. Facilities that want to go live July 1, 2025, should submit their Intent to Participate form to HCA by June 1, 2024. Submitting this document signals a facility's:

- Agreement to participate in the initiative
- Completion of Milestone 1 (fill out and submit the Intent to Participate form)
- Ability to receive capacity building funding
- Complete a contractual agreement with HCA expressing willingness and ability to receive capacity funds to support the planning for and implementation of the initiative.

2) Complete a Capacity Building Application which includes an Implementation Plan. This plan describes how the facility will support pre-release services and a detailed budget that:

- Covers planned expenses
- Requests capacity building funding

3) Complete a Readiness Assessment attesting to the facility's current and/or planned readiness to support pre-release services. HCA will provide a template for the assessment and review and approve submitted assessments for the facility to go-live with pre-release services.

4) Submit Interim Progress Report on initial implementation progress on implementation.

5) Submit Final Progress Report on overall implementation progress and outcomes.

The state provided information to facilities on Reentry initiative cohorts, milestones and timing. Participating facilities will receive capacity building funding upon completing the planning and implementation milestones.

Table 19: Milestone due dates by cohort

	1) Intent to Participate form	2) Implementation Plan	3) Readiness Assessment	Go-live with pre-release services	4) Interim Progress Report	5) Final Progress Report
Cohort 1	June 1, 2024	Oct. 1, 2024	March 1, 2025	July 1, 2025	May 1, 2026	Oct. 1, 2026
Cohort 2	Nov. 1, 2024	April 1, 2025	Sept. 1, 2025	Jan. 1, 2026	Dec. 1, 2026	May 1, 2027
Cohort 3	May 1, 2025	Oct. 1, 2025	March 1, 2026	July 1, 2026	May 1, 2027	Oct. 1, 2027

To accompany the invitation, HCA provided Reentry Initiative question and answer webinars for the Washington Association of Sheriffs and Police including their stakeholders and partner staff; carceral facilities including adult and youth facilities; elected county officials; and other stakeholders to include ACHs and MCOs.

Other actions for this time frame include:

- HCA created a **frequently asked questions (FAQ) document** for distribution and an email box for questions.
- The Department of Children, Youth and Family (DCYF) representing juveniles joined the bi-weekly HCA/Department of Corrections (DOC) meetings to align efforts on the reentry initiative.
- HCA distributed a Request for Information (RFI) regarding a TPA role to support administrative and care management functions.

Upcoming activities

Welcoming facilities into Cohort 1. HCA plans to work with this Cohort, over this next year. HCA is planning on some activities and resources that will help support the facility in this first phase of the Reentry Initiative, such as:

- Attending a monthly Cohort 1 meeting to discuss ongoing activities for participating facilities.
- Attending one-on-one meetings to answer facility-specific questions.
- Attending technical assistance sessions.
- Lead Cohort 1 participants through a guidance document, which provides information on the Capacity Building Application (that includes the Implementation Plan) and Readiness Assessment.

Currently, HCA is developing the Capacity Building Application (plan for facility readiness).

HCA continues to engage several advisory groups including the Re-entry Advisory Workgroup (RAW). Initially mandated by legislation, RAW offers guidance on reentry program design and implementation. Comprised of representatives from state agencies, carceral facilities, associations, community-based organizations, and other justice-involved policy leaders, RAW collaborates to improve reentry services. Furthermore, HCA ensures alignment with reentry initiative requirements through coordination with DOC, DCYF, and Juvenile Detention Facilities. In addition, several implementation subgroups have been formed to advise on facility and provider readiness, system changes, care management continuity pre-release and post-release, eligibility and enrollment, and benefit design for the pre-release period.

HCA continues to work on several priority planning efforts including the following:

- Continued discussions and information gathering regarding a TPA role to support administrative and care management functions.
- Care management design, including pre-release and immediate post-release continuity of care.
- Benefit design for mandatory and secondary services, including parameters for progression from mandatory to secondary services by facility.
- Enrollment and plan assignment pre-release and post-release, including implications on the TPA role and Medicaid billing.

Health-related social needs (HRSN) implementation accomplishments

On July 1, 2023, Washington State received approval of its 1115 waiver (MTP 2.0) for new programs.

- The **Community Hubs** focus on community-based care coordination, including screening patients, determining patient needs, connecting patients to community organizations that can provide those needs, and more.
- The **Native Hub** is a statewide network of Indian health care providers, tribal social service divisions, and Native-led, Native-serving organizations focused on whole-person care coordination.
- **Health-related social needs (HRSN) services** include nutrition, housing, rental subsidies, transportation, and other non-medical HRSN services that help a person live their healthiest life.
- **HRSN Infrastructure** provides infrastructure investments to support the readiness for HRSN service delivery. Investments include technology, planning, workforce development, and convening.

This section summarizes the HRSN development and implementation activities from April 1 through June 30, 2024.

Community Hubs

Implementation progress

Following CMS's approval of the state's HRSN Infrastructure protocols, HCA evaluated submissions for ACHs seeking DY8 and DY9 infrastructure funding to support readiness for the delivery of hub services. In addition, HCA evaluated all 9 ACH submissions of hub readiness criteria and approved all submissions to launch their hubs upon CMS approval of the HRSN services protocol. Implementation of HRSN services is still pending CMS approval of the HRSN services protocol.

Upcoming activities

HCA will develop a process for reporting requirements for hub services. The state also continues to work on coordinating and aligning hub services with other HRSN services, reentry, and walking through CMS review of the HRSN service protocols.

Native Hub

The Native Hub is being co-developed between HCA, the 29 federally recognized Tribes, the two Urban Indian Health Programs (UIHPs) in Washington State and the American Indian Health Commission.

The Native Hub is not on the same timeline as the ACH community-based care coordination hubs, as the ACHs are established entities, many of whom had experience with care coordination under MTP 1.0.

Implementation progress

The Office of Tribal Affairs, along with Tribal partners, continues to refine the model and the role of the Native Hub in other areas of MTP 2.0, focusing on the Reentry Initiative and HCMACS. This is done through presentations and conversations that are occurring at regularly scheduled meetings.

Upcoming activities

The American Indian Health Commission will be hosting a caucus for the Tribes for them to discuss the direction and functionality they need out of the Native Hub.

Health related social needs (HRSN) services and infrastructure

Implementation progress

Following CMS feedback about Washington's initial HRSN services protocol submission, the state has submitted its revised HRSN services protocol. The state has also submitted its HRSN Implementation plan this quarter. With input from an internal workgroup and the Taking Action for Healthier Communities (TAHC) Task Force, the state has determined the initial phasing of HRSN service implementation:

- Phase 1a: case management, outreach, and education (to establish the community and Native hubs) Washington State Medicaid Transformation Project 2.0 demonstration Approval period: July 1, 2023, through June 30, 2028
- Phase 1b: Recuperative care and short-term post-hospitalization housing (medical respite), Housing transition navigation services, Rent/temporary housing
- Later phases: Nutrition support, stabilization centers, day habilitation, caregiver respite, environmental adaptations

The state's internal workgroup, along with sub-groups focused on specific services, continues to guide the planning and implementation of HRSN services.

