Washington State Medicaid Transformation Project (MTP) Demonstration
Section 1115 Waiver Quarterly Report
Demonstration Year: 2 (January 1, 2018 to December 31, 2018)
Reporting Quarter: July 1, 2018 to September 30, 2018

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Introduction

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

Over the next five years, Washington aims to:

- Integrate physical and behavioral health purchasing and service delivery to better meet whole person needs.
- Convert 90 percent of Medicaid provider payments to reward outcomes instead of volume.
- Support provider capacity to adopt new payment and care models.
- Implement population health strategies that improve health equity.
- Provide new targeted services that address the needs of the state's aging populations and address key determinants of health.

The state will address the aims of the demonstration through three programs:

- Transformation through Accountable Communities of Health (ACHs) and Delivery System Reform Incentive Payment (DSRIP) program
- Long-term Services and Supports (LTSS) – Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)
- Foundational Community Supports (FCS) – Targeted Home and Community-Based Services (HCBS) for eligible individuals

Healthier Washington

The Washington State Health Care Authority (HCA) manages the work of the demonstration under the banner of Governor Jay Inslee's Healthier Washington initiative. Healthier Washington is a multi-sector partnership working to improve health, transform care delivery, and reduce costs.

To learn more about Healthier Washington, visit www.hca.wa.gov/hw.

Quarterly report – July 1, 2018 to September 30, 2018

This quarterly report summarizes the Medicaid Transformation Project (MTP) activities from July 1, 2018 through September 30, 2018. This quarterly report includes details pertaining to MTP implementation activities, including stakeholder education and engagement, planning and implementation activities, and development of key policies and procedures.

Summary of key accomplishments of the quarter

Highlights of the quarter described in the report:

- Submission and assessment of ACH semi-annual reports
- Enrollment of over 2,200 individuals in LTSS programs
- FCS provider network capacity building
- Substance use disorder (SUD) program approval and implementation design

Stakeholder and partner engagement

Demonstration-wide stakeholder engagement

During the reporting quarter, the state continued its robust stakeholder communication strategy:

- Program-specific, frequently asked questions were routinely updated in response to public interest and inquiry. Questions were generated from a variety of forums, including webinars, presentations and stakeholder interaction, and used to clarify and define programmatic development.
- One-page documents summarizing the three MTP initiatives continue to be available online. New materials are continually developed for and updated on the webpage, including information on ACH projects and earned incentives, benefit guides for MAC and TSOA, as well as FCS provider resource guides.
- A new FCS monthly newsletter, Foundations, is in the final stages of production. Robust promotion began in early September and the distribution sign-up list is growing rapidly. The first issue will be delivered October 10.
- Broad communication with stakeholders and the public was maintained through existing communication channels managed by Healthier Washington, Health Care Authority (HCA), Department of Social and Health Services (DSHS), and partner agencies, including emails to the Healthier Washington "Feedback Network" mailing lists, social media posts and quarterly email newsletter digests.
- The state held two public forums in August and September to inform the public about the progress of the Healthier Washington Medicaid Transformation and provide opportunities for meaningful public comment. The forums were heavily promoted by Healthier Washington in newsletters, targeted emails, and shared on the Healthier Washington public-facing calendar of events. ACHs helped promote the events, especially HealtherHere, which co-hosted the Tukwila event, and Better Health Together, which co-hosted the Spokane event.
    - Attendees of the forums included physical and behavioral health providers, managed care organization representatives, representatives of housing groups, Medicaid beneficiaries, members of community based organizations, and people interested in Medicaid Transformation. Guests at both events participated robustly in the public conversation periods. Discussion revolved largely around equity and social determinants of health, and the benefits offered through Long-term Services and Supports (LTSS).
    - The state will host a third public forum via webinar during the next reporting quarter.

Tribal partner engagement

HCA continued to visit every Indian Health Care Provider (IHCP) to provide clarification and guidance on the use of Medicaid Transformation funds. These visits proved invaluable to all who participated, for purposes of communication, knowledge sharing and rapport building. The state has placed importance on meeting with each of the 31 sites to provide clarification on how IHCP-specific project funds differ from both typical grant programs and traditional Medicaid funds. The following site visits and engagement activities occurred during the reporting quarter:

- July 9, 2018: Participated in a Tribal/IHCP meeting hosted by the Olympic Community of Health at the Jamestown S'Klallam Tribe to present to the IHCP health directors on IHCP-specific funds and projects, and site visit at the Quinault Indian Nation

- July 10, 2018: Site visits at Chehalis Tribe and Shoalwater Bay Tribe
- July 11, 2018: Site visit at the Nisqually Indian Tribe
- July 11, 2018: Participated in roundtable discussion on health equity with john a. powell, Director of the Haas Institute for a Fair and Inclusive Society, staff of the North Sound ACH and ACH evaluation staff from the Center for Community Health and Evaluation (CCHE)
- July 30, 2018: Site visit at the Confederated Tribes of the Colville Reservation.
- August 2, 2018: Site visit at the Cowlitz Indian Tribe
- August 6, 2018: Participated in a meeting at the Nisqually Indian Tribe on Foundational Community Supports (FCS), which included tribal staff, HCA staff and third-party administrator, Amerigroup, staff
- August 7, 2018: Site visit at the Hoh Tribe
- August 9, 2018: Attended the American Indian Health Commission of Washington State (the tribal coordinating entity for IHCP-specific funds) quarterly meeting
- August 15, 2018: Site visit at the Quileute Nation
- August 16, 2018: Site visit at the Makah Tribe
- August 17, 2018: Participated in a meeting on FCS with the American Indian Community Center (AICC), Better Health Together and Amerigroup
- August 23, 2018: Participated in the Cascade Pacific Action Alliance (CPAA) Tribal Health Directors meeting at the Nisqually Indian Tribe
- August 28, 2018: Site visit at the Lower Elwha Klallam Tribe
- August 29, 2018: Site visits at the Squaxin Island Tribe and the Skokomish Indian Tribe
- August 30, 2018: Site visits at the Sauk-Suiattle Indian Tribe and the Nooksack Indian Tribe
- September 4, 2018: Site visit at the Suquamish Tribe
- September 7, 2018: Site visit for the Puyallup Tribe of Indians
- September 10, 2018: Participated in a meeting regarding the future of Healthier Washington and the roles for statewide and community partners
- September 11, 2018: Participated in the North Sound ACH Tribal Alignment Committee meeting at the Lummi Nation
- September 14, 2018: Participated in a meeting regarding ACH and Tribal Opioid response plans
- September 20, 2018: Participated in the Better Health Together Tribal Partners Leadership Meeting at the Lake Roosevelt Health Clinic on the Colville Reservation
- September 21, 2018: Site visit at the Snoqualmie Tribe
- September 24-25, 2018: Attended the 2018 Centennial Accord at the Suquamish Tribe