Upcoming activities

The state continues to convene key external partners—notably the ACHs and MCOs—to design a collaborative process for delivering HRSN services.

The state continues to work on coordinating and aligning cross-initiatives work between HRSN services and reentry.

Quarterly expenditures

The following tables reflect quarterly expenditures for LTSS and FCS. Updated quarterly expenditures for DSRIP will be available during the next reporting period.

Table 20: DSRIP expenditures

	Q1 (July 1–September 30, 2023)	Q2 (October 1–December 31, 2023)	Q3 (January 1–March 31, 2024)	Q4 (April 1–June 30, 2024)	DY8 Total (July 1, 2023–June 30, 2024)	Funding source: Federal financial participation
Better Health Together	$0.0	$0.0	$0.0	$8,021,724	$8,021,724	$4,010,862
CHOICE	$0.0	$0.0	$0.0	$6,917,213	$6,917,213	$3,458,607
Elevate Health	$0.0	$0.0	$0.0	$5,364,236	$5,364,236	$2,682,118
Greater Health Now	$0.0	$0.0	$0.0	$10,460,610	$10,460,610	$5,230,305
HealthierHere	$0.0	$0.0	$0.0	$10,901,012	$10,901,012	$5,450,506
Thriving Together North Central Washington	$0.0	$0.0	$0.0	$4,077,056	$4,077,056	$2,038,528
North Sound	$0.0	$0.0	$0.0	$10,846,331	$10,846,331	$5,423,166
Olympic Community of Health	$0.0	$0.0	$0.0	$3,176,400	$3,176,400	$1,588,200
SWACH	$0.0	$0.0	$0.0	$5,052,441	$5,052,441	$2,526,221
Indian Health Care Providers	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0

Table 21: LTSS and FCS service expenditures

	Q1 (July 1–September 30)	Q2 (October 1–December 31)	Q3 (January 1–March 31)	Q4 (April 1–June 30)	DY8 Total (July 1, 2023–June 30, 2024)
Tailored Supports for Older Adults (TSOA)	$3,523,276	$5,388,884	$5,755,443	$8,193,419	$22,861,021.89
Medicaid Alternative Care (MAC)	$117,757	$179,833	$227,905	$249,070	$774,565.22
MAC and TSOA not eligible	$73.92	$-	$-	$-	$73.92
FCS	$13,587,308	$8,710,047	$10,649,513	$11,666,519	$44,613,387.00

Financial and budget neutrality development issues

Financial

The counts of member months eligible to receive services under MTP are detailed earlier in this report:

- **Table 7: Member months eligible to receive services**
- **Table 8: Member months eligible to receive services (Presumptive Eligibility, Post-Partum, Continuous Enrollment for Children)**

Member months for non-expansion adults are updated retrospectively, based on the current caseload forecast council (CFC) medical caseload data.

Budget neutrality

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

Designated state health programs (DSHP)

HCA continues to respond to DSHP questions from CMS during this past quarter. No new updates to provide.

Overall MTP development and issues

Operational/policy issues

HCA and agency partners continue to work with the Washington State Legislature to answer questions, provide implementation updates, and support budget development aligned with the MTP 2.0 CMS approval.

Consumer issues

The state has not experienced any major consumer issues for DSRIP, FCS, LTSS, or the SUD IMD waiver during this reporting quarter, other than general inquiries about benefits available through MTP, including new and continuing programs

MTP evaluation

The MTP independent external evaluator's (IEE) quarterly rapid cycle report was put on hold to allow the following activities:

- MTP 1.0 Summative Evaluation Report
- MTP 2.0 Evolution design

The MTP 2.0 evaluation design was submitted for CMS approval to in January of 2024. CMS provided feedback for changes in April of 2024. The evaluation design was returned to CMS June of 2024.

Upcoming IEE activities

The IEE and HCA await MTP 2.0 evaluation approval.

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

Attachment A: state contacts

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

Area	Name	Title	Phone
MTP and quarterly reports	Michael Arnis	Deputy Policy Director, SPI	360-725-0868
DSRIP program	Michael Arnis	Deputy Policy Director, SPI	360-725-0868
LTSS program	Debbie Johnson	Initiative 2 Program Manager, DSHS	360-725-2531
FCS program	Matthew Christie	Program Administrator, Foundational Community Supports	360-489-2021
SUD IMD waiver	David Johnson	Federal Programs manager	360-725-9404
MH IMD waiver	David Johnson	Federal Programs manager	360-725-9404
Continuous Eligibility	Maggie Clay	EPICS Deputy Section manager	360-725-1079
HRSN	Emma Oppenheim	Director, Medicaid Transformation Project	360-725-0868
Native Hub	Lena Nachand	Tribal Liaison, Office of Tribal Affairs	360-725-1386
Reentry	Emma Oppenheim	Director, Medicaid Transformation Project	360-725-0868
Contingency Management	Lora Weed	Acting Project Director, State Opioid Response Grant, State Opioid Response Treatment Manager	360-725-1998

For mail delivery, use the following address:

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

Attachment B: Financial Executor Portal Dashboard

Download an Excel file of this table, which shows all funds earned and distributed through the FE portal through June 30, 2024.

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
Demonstration name	Washington State Medicaid Transformation Project No. 11-W-00304/0
Approval date for demonstration	January 9, 2017
Approval period for SUD	July 1, 2018-June 30, 2023
Approval date for SUD, if different from above	July 17, 2018
Implementation date of SUD, if different from above	July 1, 2018
SUD (or if broader demonstration, then SUD -related) demonstration goals and objectives	Under Washington's 1115 demonstration waiver, the SUD program allows the state to receive Federal Financial Participation (FFP) for Medicaid recipients residing in institutions for mental disease (IMDs) under the terms of this demonstration for coverage of medical assistance including opioid use disorder (OUD)/substance use disorder (SUD) benefits that would otherwise be matchable if the beneficiary were not residing in an IMD. Under this demonstration, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to ongoing chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. Expenditure authority will allow the state to improve existing SUD services and ensure the appropriate level of treatment is provided, increase the availability of medication assisted treatment (MAT), and enhance coordination between levels of care. The state will continue offering a full range of SUD treatment options using the American Society for Addiction Medicine (ASAM) criteria for assessment and treatment decision making. Medical assistance including opioid use disorder (OUD)/substance use disorder (SUD) benefits that would

	otherwise be matchable if the beneficiary were not residing in an IMD.

2. Executive Summary

The state increased funding for outpatient SUD services, access to MOUD, and Naloxone.

The number of SUD providers increased from 9,592 in SFY 2022 to 10,876 in SFY 2023. The number of MAT providers increased from 3,908 in SFY 2022 to 4,666 in SFY 2023.

The number of individuals receiving outpatient SUD services has remained consistent over the past 12 months. The number of individuals receiving residential and inpatient services has increased slightly over the past 12 months. The number of individuals receiving withdrawal management services has increased over the past 12 months. The number of individuals receiving MAT has increased over the past 12 months.

Rates of initiation and engagement of AOD treatment have remained consistent with prior measurement years. The use of high dosage opioids in persons without cancer has remained stable over the past year.

Rates of SBIRT have increased in the past 12 months. Research within the state has highlighted some barriers to billing for SBIRT, including but not limited to staff turnover and uncertainty around reimbursement.

The rate of concurrent use of opioids and benzodiazepines has continued to decrease. The rate of continuity of pharmacotherapy for OUD has decreased slightly from CY 2021 but is consistent with prior years.

The number of overdose deaths has increased substantially over the past three years from 661 in SFY 2019 to 1,408 in SFY 2023. Trends in the data suggest that COVID-19 played a significant factor in this increase.

The rate of overdose deaths has also increased substantially from SFY 2019 to SFY 2023.

30 day and 7 day follow-up rates after an ED visit for alcohol and other drug abuse have declined from CY 2022 to CY 2023. However, the rates remain above the CY 2020 rates. 30 day and 7 day follow-up rates after an ED visit for mental illness have declined from CY 2022 to CY 2023. However, the rates remain above the CY 2020 rates.

The number of FCS beneficiaries with an inpatient or residential SUD services continues to increase and increased from 8.74% to 10.56% in the last year.

The overall SUD treatment rate has decreased slightly. However, the number of individuals receiving SUD treatment has increased over the past year.

The overall rate of ED utilization for SUD has increased slightly over the past year. This may be due to changes in overall ED use due to COVID-19.

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

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
1.2 Assessment of Need and Qualification for SUD Services			
1.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.	The monthly number of beneficiaries with an SUD diagnosis has varied slightly month-to-month, but remained within expected ranges in CY 2023.	04/01/2019 – 06/30/2019	#3: Medicaid beneficiaries with SUD diagnosis (monthly)
	N/A the state is not reporting this quarter due to a delay in metric processing.	07/01/2018 – 06/30/2019	#4: Medicaid beneficiaries with SUD diagnosis (annual)
	N/A the state is not reporting this quarter due to a delay in metric processing.	07/01/2018 – 06/30/2019	#5: Medicaid beneficiaries treated in an IMD for SUD
☐ The state has no metrics trends to report for this reporting topic.			
1.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to:			

☐ **i) The target population(s) of the demonstration.** ☐ **ii) The clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration.**			
☒ **The state has no implementation update to report for this reporting topic.**			
☐ **The state expects to make other program changes that may affect metrics related to assessment of need and qualification for SUD services.**			
☒ **The state has no implementation update to report for this reporting topic.**			
2.2 Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)			
2.2.1 Metric Trends			
☒ **The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1.**	The number of individuals receiving any SUD treatment receipt has remained consistent over the past 12 months.	04/01/2019 – 06/30/2019	#6: Any SUD Treatment
	Rates of SBIRT have increase in the past 12 months. Research within the state has highlighted some barriers to billing for SBIRT, including but not limited to staff turnover and uncertainty around reimbursement.	04/01/2019 – 06/30/2019	#7: Early Intervention
	The number of individuals receiving outpatient SUD services has remained consistent over the past 12 months.	04/01/2019 – 06/30/2019	#8: Outpatient Services
	The number of individuals receiving residential and inpatient services has increased slightly over the past 12 months.	04/01/2019 – 06/30/2019	#10: Residential and Inpatient Services

	The number of individuals receiving withdrawal management services has increased over the past 12 months.	04/01/2019 – 06/30/2019	#11: Withdrawal Management
	The number of individuals receiving MAT has increased over the past 12 months.	04/01/2019 – 06/30/2019	#12: Medication Assisted Treatment
	N/A the state is not reporting this quarter due to a delay in metric processing.	07/01/2018 – 06/30/2019	#36: Average Length of Stay in IMDs
☐ The state has no metrics trends to report for this reporting topic.			
2.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) Planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g., outpatient services, intensive outpatient services, medication assisted treatment, services in intensive residential and inpatient settings, medically supervised withdrawal management).** **☐ ii) SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and medication assisted treatment services provided to individuals in IMDs.**			

☒ The state has no implementation update to report for this reporting topic.
☐ The state expects to make other program changes that may affect metrics related to Milestone 1.
☒ The state has no implementation update to report for this reporting topic.
3.2 Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)
3.2.1 Metric Trends
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 2.
☒ The state has no trends to report for this reporting topic.
☐ The state is not reporting metrics related to Milestone 2.
3.2.2 Implementation Update
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria ☐ ii) Implementation of a utilization management approach to ensure (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, or (c) use of independent process for reviewing placement in residential treatment settings.

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

☐ **iii) Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site.**			
☒ **The state has no implementation update to report for this reporting topic.**			
☐ **The state expects to make other program changes that may affect metrics related to Milestone 3.**			
☒ **The state has no implementation update to report for this reporting topic.**			
☐ **The state is not reporting metrics related to Milestone 3.**			
5.2 Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)			
5.2.1 Metric Trends			
☒ **The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4.**	The number of SUD providers increased from 9,592 in SFY 2022 to 10,876 in SFY 2023.	07/01/2018 – 06/30/2019	#13: SUD provider availability
	The number of MAT providers increased from 3,908 in SFY 2022 to 4,666 in SFY 2023.	07/01/2018 – 06/30/2019	#14: SUD provider availability – MAT
☐ **The state has no trends to report for this reporting topic.**			
5.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to:			

☐ Planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care.			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 4.			
☒ The state has no implementation update to report for this reporting topic.			
6.2 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)			
6.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 5.	Rates of initiation and engagement of AOD treatment have remained consistent with prior measurement years.	01/01/2017 – 12/31/2017	#15: Initiation and Engagement of Alcohol and Other Drug Treatment
	The use of opioids at high dosage in persons without cancer has remained stable over the past year.	01/01/2018 – 12/31/2018	#18: Use of Opioids at High Dosage in Persons without Cancer (modified by State)

	The rate of concurrent use of opioids and benzodiazepines has continued to decrease.	01/01/2018 – 12/31/2018	#21: Concurrent Use of Opioids and Benzodiazepines (modified by State)
	The rate of continuity of pharmacotherapy for OUD has decreased slightly from CY 2021 but is consistent with prior years.	01/01/2018 – 12/31/2018	#22: Continuity of Pharmacotherapy for Opioid Use Disorder (modified by State)
☐ The state has no trends to report for this reporting topic.			
6.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD.** **☐ ii) Expansion of coverage for and access to naloxone.**			
☒ The state has no implementation update to report for this reporting topic.			