Additionally, DSHS Aging and Long-Term Support Administration (ALTSA) met with a number of tribes to discuss Medicaid services including FCS and LTSS during the reporting period:

- August 22, 2018: Sent public service announcement regarding caregiving to 28 distinct emails representing tribal newspapers (see Attachment B)
- September 21, 2018: Discussed MAC/TSOA and other Medicaid services at a meeting with the Hoh Tribe
- September 24, 2018: Discussed a variety topics with tribes, including MAC and TSOA, at the DSHS Health Summit

- September 11, 2018: Distributed PSA for caregiving services, including MAC/TSOA and distributed updated chart of services with MAC/TSOA listed, at the DSHS Indian Policy Advisory Subcommittee meetings for Aging and Developmental Disability Services

DSRIP program stakeholder engagement activities

Representatives of HCA have participated in numerous stakeholder engagement activities, including public forums, presentations, emails, webinars, and direct technical assistance. HCA continued to host weekly Transformation Alignment Calls with ACHs, key state partners, and other stakeholders and partners by invitation or request. Among other topics, themes this quarter included MTP reporting and implementation planning guidance, Medicaid Transformation Learning Symposium planning, and various data and analytics presentations to discuss available or developing resources to support implementation and monitoring.

HCA Director Sue Birch attended several ACH board meetings and met with ACH partners and staff in a variety of forums during this quarter. Topics included Medicaid Transformation, the role of ACHs to support Healthier Washington, and payment reform for rural partners.

Additionally, the following engagement activities occurred during the reporting quarter:

- July 20, 2018: The Health Innovation Leadership Network (HILN) held its quarterly meeting, continuing the discussion around strategies to advance health equity across Healthier Washington efforts, including aligned efforts within Medicaid Transformation. Participants included ACHs, tribal partners, payers, state agencies, and state associations. Staff members from HCA and HealthierHere presented on community-led health equity efforts, and integrating community voice into health systems transformation.
- August 14, 2018: HCA presented an update to the Health IT Operational Plan to ACHs and stakeholders. The HIT team highlighted the SUD workgroup, MTP waiver amendment, and the 2019 Health IT Operations Plan planning.
- September 11, 2018: HCA presented an update to the Health IT Operational Plan to ACHs and stakeholders. The HIT team highlighted the Health IT Operations Plan Q2 report, SUD workgroup, MTP waiver amendment, Master Patient Index, and Provider Directory.
- September 28, 2018: The state released the updated DSRIP Measurement Guide on the Medicaid Transformation resources webpage. The update incorproated stakeholder feedback received during the public review period in February, as well as updates to reflect DSRIP program development.

LTSS program stakeholder engagement activities

The following LTSS stakeholder engagement activities occurred during the reporting quarter:

- July 26, 2018: A joint presentation with Community Services Division and ALTSA/AAA was conducted in Yakima for the Virginia Mason Hospital discharge planners. The purpose of the presentation was to inform discharge planners about financial eligibility for LTSS programs, the services/supports available through these programs and how to make referrals. Information about caregiver supports under MAC and TSOA was included in this discussion.
- August 2018: DSHS Home and Community Services (HCS) Director Bea Rector highlighted the work under Medicaid Transformation at the NASUAD Annual HCBS Conference, in a session titled “Unpaid Family Caregiver Supports and Services to Delay or Divert at Risk Individuals from Intensive LTSS.” The

purpose of this session was to illustrate to other states and partners the innovative way that Washington State is supporting unpaid family caregivers through the 1115 waiver.

- ALTSA joined with local hospital systems to sponsor a series of hospital summits across the state aimed at cross-system learning, collaboration, and design of an actionable plan at the local level to move forward on reducing barriers to discharging clients from hospitals back to the community. During these events, the state highlighted programs under the LTSS program as yet another way to meet the needs of care receivers and their caregivers in the community.
    - July 13, 2018: Clark and Cowlitz Hospital Transitions Solutions Summit
    - September 13, 2018: Spokane Area Hospital Transitions Solutions Summit

In addition, the following MAC and TSOA outreach campaign activities occurred during the quarter:

- MAC and TSOA brochures were updated and made available during this quarter. Revisions included adding more culturally diverse photos. They can be viewed at DSHS 22-1781.pdf, DSHS 22-1782.pdf, DSHS 22-1739.pdf.
- Caregiver outreach articles were published in a Yakima area newspaper for Spanish speaking community members.
- MAC/TSOA social media advertisements were placed on Facebook and Comcast venues.

FCS program stakeholder engagement activities

During the reporting quarter, staff from HCA's Policy Division and Division of Behavioral Health and Recovery (DBHR), ALTSA, and Amerigroup Washington (the FCS Third Party Administrator) supported a variety of stakeholder engagement activities. An aggregated summary of activities is listed in the table below.

FCS Program Stakeholder Engagement Activities			
	July	August	September
Training and assistance provided to individual organizations	22	16	39
Community and regional presentations and training events	3	9	3
Informational webinars	0	2	3
Stakeholder engagement meetings	6	4	8
Total Activities	**31**	**31**	**53**

Key concerns raised by stakeholders

DSRIP program stakeholder concerns. Some stakeholders have requested more information regarding the use of DSRIP funds once earned and paid out by ACHs. In response, HCA has developed quarterly incentive reports, using information from the Financial Executor portal, to supplement ACH narrative reporting. The quarterly incentive reports describe how funds are used according to the established use categories, and are available on

the Medicaid Transformation resources page.[1] In addition, HCA continues to work with the Financial Executor to develop a public-facing website to streamline access to funds flow information.

FCS program stakeholder concerns. Community Support Service (CSS) providers requested clarification regarding chronic homelessness documentation requirements for the purpose of FCS eligibility. Local, state, and federal housing and service programs that use the U.S. Department of Housing and Urban Development's (HUD) definition of chronic homelessness require different standards of documentation to prove that an individual meets the HUD definition of chronic homelessness. In response, the state developed FCS chronic homelessness documentation guidance. The state has received feedback from providers that this clarification has addressed the confusion regarding chronic homelessness documentation requirements.

[1] https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-resources

DSRIP program implementation accomplishments

This section summarizes DSRIP program implementation activities and accomplishments from July 1, 2018 through September 30, 2018. Key accomplishments for this quarter include:

- Submission and assessment of ACH semi-annual reports
- Continued activity in the Financial Executor Portal for ACHs and IHCPs
- Continued development and technical assistance for DSRIP performance measurement

ACH semi-annual reports

In accordance with the DSRIP Planning Protocol, ACHs report to the state information necessary to evaluate ACH projects using a standard reporting form. On July 31, ACHs submitted their first semi-annual reports to the state, reporting on project planning and implementation activities that occurred from January 1 through June 30, 2018.

All nine ACH semi-annual reports were made available to the public on the state's Medicaid Transformation resources page, under ACH submitted documents.[2] Through the first semi-annual report, ACHs demonstrated progress on each of their projects as measured by project-specific milestones and standard reporting requirements.

Upon report submission, the Independent Assessor (IA) conducted a thorough review and assessment of all ACH semi-annual reports, including a minimum submission requirements review, assessment by primary and secondary reviewers, and a supplemental request for information process.

The IA's assessment concluded in September 2018. All ACHs demonstrated completion of project milestones for the reporting period, providing complete responses to reporting requirements. The IA identified the following key themes from its review and assessment of ACH semi-annual reports:

- **Continued progress in planning by all ACHs:** The semi-annual reports highlighted that the ACHs are continuing to make significant progress in planning for implementation of their selected projects. Thorough current state assessments were conducted focused on key areas. They have either released or are in process of releasing forms of agreement to potential partnering providers. They have had extensive community engagement and also highlight identified areas of technical assistance needed by partnering providers.

- **Collaboration:** ACHs noted extensive collaboration on a variety of topics, including opportunities to jointly engage partnering providers that participate in two or more regions. ACHs are involved in ongoing meetings, and the ACH Executive Directors meet weekly to coordinate, review initiatives, and foster collaboration.

- **Partnering provider engagement in Transformation planning**. ACHs are involving partnering providers in planning in a variety of ways. In addition for asking for their response to various surveys and

[2] https://www.hca.wa.gov/about-hca/healthier-washington/ach-submitted-documents

involvement in interviews as part of current state assessments, below are a few examples noted by ACHs where they are involving partnering providers:

  - Working with partnering providers to articulate specific evidence-based care model and practice guidelines providers will need to follow for each project.
  - Identifying partnering providers who can serve as champions of identified best practices.

- **Ongoing effort by ACHs to address administrative burden for partnering providers engaged in Medicaid Transformation across ACH boundaries.** ACHs indicate they will continue to convene and coordinate across partners in areas related to (but not limited to) ensuring alignment in cross-region provider goals, initiatives, quality improvement and assessments.
- **Partnering provider technical assistance**: ACHs are identifying and acting on needs for technical assistance and training among partnering providers. Various technical assistance, training, and learning collaboratives have been offered and are being planned to meet ongoing needs for support in transformation.

The IA determined that all nine ACHs earned the full Achievement Values associated with their semi-annual reports. The table below shows the milestones achieved and Achievement Values earned by each ACH.

	BHT	CPAA	GCACH	HH	NCACH	NSACH	OCH	PCACH	SWACH
P4R Milestones Jan-June 2018	*Achievement values earned for reporting on semi-annual progress by ACH*								
Completed Semi-annual Report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Milestone 1: Capacity Assessment	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Milestone 2: Domain I	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Milestone 3: Evidence-based Approaches and Target Populations	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Milestone 4: Partnering Providers	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Earned AVs / Potential AVs	*5.0 / 5.0*	*5.0 / 5.0*	*5.0 / 5.0*	*5.0 / 5.0*	*5.0 / 5.0*	*5.0 / 5.0*	*5.0 / 5.0*	*5.0 / 5.0*	*5.0 / 5.0*
Number of Projects	*4*	*6*	*4*	*4*	*6*	*8*	*6*	*4*	*4*
Percent AV Earned for Each Project	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*

Incentive funds for earned Achievement Values will be distributed to ACHs through the Financial Executor in Q4 2018.

Next steps

The next project milestone for ACHs is submission of Implementation Plans, which lay the groundwork for current and future work steps required for successful implementation of transformation project strategies and achievement of key project milestones. ACHs will submit Implementation Plans to the state on October 1. The IA will conduct a thorough review and assessment of Implementation Plans during Q4 2018.

Financial Executor Portal activity

ACHs continue to distribute incentive funds to partnering providers through the Financial Executor Portal. During the reporting quarter, ACHs distributed over $21 million to 228 partnering providers and organizations in support of project planning and implementation activities. Additionally, the state continues to distribute earned incentive funds to Indian Health Care Providers (IHCPs), totaling approximately $782,000 for Q3. Attachment C provides a detailed account of all funds earned and distributed through the Financial Executor Portal to date.

The state's Financial Executor, Public Consulting Group (PCG), continued to provide direct technical assistance and resources to ACHs as they registered and distributed payments to providers in the Portal during this quarter. Additionally, HCA held regular calls with ACH finance leads to gather feedback on the successes and challenges of using the Portal. PCG will conduct a Portal "refresh" in Q4 to make process improvements and address ACH needs and concerns regarding Portal functionality.