☐ **The state expects to make other program changes that may affect metrics related to Milestone 5.**			
☐ **The state has no implementation update to report for this reporting topic.**			
7.2 Improved Care Coordination and Transitions between Levels of Care (Milestone 6)			
7.2.1 Metric Trends			
☒ **The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 6.**	30 day and 7 day follow-up rates after an ED visit for alcohol and other drug abuse have declined from CY 2022 to CY 2023. However, the rates remain above the CY 2020 rates.	01/01/2017 – 12/31/2017	#17(1): Follow-Up after Emergency Department Visit for Alcohol or Other Drug Dependence
	30 day and 7 day follow-up rates after an ED visit for mental illness have declined from CY 2022 to CY 2023. However, the rates remain above the CY 2020 rates.	01/01/2017 – 12/31/2017	#17(2): Follow-Up after Emergency Department Visit for Mental Illness
☐ **The state has no trends to report for this reporting topic.**			
7.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to:			

☐ Implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports.			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 6.			
☒ The state has no implementation update to report for this reporting topic.			
8.2 SUD Health Information Technology (Health IT)			
8.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its Health IT metrics.	N/A the state is not reporting this quarter due to a change in the source system data.	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 overall SUD treatment rate has decreased slightly. However, the number of individuals receiving SUD treatment has increased over the past year.	07/01/2018 – 06/30/2019	Q2: Substance Use Disorder

			Treatment Penetration Rate
	The number of FCS beneficiaries with an inpatient or residential SUD services continues to increase and increased from 8.74% to 10.56% in the last year.	07/01/2018 – 06/30/2019	Q3: Foundational Community Supports Beneficiaries with Inpatient or Residential SUD Services
☐ The state has no trends to report for this reporting topic.			
8.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) How health IT is being used to slow down the rate of growth of individuals identified with SUD.** **☐ ii) How health IT is being used to treat effectively individuals identified with SUD.** **☐ iii) How health IT is being used to effectively monitor "recovery" supports and services for individuals identified with SUD.** **☐ iv) Other aspects of the state's plan to develop the health IT infrastructure/capabilities**			

at the state, delivery system, health plan/MCO, and individual provider levels. **☐ v) Other aspects of the state's health IT implementation milestones.** **☐ vi) The timeline for achieving health IT implementation milestones.** **☐ vii) Planned activities to increase use and functionality of the state's prescription drug monitoring program.**			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Health IT.			
☐ The state has no implementation update to report for this reporting topic.			
9.2 Other SUD-Related Metrics			
9.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to other SUD-related metrics.	The overall rate of ED utilization for SUD has increased slightly over the past year. This may be due to changes in overall ED use due to COVID-19.	04/01/2019 – 06/30/2019	#23: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries
	The overall rate of IP stays for SUD has increased slightly over the past year. This may be due to changes in overall IP use due to COVID-19.	04/01/2019 – 06/30/2019	#24: Inpatient Stays for SUD per

			1,000 Medicaid Beneficiaries
	The rate of readmission among beneficiaries with SUD has increased slightly, but remains lower than pre-COVID measurement years.	07/01/2018 – 06/30/2019	#25: Readmissions Among Beneficiaries with SUD
	The number of overdose deaths has increased substantially over the past three years from 661 in SFY 2019 to 1,408 in SFY 2023. Trends in the data suggest that COVID-19 played a significant factor in this increase.	07/01/2017 – 06/30/2018	#26: Overdose Deaths (count)
	The rate of overdose deaths has also increased substantially from SFY 2019 to SFY 2023.	07/01/2017 – 06/30/2018	#27: Overdose Deaths (Rate)
	N/A the state is not reporting this quarter due to a delay in metric processing.	01/01/2017 – 12/31/2017	#40: Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD.
	The overall rate of ED utilization for SUD has increased slightly over the past year. This may be due to changes in overall ED use due to COVID-19.	04/01/2019 – 06/30/2019	#23: Emergency Department Utilization for SUD per 1,000

	Medicaid Beneficiaries
☐ The state has no trends to report for this reporting topic.	
9.2.2 Implementation Update	
☐ The state expects to make other program changes that may affect metrics related to other SUD-related metrics.	
☒ The state has no implementation update to report for this reporting topic.	
10.2 Budget Neutrality	
10.2.1 Current status and analysis	
☐ If the SUD component is part of a broader demonstration, the state should provide an analysis of the SUD-related budget neutrality and an analysis of budget neutrality. Describe the status of budget neutrality and an analysis of the budget neutrality to date.	
10.2.2 Implementation Update	
☐ The state expects to make other program changes that may affect budget neutrality	
☒ The state has no implementation update to report for this reporting topic.	
11.1 SUD-Related Demonstration Operations and Policy	
11.1.1 Considerations	
☐ States should highlight significant SUD (or if broader demonstration, then SUD-related) demonstration operations or policy	

considerations that could positively or negatively affect beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.
☒ The state has no related considerations to report for this reporting topic.
11.1.2 Implementation Update
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) How the delivery system operates under the demonstration (e.g., through the managed care system or fee for service).** **☐ ii) Delivery models affecting demonstration participants (e.g., Accountable Care Organizations, Patient Centered Medical Homes).** **☐ iii) Partners involved in service delivery.**
☒ The state has no implementation update to report for this reporting topic.
☐ The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector

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

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

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

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

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

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

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

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

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

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

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

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

State	Washington
Demonstration name	Washington State Medicaid Transformation Project No. 11-W-00304/0
Approval date for demonstration	January 9, 2017
Approval period for SMI/SED	July 1, 2018-June 30, 2023
Approval date for SMI/SED, if different from above	November 6. 2020
Implementation date of SMI/SED, if different from above	December 23, 2020
SMI/SED (or if broader demonstration, then SMI/SED - related) demonstration goals and objectives	This demonstration amendment will provide authority for the state to receive FFP for delivering treatment to Medicaid beneficiaries diagnosed with SMI while they are short-term residents in settings that qualify as IMDs, primarily to receive treatment for SMI. The goal of this amendment is for the state to maintain and enhance access to mental health services, and continue delivery system improvements to provide more coordinated and comprehensive treatment for beneficiaries with SMI. With this approval, beneficiaries will have access to a continuum of services at new settings that, absent this amendment, would be ineligible for payment for most Medicaid enrollees.

2. Executive Summary

The state increased funding for outpatient and crisis services.

Across all three categories (all, less than/equal to 60 days, greater than 60 days), there was a decrease in the average length of stay despite an overall increase in the total number of stays. Across all three categories (all, less than/equal to 60 days, greater than 60 days), there was a decrease in the average length of stay despite an overall increase in the total number of stays.

The overall readmission rate remained stable from CY 2022 (14.65%) to CY 2023 (14.69%) despite a significant increase in the denominator and numerator.

The Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics increased slightly.

30 day and 7 day follow-up rates after an ED visit for alcohol and other drug abuse have declined from CY 2022 to CY 2023. However, the rates remain above the CY 2020 baseline rates.

30 day and 7 day follow-up rates after an ED visit for mental illness have declined from CY 2022 to CY 2023. However, the rates remain above the CY 2020 baseline rates.