DSRIP program measurement development

In DY 2 Q1, HCA made the DSRIP Measurement Guide available for public review and comment on the Medicaid Transformation webpage. Key themes raised during the public review period included:

- Additional detail about how statewide accountability works, how ACHs can earn incentives for VBP adoption and high performance.
- Clarification about aspects of P4P metric production and connection to Project Incentives.
- Information about pay-for-reporting metrics and definitions.
- Greater detail about how DSRIP quality and outcome metrics were selected.
- Request for more detail in the Project P4P technical specification sheets.

In response, the state compiled feedback received and worked on revisions to enhance clarity, comprehensiveness, and consistency throughout the document throughout Q2. HCA developed new chapters and appendices to describe DSRIP program development that occurred since the DY 2 Q1 release. The state made available the refreshed Measurement Guide during Q3, including a summary of changes, on the Medicaid Transformation resources page.[3]

HCA will continue to monitor stakeholder questions related to the Measurement Guide, and update the document as necessary to capture further DSRIP program development.

Upcoming activities

- ACH submission of Implementation Plans, October 2018
- Continued activity in the Financial Executor Portal, ongoing

[3] https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf
https://www.hca.wa.gov/assets/measurement-guide-public-comment-summary.pdf

- State to release ACH Project Pay-for-Performance (P4P) metric baseline results and improvement targets for the first performance year (2019), Q4 2018
- State to release enhanced Healthier Washington Measures Dashboard, an interactive dashboard that allows people to explore Washington State population and measures data, in Q4 2018. Update will include ACH Project P4P metrics under Medicaid Transformation.

Long-term Services and Supports (LTSS) implementation accomplishments

This section summarizes LTSS program development and implementation activities conducted from July 1, 2018 through September 30, 2018. Key accomplishments for this quarter include:

- Enrollment of over 2,200 individuals as of September 28, 2018.
- As a follow-up to the statewide Barrier Busting Event (BBE), the state held 90-, 120-, and 150-day check-in meetings to review progress on deliverables to assist with removing barriers and improve policy, processes and systems. All deliverables from this event will be completed and BBE workgroups dissolved by December 31, 2018.

Network adequacy for LTSS programs, MAC and TSOA

As of September 30, 2018, seven of the ten Area Agencies on Aging (AAAs) that submitted their 2018 milestone documents have achieved network adequacy goals in their service area across all covered benefits. Three AAAs have not yet reached their completion date for the respective network adequacy milestone. These milestone documents must be submitted with completion date of achieving network adequacy by the end of December 2018.

AAAs across the state continue to report that home care agencies are experiencing workforce recruitment and retention strategies.

Network adequacy compliance by the AAAs will continue to be monitored by ALTSA and DSHS Home and Community Services (HCS) division.

Assessment and systems update

HCS and AAA staff continue to identify, track and prioritize fixes and enhancements necessary in the various systems that support MAC and TSOA service delivery, including GetCare, CARE, ProviderOne, and Barcode. This is part of an ongoing change control process for these systems. During this quarter the following modifications were completed:

- Revisions to the TSOA without a caregiver screening and assessment tools have been reviewed and will move into development phase in the next quarter.
- The annual nursing facility level of care (NFLOC) assessment was developed and implemented in the GetCare system to facilitate completion of the first annual NFLOC reviews for MAC and TSOA enrollees beginning in September.

Staff readiness and training

The GetCare Desk Manual, a deliverable from the BBE, was published in September. This manual includes both policy and system application guidance related to MAC and TSOA intake, screening, assessment, service authorization and case management work in the GetCare application.

ALTSA program managers continue to meet regularly with both HCS and AAA lead managers to review policy questions related to implementation of MAC and TSOA programs. These meetings are also used to share successes and address any issues that may be impacting service delivery.

Program training for MAC and TSOA case management, LTC case management, and community partners began in September and will continue across the state through the end of November. These training sessions include

updates to policy, refreshers, and collaboration activities. As requested during the BBE, these in-person, statewide meetings will continue to occur on a quarterly basis. Regionally requested training will continue to be available for specific topic areas on an as needed basis.

Data and reporting

Refinements to MTD report 0001 and 0004 have been completed this quarter in order to better reflect care plan development proficiencies.

The following tables detail beneficiary enrollment by program.

LTSS beneficiaries by program as of 9/28/18	
MAC	**TSOA**
55	2119

Number of new enrollees in quarter by program	
MAC	**TSOA**
18	572

Number of new person-centered service plans in quarter by program	
MAC	**TSOA**
2	185

Number of beneficiaries self-directing services under employer authority[4]	
MAC	**TSOA**
0	0

Community outreach and engagement efforts continue in order to increase enrollment in both programs.

Proficiency with completion of care plans continues to increase. This is an area the state continues to monitor and provide technical/training assistance as needed.

State rulemaking

The state will be revising Washington Administrative Code for TSOA in the next quarter due to the revisions of the TSOA screening and assessment tools completed during this quarter.

Upcoming activities

- "What's Up?" the first issue of a MAC and TSOA newsletter for internal ALTSA staff will be distributed in October 2018.

[4] The state will not be utilizing individual providers for self-directing services until implementation of the Washington State Consumer Directed Employer.

- Development of an Initiative 2 communication protocol to provide guidance for consistent communications about the MAC and TSOA programs among ALTSA and HCA staff.

Foundational Community Supports (FCS) implementation accomplishments

This section summarizes Foundational Community Supports (FCS) program development and implementation activities conducted from July 1, 2018 through September 30, 2018. Key accomplishments for the quarter include:

- Total number of individuals enrolled in FCS services at the end of Q3: 1,941
    - Individual Placement and Support (CSS): 1,308
    - Community Support Services (IPS): 707
    - Note: the IPS and CSS caseloads include 74 people enrolled in both services.
- Q3 providers contracted: 85 (248 service locations)
- Services billed to date: $649,269 (based on claims submitted)
- FCS continuous quality improvement activities launched through statewide fidelity trainings.
- FCS network adequacy standards were drafted and are on track to be implemented by the end of Q4.
- Continued outreach and support for prospective and current FCS providers to build the FCS provider network and increase the service delivery capacity of contracted providers.