The rates of mental health inpatient service utilization have varied slightly but remained generally consistent over the past 12 months (January 2023 to December 2023).

The rates of mental health intensive outpatient and partial hospitalization service utilization have increased slightly over the past 12 months.

The rates of mental health outpatient service utilization have increased over the past 12 months.

The rates of mental health emergency department service utilization have increased slightly over the past 12 months, but remain lower than pre-COVID rates.

The rate of telehealth mental health service utilization has decreased over the past 12 months, but remains significantly higher than pre-COVID utilization.

The overall rate of mental health service utilization has decreased over the past 12 months, but remains higher than the prior 12 months.

The monthly count of beneficiaries with SMI/SED decreased slightly across CY 2023.

The rate of access to preventive/ambulatory health services for Medicaid beneficiaries with SMI decreased from 95.26% in CY 2022 to 94.01% in CY 2023. However, there was a significant increase in both the denominator and numerator for the metric and the total number of individuals who accessed preventive/ambulatory health services increased by almost 50,000 individuals.

Metabolic monitoring rates remained largely consistent, with a slight decrease in the rate of blood glucose testing submetric.

The mental health treatment rate has increased from 53.49% in CY 2022 to 56.84% in CY 2023.

The percentage of FCS service recipients who had inpatient or residential mental health services continues to increase, from 11.16% in CY 2022 to 13.27% in CY 2023.

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

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
1.2 Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings (Milestone 1)			
1.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1.	The Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics increased slightly from 58.86% in CY 2022 to 60.6%.	01/01/2023 - 12/31/2023	Use of First-Line Psychosocial Care for Children and Adolescents on Anti-psychotics (APP-CH)
☐ The state has no metrics trends to report for this reporting topic.			
1.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) The licensure or accreditation processes for participating hospitals and residential settings** **☐ii) The oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements** **☐ iii) The utilization review process to ensure beneficiaries have access to the appropriate**			

levels and types of care and to provide oversight on lengths of stay **☐ iv) The program integrity requirements and compliance assurance process** **☐ v) The state requirement that psychiatric hospitals and residential settings screen beneficiaries for comorbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions** **☐ vi) Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings**		
☒ The state has no implementation update to report for this reporting topic.		
☐ The state expects to make the following program changes that may affect metrics related to Milestone 1.		
☒ The state has no implementation update to report for this reporting topic.		
2.2 Improving Care Coordination and Transitions to Community-Based Care (Milestone 2)		
2.2.1 Metric Trends		
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 2.	N/A state is not currently reporting this metric.	All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and

			Behavioral Health Care (PMH-20)
	The overall readmission rate remained stable from CY 2022 (14.65%) to CY 2023 (14.69%) despite a significant increase in the denominator and numerator.	01/01/2023 - 12/31/2023	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)
	N/A the state is not reporting this metric this quarter due to a delay in metric production.		Medication Continuation Following Inpatient Psychiatric Discharge
	N/A the state is not reporting this metric this quarter due to a delay in metric production.		Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH)
	N/A the state is not reporting this metric this quarter due to a delay in metric production.		Follow-up After Hospitalization for Mental Illness: Age 18 and

			Older (FUH-AD)
	30 day and 7 day follow-up rates after an ED visit for alcohol and other drug abuse have declined from CY 2022 to CY 2023. However, the rates remain above the CY 2020 baseline rates.	01/01/2023 - 12/31/2023	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA-AD)
	30 day and 7 day follow-up rates after an ED visit for mental illness have declined from CY 2022 to CY 2023. However, the rates remain above the CY 2020 baseline rates.	01/01/2023 - 12/31/2023	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)
☐ The state has no metrics trends to report for this reporting topic.			
2.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) Actions to ensure that psychiatric hospitals and residential treatment settings carry out intensive predischarge planning, and include community-based providers in care transitions** **☐ ii) Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers**			

☐ **iii) State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers within 72 hours post discharge** ☐ **iv) Strategies to prevent or decrease the lengths of stay in EDs among beneficiaries with SMI or SED (e.g., through the use of peers and psychiatric consultants in EDs to help with discharge and referral to treatment providers)** ☐ **v) Other State requirements/policies to improve care coordination and connections to community based care**			
☒ **The state has no implementation update to report for this reporting topic.**			
☐ **The state expects to make other program changes that may affect metrics related to Milestone 2.**			
☒ **The state has no implementation update to report for this reporting topic.**			
3.2 Access to Continuum of Care, Including Crisis Stabilization (Milestone 3)			
3.2.1 Metric Trends			
☒ **The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 3.**	The rates of mental health inpatient service utilization have varied slightly but remained generally consistent over the past 12 months (January 2023 to December 2023).	10/01/2023 - 10/31/2023	Mental Health Services Utilization - Inpatient
	The rates of mental health intensive outpatient and partial hospitalization service utilization have increased slightly over the past 12 months (January 2023 to December 2023).	10/01/2023 - 10/31/2023	Mental Health Services Utilization - Intensive Outpatient and Partial

			Hospitalization
	The rates of mental health outpatient service utilization have increased over the past 12 months (January 2023 to December 2023).	10/01/2023 - 10/31/2023	Mental Health Services Utilization - Outpatient
	The rates of mental health emergency department service utilization have increased slightly over the past 12 months, but remain lower than pre-COVID rates.	10/01/2023 - 10/31/2023	Mental Health Services Utilization - ED
	The rate of telehealth mental health service utilization has decreased over the past 12 months, but remains significantly higher than pre-COVID utilization.	10/01/2023 - 10/31/2023	Mental Health Services Utilization - Telehealth
	The overall rate of mental health service utilization has decreased over the past 12 months, but remains higher than the prior 12 months (CY 2022).	10/01/2023 - 10/31/2023	Mental Health Services Utilization - Any Services
	Across all three categories (all, less than/equal to 60 days, greater than 60 days), there was a decrease in the average length of stay despite an overall increase in the total number of stays.	10/01/2023 - 10/31/2023	Average Length of Stay in IMDs
	N/A the state is not reporting this metric this quarter due to a delay in metric production.		Beneficiaries With SMI/SED Treated in an IMD for

			Mental Health
☐ **The state has no trends to report for this reporting topic.**			
3.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) State requirement that providers use an evidenced-based, publicly available patient assessment tool to determine appropriate level of care and length of stay** **☐ ii) Other state requirements/policies to improve access to a full continuum of care including crisis stabilization**			
☒ **The state has no implementation update to report for this reporting topic.**			
☐ **The state expects to make other program changes that may affect metrics related to Milestone 3.**			
☒ **The state has no implementation update to report for this reporting topic.**			
4.2 Earlier Identification and Engagement in Treatment, Including Through Increased Integration (Milestone 4)			
4.2.1 Metric Trends			
☒ **The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4.**	The monthly count of beneficiaries with SMI/SED decreased slightly across CY 2023.	10/01/2023 - 10/31/2023	Count of Beneficiaries With SMI/SED (monthly)
	N/A the state is not reporting this metric this quarter due to a delay in metric production.		Count of Beneficiaries With

			SMI/SED (annually)
	N/A the state is not reporting this metric this quarter due to a delay in metric production.		Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)
	The rate of access to preventive/ambulatory health services for Medicaid beneficiaries with SMI decreased from 95.26% in CY 2022 to 94.01% in CY 2023. However, there was a significant increase in both the denominator and numerator for the metric and the total number of individuals who accessed preventive/ambulatory health services increased by almost 50,000 individuals.	10/01/2023 - 10/31/2023	Access to Preventive/ Ambulatory Health Services for Medicaid Beneficiaries With SMI
	Metabolic monitoring rates remained largely consistent, with a slight decrease in the rate of blood glucose testing submetric.	10/01/2023 - 10/31/2023	Metabolic Monitoring for Children and Adolescents on Antipsychotics
	N/A the state is not reporting this metric this quarter due to a delay in metric production.		Follow-Up Care for Adult Medicaid Beneficiaries Who are

	Newly Prescribed an Antipsychotic Medication
☐ **The state has no trends to report for this reporting topic.**	
4.2.2 Implementation Update	
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ **i) Strategies for identifying and engaging beneficiaries in treatment sooner (e.g., with supported education and employment)** ☐ **ii) Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment** ☐ **iii) Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED** ☐ **iv) Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people**	
☒ **The state has no implementation update to report for this reporting topic.**	
☐ **The state expects to make other program changes that may affect metrics related to Milestone 4.**	
☐ **The state has no implementation update to report for this reporting topic.**	

5.2 SMI/SED Health Information Technology (Health IT)			
5.2.1 Metric Trends			
☐ **The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its health IT metrics.**		01/01/2023 - 12/31/2023	Community Based Psychiatric Hospitals Using HIT for Discharge Summaries
	The mental health treatment rate has increased from 53.49% in CY 2022 to 56.84% in CY 2023.	01/01/2023 - 12/31/2023	Mental Health Treatment Penetration Rate
	The percentage of FCS service recipients who had inpatient or residential mental health services continues to increase, from 11.16% in CY 2022 to 13.27% in CY 2023.	01/01/2023 - 12/31/2023	Foundational Community Supports for Beneficiaries with Inpatient or Residential Mental Health Services
☐ **The state has no trends to report for this reporting topic.**			
5.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ **i) The three statements of assurance made in the state's health IT plan**			

☐ **ii) Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider and/or physician/mental health provider to community based supports** ☐ **iii) Electronic care plans and medical records** ☐ **iv) Individual consent being electronically captured and made accessible to patients and all members of the care team** ☐ **v) Intake, assessment and screening tools being part of a structured data capture process so that this information is interoperable with the rest of the health IT ecosystem** ☐ **vi) Telehealth technologies supporting collaborative care by facilitating broader availability of integrated mental health care and primary care** ☐ **vii) Alerting/analytics** ☐ **viii) Identity management**		
☒ **The state has no implementation update to report for this reporting topic.**		
☐ **The state expects to make the following program changes that may affect metrics related to health IT.**		
☒ **The state has no implementation update to report for this reporting topic.**		
6.2 Other SMI/SED-Related Metrics		
6.2.1 Metric Trends		
☒ **The state reports the following metric trends, including all changes (+ or -) greater than two 2**	N/A the state is not reporting this metric this quarter due to available data not being sufficiently mature.	Total Costs Associated With Mental

percent related to other SMI/SED-related metrics.			Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential
	N/A the state is not reporting this metric this quarter due to available data not being sufficiently mature.		Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED – Not Inpatient or Residential
	Across CY 2023, the number of grievances related to services for SMI/SED has remained low.	01/01/2023 - 12/31/2023	Grievances Related to Services for SMI/SED
	The number of appeals related to services for SMI/SED varied from quarter to quarter in CY 2023.	01/01/2023 - 12/31/2023	Appeals Related to Services for SMI/SED
	The number of critical incidents related to services for SMI/SED varied from quarter to quarter in CY 2023 but remained in the general range seen in prior years.	01/01/2023 - 12/31/2023	Critical Incidents Related to Services for SMI/SED

	N/A the state is not reporting this metric this quarter due to available data not being sufficiently mature.	Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED
	N/A the state is not reporting this metric this quarter due to available data not being sufficiently mature.	Per Capita Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED
☐ The state has no trends to report for this reporting topic.		
6.2.2 Implementation Update		
☐The state expects to make the following program changes that may affect other SMI/SED-related metrics.		
☒ The state has no implementation update to report for this reporting topic.		
7.1 Annual Assessment of the Availability of Mental Health Providers		
7.1.1 Description Of Changes To Baseline Conditions And Practices		
☐ Describe and explain any changes in the mental health service needs (for example, prevalence and distribution of SMI/SED) of		

Medicaid beneficiaries with SMI/SED compared to those described in the Initial Assessment of Availability of Mental Health Services. **Recommended word count is 500 words or less.**
☐ This is not an annual report, therefore the state has no update to report for this reporting topic.
☐Describe and explain any changes to the organization of the state's Medicaid behavioral health service delivery system compared to those described in the Initial Assessment of Availability of Mental Health Services. Recommended word count is 500 words or less.
☐ This is not an annual report, therefore the state has no update to report for this reporting topic.
☐ Describe and explain any changes in the availability of mental health services for Medicaid beneficiaries with SMI/SED in the state compared to those described in the Initial Assessment of Availability of Mental Health Services. At minimum, explain any changes across the state in the availability of the following services: inpatient mental health services; outpatient and community-based services; crisis behavioral health services; and care coordination and care transition planning. Recommended word count is 500 words or less.
☐ This is not an annual report, therefore the state has no update to report for this reporting topic.
☐Describe and explain any changes in gaps the state identified in the availability of mental health services or service capacity while completing the Availability Assessment compared to those described in the Initial Assessment of Availability of Mental Health Services.

Recommended word count is 500 words or less.
☐This is not an annual report, therefore the state has no update to report for this reporting topic.
7.1.2 Implementation Update
☐ Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) The state's strategy to conduct annual assessments of the availability of mental health providers across the state and updates on steps taken to increase availability** **☐ ii) Strategies to improve state tracking of availability of inpatient and crisis stabilization beds**
☒ The state has no implementation update to report for this reporting topic.
8.1 SMI/SED Financing Plan
8.1.1 Implementation Update
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, and observation/assessment centers, with a coordinated community crisis response that involves law enforcement and other first responders** **☒ ii) Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial**

hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model
☐ The state has no implementation update to report for this reporting topic.
9.2 Budget Neutrality
9.2.1 Current Status and Analysis
☐ If the SMI/SED component is part of a broader demonstration, the state should provide an analysis of the SMI/SED-related budget neutrality and an analysis of budget neutrality as a whole. Describe the current status of budget neutrality and an analysis of the budget neutrality to date.
9.2.2 Implementation Update
☐ The state expects to make the following program changes that may affect budget neutrality.
☒ The state has no implementation update to report for this reporting topic.
10.1 SMI/SED-Related Demonstration Operations and Policy
10.1.1 Considerations
☐ States should highlight significant SMI/SED (or if broader demonstration, then SMI/SED-related) demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SMI/SED

demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.
☒The state has no related considerations to report for this topic.
10.1.2 Implementation Update
☐ The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities.
☒ The state has no implementation update to report for this reporting topic.
☐The state is working on other initiatives related to SMI/SED.
☒The state has no implementation update to report for this reporting topic.
☐The initiatives described above are related to the SMI/SED demonstration as described (States should note similarities and differences from the SMI/SED demonstration).
☒The state has no implementation update to report for this reporting topic.
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) How the delivery system operates under the demonstration (e.g. through the managed care system or fee for service)** **☐ ii) Delivery models affecting demonstration participants (e.g. Accountable Care**