During the reporting quarter, the state focused on building the capacity of the FCS provider network. This included increasing the number of contracted providers and service locations and supporting providers in increasing their internal capacity to implement and grow their delivery of FCS services. Activities that supported the growth of the provider network included outreach to individual providers by state staff and Amerigroup Washington staff. Activities that increased internal provider capacity included one-on-one technical assistance, group and community trainings, webinar trainings, monthly question and answer forums for providers, and an enhanced provider communication strategy.

The state also launched its continuous quality improvement strategy during this quarter. Four, day-long FCS fidelity reviewer trainings took place in Eastern and Western Washington. Two of the trainings focused on FCS Supported Employment – Individual Placement and Support (IPS) services, and two of the training focused on FCS Community Support Services (CSS). The events were free for FCS providers to attend and provided an in-depth training for providers to learn about the FCS service fidelity models, learn how to conduct internal and external service fidelity reviews, and learn about FCS quality improvement resources and activities that will be offered in the future. Starting in 2019, the state will organize FCS provider fidelity learning collaboratives and will conduct fidelity reviews of contracted FCS providers.

The state also drafted FCS network adequacy standards during this quarter. These standards are being finalized by HCA leadership and are on track to be incorporated into Amerigroup Washington's FCS Third Party Administrator contract by the end of the year. Final FCS network adequacy standards and additional network adequacy standard implementation updates will be shared in future reports.

Network adequacy for FCS

Network development during Q3 focused on developing contracts with qualified providers who are non-traditional Medicaid providers and needed additional support to navigate the FCS contracting process. These providers included employment and social service providers who have experience delivering CSS and IPS services, but are new to Medicaid. Network development also focused on rural counties and tribes, and there are a couple of tribes that are now in the process of developing an FCS contract with Amerigroup Washington.

The number of FCS contracted providers increased from 76 at the end of Q2 to 85 at the end of Q3, and the number of FCS service locations increased from 213 at the end of Q2 to 248 at the end of Q3. The state and Amerigroup Washington will continue to work to grow the FCS provider network during Q4.

FCS Provider Network Development						
	July		August		September	
FCS Service Type	Contracts	Service Locations	Contracts	Service Locations	Contracts	Service Locations
Supported Employment (IPS)	26	82	27	82	27	83
Community Support Services (CSS)	18	32	18	33	16	28
CSS and IPS	34	106	38	130	42	137
Total	**78**	**220**	**83**	**245**	**85**	**248**

Client Enrollment

The total number of clients enrolled in FCS increased from 893 people at the end of Q2 to 1,941 people at the end of Q3. FCS Supported Employment IPS continues to have the largest number of people enrolled, with 625 people enrolled at the end of Q2 and 1,308 people enrolled at the end of Q3 (this includes 74 people enrolled in both IPS and CSS services during Q3).

During Q3, the state and Amerigroup Washington invested significant staff resources in supporting CSS providers to build their internal capacity to serve clients and build CSS referral pathways. CSS client enrollment has increased at a slower rate than IPS client enrollment because CSS providers are typically smaller organizations and are non-traditional Medicaid providers. The state and Amerigroup Washington plan to provide ongoing support and technical assistance to CSS providers in order to continue to grow the CSS caseload during Q4.

FCS Client Enrollment			
	July	August	September
Supported Employment (IPS)	865	1,066	1,234
Community Support Services (CSS)	400	509	633
CSS and IPS	29	58	74
Total Enrollment	**1,294**	**1,633**	**1,941**

Additional information about the characteristics of FCS clients are included in the tables below. FCS continues to reach people with high rates of behavioral health diagnoses and people who are receiving services from multiple systems of care. A high rate (approximately 45%) of FCS enrollees continue to be Affordable Care Act Medicaid Expansion Adults.

FCS Client Risk Profile

		Meet HUD Homeless Criteria	Avg. PRISM Risk Score	Serious Mental Illness
July	IPS	81 (9%)	1.18	685 (77%)
	CSS	113 (26%)	1.83	337 (79%)
August	IPS	105 (10%)	1.16	832 (75%)
	CSS	143 (26%)	1.80	422 (77%)
September*	IPS	122 (10%)	1.19	934 (78%)
	CSS	164 (26%)	1.86	491 (78%)

HUD = Housing and Urban Development | **PRISM** = Predictive Risk Intelligence System
**Complete data from September is not yet available*

FCS Client Risk Profile Continued				
		Mental Health Treatment Need	SUD Treatment Need	Co-occurring MH + SUD Treatment Need Flags
July	IPS	856 (96%)	455 (51%)	449 (51%)
	CSS	419 (98%)	309 (72%)	302 (70%)
August	IPS	1,060 (96%)	553 (50%)	544 (49%)
	CSS	535 (97%)	393 (71%)	382 (69%)
September*	IPS	1,150 (96%)	604 (50%)	594 (49%)
	CSS	611 (97%)	449 (71%)	438 (69%)

MH = Mental Health | **SUD** = Substance Use Disorder
**Complete data from September is not yet available*

FCS Client Service Utilization					
		Long-Term Services and Supports	Mental Health Services	SUD Services	CARE + MH or SUD Services
July	IPS	272 (29%)	740 (83%)	200 (22%)	172 (19%)
	CSS	139 (30%)	353 (82%)	129 (30%)	94 (22%)
August	IPS	336 (30%)	904 (82%)	235 (21%)	213 (19%)
	CSS	167 (28%)	446 (81%)	172 (31%)	111 (20%)
September*	IPS	369 (31%)	972 (81%)	256 (21%)	234 (19%)

	CSS	188 (28%)	498 (79%)	196 (31%)	128 (20%)

MH = Mental Health | **SUD** = Substance Use Disorder
**Complete data from September is not yet available*

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	CN & CHIP Children
July	IPS	334 (38%)	32 (4%)	89 (10%)	398 (45%)	36 (4%)
	CSS	164 (38%)	31 (7%)	41 (10%)	193 (45%)	NA
August	IPS	414 (38%)	41 (4%)	115 (10%)	492 (45%)	41 (3%)
	CSS	202 (37%)	39 (7%)	47 (9%)	261 (47%)	NA
September*	IPS	450 (37%)	52 (4%)	125 (10%)	535 (45%)	39 (3%)
	CSS	240 (38%)	44 (7%)	54 (9%)	291 (46%)	NA

ACA = Affordable Care Act | **CHIP** = Children's Health Insurance Program | **CN** = Categorically Needy
**Complete data from September is not yet available*

Other FCS program activity

The state developed a webinar training series to help non-traditional Medicaid providers learn how to add FCS services to their organization's book of business. Many non-traditional Medicaid providers who are qualified FCS providers have never been reimbursed for delivering services under a fee-for-service (FFS) delivery and payment model, and they have needed extra support to understand how to change their internal operations and staffing models in order to successfully implement FCS services. The state worked with national technical assistance organizations to develop trainings for providers during Q3, and the trainings will be implemented during Q4.

The state also created and implemented an FCS communication plan during Q3 to bolster communication to FCS providers and stakeholders. Two new communication tools were developed, including a statewide monthly newsletter that has over 500 people subscribed and a public calendar listing upcoming FCS training opportunities and events. In addition to creating new tools, the state has refreshed FCS communication materials and created new materials, such as the FCS Chronic Homelessness Documentation Guidance.

Upcoming activities

- A new mapping tool that will allow stakeholders to search for FCS providers in every county in Washington is under development using the Tableau platform and is on track to be published by December 2018.

- FCS network adequacy standards have been drafted by the state and are being reviewed by state leadership. Final FCS network adequacy standards are on track to be implemented by December 2018.
- FCS continuous quality improvement activities launched during Q3. During Q4, the state will plan for the creation FCS quality improvement learning collaboratives and implementation FCS fidelity reviews, which will be implemented in 2019 and will continue throughout Demonstration Years 3, 4, and 5.

Substance Use Disorder (SUD) program implementation accomplishments

In July 2018, Washington State received approval of its 1115 waiver amendment to receive federal financial participation (FFP) for substance use disorder (SUD) treatment services, including short-term residential services provided in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD). This section summarizes SUD program development and implementation activities conducted from July 1, 2018 through September 30, 2018.

Implementation Plan

In accordance with the amended Special Terms and Conditions (STCs), the state is required to submit an implementation plan for the SUD program, incorporating six key milestones outlined by CMS. At the time of the waiver application, Washington met a number of these milestones in its provision of SUD services. Where the state did not meet the milestones, it agreed to implement changes. These changes, included in the state's SUD implementation plan, are described below:

- **Milestone 2:** While the state met the requirement for an independent assessment prior to residential treatment in the managed care system, it agreed to make changes to the assessment process for the fee-for-service (FFS) system. The FFS mainly impacts AI/AN individuals at this time. The state plans to update the FFS SUD Billing Guide to require an independent assessment as outlined in the final STCs. A subgroup was formed to address these changes and the state does not anticipate any delays making these changes to the FFS SUD Billing Guide.
- **Milestone 3:** The state will require all residential SUD agencies to provide or facilitate access to MAT. A sub-workgroup was formed and continues to meet regularly. The group is currently finalizing contract language to meet the requirements of the milestone. The state expects to have the requirement in the July 1, 2019 Prepaid Inpatient Health Plan (PIHP) contracts.
- **Milestone 4:** The state will assess the availability of MAT services across the state, including both outpatient and residential agencies that provide MAT services and their current ability to accept clients. A subgroup was formed to address this milestone, including both policy and data subject matter experts. At this time, the state is analyzing what data are available and working on definitions for various data points. The overall assessment has proven to be complex, involving multiple state agencies, including DSHS, HCA, and the Department of Health.
- **Milestone 6:** The state will require residential and outpatient providers to improve coordination between levels of care. A sub-workgroup was formed and continues to meet regularly. The group is currently finalizing contract language to meet the requirements of the milestone. The state expects to have the requirement in the July 1, 2019 PIHP contracts.

Health Information Technology (HIT)

The state's SUD implementation plan includes a Health Information Technology (HIT) component, outlining the state's agreement to implement several new SUD HIT tasks into the larger 1115 HIT Plan. During this quarter, a workgroup was formed to develop the work steps and resources required to meet the SUD HIT milestones outlined in the implementation plan. The state does not anticipate any issues meeting the agreed upon tasks at this time.

Evaluation design

As part of the amended STCs, the state agreed to make changes to the current evaluation design. A workgroup was formed to address these changes. HCA, DSHS Research and Data Analysis (RDA) division, and the Independent External Evaluator (IEE) will continue to develop and incorporate the SUD evaluation design into the larger MTP demonstration evaluation design.

Monitoring Protocol

In accordance with the amended STCs, the state is required to submit its SUD Monitoring Protocol by mid-December 2018. The state is currently working with its federal partners to obtain SUD metric technical specifications to aid in the development of this protocol.

Upcoming activities

- Continued development of SUD Monitoring Protocol, ongoing.
- Continued development of SUD evaluation design, ongoing.

Quarterly expenditures

The following tables reflect quarterly expenditures for Demonstration Year (DY) 2. During the reporting period of July 1 through September 30, 2018. Note: the state did not have any expenditures under DSRIP or FCS during this reporting period.

DSRIP Expenditures						
	Q1	Q2	Q3	Q4	DY 2 Total	Funding Source
	January 1 – March 31, 2018	April 1 – June 30, 2018	July 1 – September 30, 2018	October 1 – December 31, 2018	January 1 – December 31, 2018	Federal Financial Participation
Accountable Communities of Health						
Better Health Together	$8,629,990	$7,209,119	$0	-	$15,839,109	$7,919,555
Cascade Pacific Action Alliance	$9,301,288	$6,553,744	$0	-	$15,855,032	$7,927,516
Greater Columbia	$10,983,624	$13,248,808	$0	-	$24,232,432	$12,116,216
HealthierHere	$17,259,981	$20,373,755	$0	-	$37,633,736	$18,816,868.00
North Central	$7,691,357	$3,276,872	$0	-	$10,968,229	$5,484,114.50
North Sound	$13,709,292	$14,163,052	$0	-	$27,872,344	$13,936,172.00
Pierce County	$9,414,535	$11,593,208	$0	-	$21,007,743	$10,503,871.50
Olympic Community of Health	$4,594,020	$2,621,498	$0	-	$7,215,518	$3,607,759
SWACH	$14,167,487	$4,587,621	$0	-	$18,755,108	$9,377,554
IHCP-specific Projects						
Indian Health Care Providers	$5,400,000	$0	$0	-	$5,400,000	$2,700,000