Organizations, Patient Centered Medical Homes) **☐ iii) Partners involved in service delivery** **☐ iv) The state Medicaid agency's Memorandum of Understanding (MOU) or other agreement with its mental health services agency**
☒The state has no implementation update to report for this reporting topic.
11 SMI/SED Demonstration Evaluation Update
11.1. Narrative Information
☐ Provide updates on SMI/SED evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. See report template instructions for more details.
☒ The state has no SMI/SED demonstration evaluation update to report.
☐Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.
☒The state has no SMI/SED demonstration evaluation update to report.
☐List anticipated evaluation-related deliverables related to this demonstration and their due dates.
☒The state has no SMI/SED demonstration evaluation update to report.
12.1 Other Demonstration Reporting
12.1.1 General Reporting Requirements

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

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

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

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

("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 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.

Washington State Health Care Authority

Medicaid Quality Improvement Program

Report to Joint Select Committee on Health Care Oversight

Reporting period: April 1, 2024–June 30, 2024

Background

The Washington State Legislature authorized the Medicaid Quality Improvement Program (MQIP) during the 2020 Legislative session to support the Medicaid Transformation Project (MTP). MQIP allows Washington State to implement quality improvement programs for people enrolled in Apple Health (Medicaid).

Under MQIP, Medicaid managed care organizations (MCOs) are responsible for partnering with participating public hospitals to implement activities that:

- Reinforce the delivery of quality health care
- Support community health

Through MQIP, MCOs will receive incentive funds to share with participating public hospitals when they meet specific milestones. The Association of Washington Public Hospital Districts (AWPHD) and University of Washington Medicine (UW Medicine) are state public hospitals participating under MQIP, in partnership with MCOs.

HCA worked with MQIP partners throughout Q2 2023 to discuss new program parameters for MQIP 2.0 to correspond with the launch of MTP 2.0 effective July 1, 2023. The milestones under MQIP 2.0 will restart at Milestone 1 based on the new parameters being established.

Under MQIP 2.0, HCA will focus on improving social needs screening rates and reporting to help address inequities and social determinants of health. To do this, HCA will engage collaboratively with MCOs and their network providers to design a strategy to improve social needs screening rates and reporting.

The initial design of MQIP 2.0 was focused on alignment with the new National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measure, Social Need Screening and Intervention (SNS-E). However, after partnering providers completed Milestone 1, the focus of MQIP 2.0 shifted to pursue social needs screening projects more broadly. MCOs and their network providers will screen patients for three types of social needs: food, housing, and transportation.

Implementation status and results

During Q3 of 2023, HCA implemented a social needs screening survey as a required deliverable for all MQIP partners. This survey captures information regarding SNS-E readiness, current practices regarding social needs screening and interventions, and information regarding screening categories and tools used.

During Q4 of 2023, all MQIP partners completed the survey to receive payments for Milestone 1. These survey results informed discussions regarding social needs screening, appropriate screening categories and tools, and alignment between SNS-E requirements and other agency priorities such as Health-Related Social Needs (HRSN) services under MTP 2.0. Key results from the survey included the following:

- The top three tools used for social needs screenings were the following: Protocol for Responding to and Assessing Patients Assets, Risks and Experiences (PRAPARE), Accountable Health Communities, Hunger Vital Sign
- Other HRSN categories identified were financial resources, social connectedness, and safety.
- Most social needs screenings occur upon enrollment within an MCO or entry into a provider facility.

- The top barriers identified in implementing SNS project changes were billing coding issues, data infrastructure and fragmentation, and capacity issues with both providers and community-based organizations to address positive social needs screenings.

During Q1 of 2024, MQIP partners created a SNS project proposal that works to standardize SNS practices across partnering public hospitals. HCA approved MQIP partners project proposal in early Q2 of 2024.

Recognizing the importance of social needs screenings for care coordination, efforts are currently underway to create consistency and reduce variability in SNS across both UW and AWPHD's health delivery systems. Practices are being developed locally by individual clinics or facilities. Currently, there is no uniform referral practice, but efforts are in progress to align practices and goals. Referrals are primarily internal, facilitated through limited social worker outreach, with each entity having its own resources and processes to support patients in meeting their social needs. Much of this variation is due to geographical differences and the availability of external resources.

There is a continuous effort to create and maintain a shared set of resources by health systems or hospitals. However, access to and availability of various resources remains limited.

To address current state and streamline social needs screening and referral practices, MCOs and partnering providers will seek to:

- Reduce variation and support resource alignment across provider networks
- Develop shared screening policies and procedures
- Develop shared referral processes and procedures

In Q3 of 2024, MQIP partners will work on implementing the infrastructure needed to undertake a project of this scale. These activities include stakeholder convening across provider networks, defining shared tools and measure sets available in current electronic health record systems, and selecting and implementing pilot sites for Q4.

Milestones, payment, and improvement measures

Reporting periods occur every six months and each reporting period represents a milestone for approval and payment.

As part of achieving a milestone, AWPHD and UW Medicine submit an implementation plan status report, updated work plan, or other required deliverables based on parameters established by HCA. Data from Milestone 1 survey completion will be reported in future MQIP reports once those results have been synthesized.

Washington State Health Care Authority

Expenditures

HCA released MQIP payments for Milestone 2 in June 2024. The total payment amount was $104,706,785.96 across MQIP partners.