LTSS and FCS Service Expenditures					
	Q1	Q2	Q3	Q4	DY 2 Total
	January 1 – March 31, 2018	April 1 – June 30, 2018	July 1 – September 30, 2018	October 1 – December 31, 2018	January 1 – December 31, 2018
Tailored Supported for Older Adults	$314,035	$631,626	$945,915	-	$1,891,576
Medicaid Alterative Care	$8,107	$8,359	$15,901	-	$32,367
MAC and TSOA Not Eligible	$210	$1,316	$61	-	$1,587
Foundational Community Supports	$0	$23,800	$0	-	$23,800

Overall demonstration development/issues

Operational/policy issues

Implementation activities for DSRIP, LTSS, and FCS are currently underway. There are no significant operational or policy issues to report for this quarter.

Consumer issues

During Q3, interest in FCS services exceeded the capacity of the state's available provider network in certain areas of the state. Amerigroup Washington (the FCS Third Party Administrator) is working to increase FCS service availability in these communities.

The state has not experienced any major consumer issues for the DSRIP and LTSS programs during this reporting quarter, other than general inquiry about benefits available through the MTP.

Quality assurance/monitoring activity

Amerigroup Washington developed a 2018 Quality Management Program Plan per its contract with the state during Q3. The plan will be updated annually and monitored by the state.

Demonstration evaluation

During the reporting period, the state executed its contract with Oregon Health and Science University (OHSU), allowing robust implementation of their role as Independent External Evaluator (IEE) for the Healthier Washington Medicaid Transformation. The state actively supported a number of key activities to support the IEE's continued on boarding and introduction to all Medicaid Transformation initiatives. These included:

- Working sessions to define the first phase of data for the IEE's quantitative analysis.
- Providing documentation in support of the IEE's Washington State Institutional Review Board application and the state's commitment to data support.
- Facilitation of fact-gathering meetings with subject matter experts to ground the IEE in Transformation initiatives.

The state also received the IEE's first quarterly monitoring report (Attachment D). The report is a high-level summary of key activities, and includes an overview, methods, and findings for this reporting period. The report focuses in large part on DSRIP activities. It notes additional support is needed to expand the IEE's understanding of the components of the Medicaid Transformation Project and related activities.

The state has also begun discussions with the IEE about best options for expansion of the original contracted scope of work to include evaluation of the SUD program.

Value-based payment

HCA submitted its annual update to the state's Value-based Roadmap Apple Health Appendix on October 1, 2018. The Apple Health Appendix, in accordance with the STCs, describes how the MTP is supporting providers and managed care organizations in moving along the value-based care continuum, and establishes targets for VBP attainment and related incentives under DSRIP for MCOs and ACHs.

Health IT

HCA submitted its Health IT Strategic Roadmap and Operational Plan on December 1, 2017. The Health IT Strategic Roadmap identifies activities necessary to advance the use of interoperable Health IT and HIE across the care continuum in support of the programmatic objectives of the MTP. During the reporting quarter, the HIT team held webinars for state partners, ACHs, and other stakeholders to provide updates on the Operational Plan progress.

The state is developing the 2019 Health IT Operational Plan for the MTP. In addition, HCA is operationalizing the tasks in the SUD Health IT Plan that was added as a result of the SUD waiver amendment. HCA will incorporate the SUD Health IT Plan tasks into the tasks in the 2019 Health IT Operational Plan. HCA anticipates submission of the 2019 Health IT Operational Plan to CMS in December 2018.

Integrated managed care

One of the key goals of the MTP is the comprehensive integration of physical and behavioral health services. During the reporting quarter, HCA continued to support regional transitions to integrated managed care, including the following activities:

- Education activities were conducted to prepare managed care organizations (MCOs) and behavioral health organizations (BHOs) for integrated care. Key educational activities conducted include: Hosting bi-weekly knowledge transfer webinars with the mid-adopter regions and MCOs to educate the MCOs on BH programs and services, and developed guidance documents for enrollment and billing processes.
- HCA worked with the mid-adopter regions (2019 implementation) to develop communications plans, and develop client, provider, and community communications regarding the change to integrated managed care.
- HCA provided technical assistance and support to mid-adopter regions to develop regional Early Warning Systems, and monitored provider readiness activities.
- HCA conducted readiness reviews to verify that, in each mid-adopter region, the MCOs and Behavioral Health-Administrative Services Organizations (BH-ASOs) are ready for implementation of integrated managed care on 1/1/2019.

HCA will continue to engage stakeholders and beneficiaries regarding changes to managed care coverage in each region.

Financial/budget neutrality development/issues

Financial

The state is currently working with its partners at the State Auditor's Office on a routine agency audit on MTP expenditures.

Budget neutrality

The state is continuing conversations with CMS to discuss impacts of LTSS funding increases on budget neutrality. The state is also working on SUD budget neutrality reporting and will provide an update once it is available. Per the amended STCs, the state anticipates receiving its budget neutrality monitoring tool from CMS by end of calendar year 2018.

Below are the counts of Non-Expansion Adults member months eligible to receive services under the MTP. Member months are updated retrospectively based on the November 2018 Caseload Forecast Council (CFC) medical caseload data. June 2018 through September 2018 are forecasted caseload figures from CFC.

Member months eligible to receive services count	
Calendar Month	Budget Neutrality Eligibility Groups
Jan-17	375,738
Feb-17	374,567
Mar-17	374,110
Apr-17	372,950
May-17	372,501
Jun-17	372,426
Jul-17	371,544
Aug-17	371,290
Sep-17	370,057
Oct-17	369,881
Nov-17	369,720
Dec-17	369,728
Jan-18	369,736
Feb-18	368,336
Mar-18	368,138
Apr-18	366,815
May-18	367,124
Jun-18	366,266
Jul-18	366,342
Aug-18	366,456
Sept-18	366,155
Total	7,769,879

Designated State Health Programs (DSHP)

No significant DSHP updates to provide for this reporting quarter.