Table 1: MCO-earned admin and payments to public hospitals (June 2024)

	Amerigroup	Community Health Plan	Coordinated Care	Molina	United Healthcare	Total
Admin	$150,000.00	$150,000.00	$150,000.00	$150,000.00	$150,000.00	$750,000.00
UW Medicine	$11,643,160.00	$9,979,851.00	$40,751,060.00	$10,811,506.77	$9,979,851.00	$83,165,428.77
Evergreen Healthcare & Valley Medical Center	$2,561,496.00	$2,195,568.00	$8,965,232.19	$2,378,530.00	$2,195,568.00	$18,296,394.19
AWPHD	$140,000.00	$120,000.00	$490,000.00	$130,000.00	$120,000.00	$1,000,000.00
Public Hospitals Statewide	$209,294.50	$179,396.00	$732,531.50	$194,345.00	$179,396.00	$1,494,963.00
Total	$14,703,950.50	$12,624,815.00	$51,088,823.69	$13,664,381.77	$12,624,815.00	$104,706,785.96

Washington State Health Care Authority

Medicaid Transformation Project

Health Care Authority	SFY 22-23 Budget	SFY 22 Expenditures to Date	SFY 23 Expenditures to Date	SFY 22-23 Total Expenditures	SFY 24-25 Budget	SFY 24 Expenditures to Date	SFY 25 Expenditures to Date	SFY 24-25 Total Expenditures
MTP 2.0	**$0**	**$0**	**$0**	**$0**	**$146,982,000**	**$2,157,980**	**$0**	**$2,157,980**
Admin (GF-F)	$0	$0	$0	$0	$ 5,196,000	$2,157,980	$0	$2,157,980
HRSN Services (GF-F)	$0	$0	$0	$0	$ 141,786,000	$0	$0	$0
MTP 2.0	**$88,813,000**	**$40,640,750**	**$11,803,229**	**$52,443,980**	**$146,982,000**	**$2,157,975**	**$0**	**$2,157,975**
Admin (GF-L)	$6,259,500	$2,095,400	$2,698,013	$4,793,413	$ 5,196,000	$2,157,975	$0	$2,157,975
HRSN Services (GF-L)	$82,553,500	$38,545,351	$9,105,217	$47,650,567	$ 141,786,000	$0	$0	$0
Initiative 1 - DSRIP	**$93,094,000**	**$42,934,419**	**$12,037,457**	**$54,971,876**	**$3,137,000**	**$807,560**	**$0**	**$807,560**
Admin (GF-F)	$10,540,500	$4,389,068	$2,932,241	$7,321,309	$3,137,000	$807,560	$0	$807,560
DSRIP Incentives (GF-F)	$82,553,500	$38,545,351	$9,105,217	$47,650,567	$0	$0	$0	$0
Initiative 1 - DSRIP	**$88,813,000**	**$40,640,750**	**$12,037,453**	**$52,678,204**	**$3,137,000**	**$807,559**	**$0**	**$807,559**
Admin (GF-L)	$6,259,500	$2,095,400	$2,932,237	$5,027,637	$3,137,000	$807,559	$0	$807,559
DSRIP Incentives (GF-L)	$82,553,500	$38,545,351	$9,105,217	$47,650,567	$0	$0	$0	$0
Initiative 2 - DSHS MAC/TSOA**	$79,456,000	$22,281,245	$36,606,249	$58,887,494	$116,654,000	$22,595,386	$0	$22,595,386
MAC/TSOA (GF-F)	$39,728,000	$11,140,623	$17,942,783	$29,083,406	$58,321,000	$11,398,827	$0	$11,398,827
MAC/TSOA (GF-L)	$39,728,000	$11,140,622	$18,663,466	$29,804,089	$58,333,000	$11,196,558	$0	$11,196,558
Initiative 3 - FCS	**$57,244,000**	**$22,207,860**	**$34,223,664**	**$56,431,524**	**$65,148,000**	**$39,194,343**	**$0**	**$39,194,343**
FCS SE ADMIN (GF-F)	$1,046,500	$837,747	$632,865	$1,470,612	$ 1,106,000.00	$809,423	$0	$809,423
FCS SE ADMIN (GF-L)	$1,046,500	$320,018	$632,865	$952,883	$ 1,106,000.00	$809,422	$0	$809,422
FCS SE SERVICES (GF-F)	$14,919,690	$6,099,491	$6,157,951	$12,257,442	$ 17,705,980.00	$7,259,479	$0	$7,259,479
FCS SE SERVICES (GF-L)	$6,094,810	$1,190,489	$2,754,074	$3,944,563	$ 7,232,020.00	$2,893,196	$0	$2,893,196
FCS SH ADMIN (GF-F)	$1,853,000	$1,372,000	$1,472,386	$2,844,387	$ 2,002,500.00	$2,000,804	$0	$2,000,804
FCS SH ADMIN (GF-L)	$1,852,000	$609,287	$1,472,386	$2,081,674	$ 2,002,500.00	$2,000,803	$0	$2,000,803
FCS SH SERVICES (GF-F)	$21,605,550	$9,653,753	$14,454,503	$24,108,255	$ 24,135,030.00	$16,396,528	$0	$16,396,528
FCS SH SERVICES (GF-L)	$8,825,950	$2,125,074	$6,646,633	$8,771,708	$ 9,857,970.00	$7,024,688	$0	$7,024,688
Agency Admin (GF-F)	$0	$0	$0	$0	$0	$0	$0	$0
Initiative 3 - FCS**	**$1,170,000**	**$615,387**	**$493,594**	**$1,108,981**	**$1,580,000**	**$817,335**	**$0**	**$817,335**
DSHS FCS ADMIN (GF-F)	$585,000	$307,694	$246,797	$554,490	$790,000	$408,668	$0	$408,668
DSHS FCS ADMIN (GF-L)	$585,000	$307,693	$246,797	$554,490	$790,000	$408,667	$0	$408,667

DSHS - ALTSA	SFY 22 Budget	SFY 22 Expenditures to Date		SFY 22 Expenditures to Date	SFY 24-25 Budget	SFY 24 Expenditures to Date	SFY 25	SFY 24-25 Expenditures to Date
Initiative 2 - MAC and TSOA	**$29,292,000**	$27,344,798	$0	**$27,344,798**	$ -		$0	**$0**
Initiative 3 - FCS	**$624,000**	$350,546	$0	**$350,546**	$0	$0	$0	**$0**

DSHS and HCA (Community Behavioral Health)	SFY 22-23 Budget	SFY 22 Expenditures to Date*	SFY 23 Expenditures to Date*	SFY 22- 23 Expenditures to Date*	SFY 24-25 Budget	SFY 24 Expenditures to Date*	SFY 25 Expenditures to Date*	SFY 24-25 Expenditures to Date*
Initiative 3 - FCS	**$3,364,000**	**$937,771**	**$752,540**	**$1,690,311**	**$4,367,000**	**$1,041,826**	**$0**	**$1,041,826**
FCS (GF-F)	$2,104,000	$711,715	$376,218	$1,087,933	$2,183,500	$520,914	$0	$520,914
FCS (GF-L)	$1,260,000	$226,056	$376,322	$602,377	$2,183,500	$520,912	$0	$520,912

*Administrative staff costs only. FCS admin and service expenditures (TPA costs) are paid from HCA's budget. As of SFY19, CBH merged with HCA.

**Per ESSB 5092, effective January 1, 2022 DSHS waiver expenditures (for Initiative 2 and 3) are appropriated under HCA's budget.

DSRIP - Delivery System Reform Incentive Payment

FCS - Foundational Community Supports

MAC and TSOA - Medicaid Alternative Care and Tailored Supports for Older Adults

Expenditures are reported on a cash basis and include liquidations.