Summary of additional resources, enclosures and attachments

Additional resources

More information about Washington's Medicaid Transformation demonstration is available at: https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation.

Interested parties can sign up to be notified of demonstration developments, release of new materials, and opportunities for public comment through the Healthier Washington listserv.

Summary of enclosures and attachments

Attachment	Document Title/Description
A	State contacts
B	Article for Senior Tribal Newspapers in Washington
C	Financial Executor Portal dashboard
D	Medicaid Transformation Project Evaluation: Rapid-cycle Monitoring Report

Attachment A: State contacts

Identify the individual(s) that CMS may contact should any questions arise:

Area	Name	Title	Phone
MTP and quarterly reports	Kaitlyn Donahoe	Senior Health Policy Analyst, Medicaid Transformation	(360) 725-0874
DSRIP program	Chase Napier	Manager, Medicaid Transformation	(360) 725-0868
LTSS program	Kelli Emans	Managed Care Policy Analyst, DSHS	(360) 725-3213
FCS program	Melodie Pazolt	Deputy Director, Behavioral Health and Recovery	(360) 725-0487
SUD program	Melodie Pazolt	Deputy Director, Behavioral Health and Recovery	(360) 725-0487

For mail delivery, use the following address:

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

Attachment B: Article for Senior Tribal Newspapers in Washington

Below is a copy of an article representing outreach and engagement efforts happening across Initiative 2 to identify caregivers and inform them that help is available. During the reporting quarter, this article was disseminated to tribal newspapers.

You call it "getting mom groceries" – We call it caregiving

You may know an Elder or an adult with chronic conditions that isn't able to handle everyday things the way they used to. Changes in health and situation can decrease a person's ability to take care of their home, plan and shop for food, cook meals, bathe, toilet or keep on top of their medications. Families step in to help but it can be difficult to balance everything and not become overwhelmed. There are options available to support families and the care they are giving.

Not sure if you need help or what type of services you might be interested in? Just talking with a local expert can provide you with resources and helpful ideas. The Department of Social and Health Services (DSHS) and the local Area Agency on Aging or Community Living Connections offices have programs available all across Washington state that include a wide variety of services and supports for caregivers. Many tribes also have tribal respite services and/or kinship navigators that can help connect unpaid family or kinship caregivers to supports and services. Reach out to your Tribal Social Services Department.

Learn more about services by calling 1-855-567-0252 or go to https://www.dshs.wa.gov/altsa/kinship-care-support-services. Additional information about long-term services and supports can be found at: https://www.dshs.wa.gov/ALTSA/resources to be put in touch with the local regional office or visit https://www.waclc.org/consumer/explore/support_for_family_caregivers/index.php for a variety of support options.

Attachment C: Financial Executor Portal dashboard

See next page.

All funds earned and distributed through the Financial Executor through September 30, 2018.

	Better Health Together	Cascade Pacific Action Alliance	Greater Columbia ACH	HealthierHere	North Central ACH	North Sound ACH	Olympic Community of Health	Pierce County ACH	SWACH	IHCP-Specific Projects	Total
Funds Earned											
Projects											
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	$7,679,569	$5,485,405	$11,317,258	$17,784,263	$2,504,207	$6,911,611	$2,835,533	$8,377,710	$4,886,999		$67,782,557
2B: Community-Based Care Coordination	$5,279,703	$3,771,217			$1,721,642	$4,751,733		$5,759,676	$3,359,811		$24,643,781
2C: Transitional Care		$2,228,446	$4,597,636	$7,224,857	$1,017,334	$2,807,842					$17,876,115
2D: Diversion Interventions					$1,017,334	$2,807,842	$1,151,936				$4,977,112
3A: Addressing the Opioid Use Public Health Crisis	$959,946	$685,676	$1,414,658	$2,223,033	$313,026	$863,952	$354,442	$1,047,214	$610,875		$8,472,821
3B: Reproductive and Maternal/Child Health		$857,095				$1,079,939	$443,052				$2,380,085
3C: Access to Oral Health Services						$647,964	$265,831				$913,795
3D: Chronic Disease Prevention and Control	$1,919,892	$1,371,351	$2,829,314	$4,446,065	$626,051	$1,727,903	$708,883	$2,094,428	$1,221,749		$16,945,637
Other Funding											
Behavioral Health Integration Incentives			$4,073,566	$5,955,517	$2,312,792	$4,332,435		$3,728,715	$8,675,674		$29,078,699
Value-Based Payment (VBP) Incentives and High Performance Pool		$1,455,842			$1,455,842	$1,941,123	$1,455,842				$6,308,649
IHCP-Specific Projects										$5,400,000	$5,400,000
Total Funds Earned	***$15,839,109***	***$15,855,032***	***$24,232,432***	***$37,633,736***	***$10,968,229***	***$27,872,344***	***$7,215,518***	***$21,007,743***	***$18,755,108***	***$5,400,000***	***$184,779,251***
Funds Distributed											
Use Categories											
Administration	$566,671	$176,384	$679,000			$1,833,126	$11,081				$3,266,262
Community Health Fund		$940,715				$1,800,000					$2,740,715
Health Systems and Community Capacity Building	$835,000	$219,536			$104,000	$189,400		$517,085		$550,000	$2,415,021
Integration Incentives	$1,430,000				$35,872			$1,715,209			$3,181,081
Project Management		$999,510	$287,000		$323,797	$96,238					$1,706,545
Provider Engagement, Participation and Implementation	$3,256,000	$329,184	$441,000	$3,595,150	$1,832,390	$1,820,000	$1,723,420	$1,742,000	$392,500	$2,346,765	$17,478,409
Provider Performance and Quality Incentives											
Reserve / Contingency Fund		$587,947				$360,000					$947,947
Shared Domain 1 Incentives	$4,505,699	$4,096,090	$5,734,526	$9,011,399	$2,048,045	$6,144,136	$1,638,436	$4,915,308	$2,867,263		$40,960,902
Total Funds Distributed	***$10,593,370***	***$7,349,366***	***$7,141,526***	***$12,606,549***	***$4,344,104***	***$12,242,900***	***$3,372,937***	***$8,889,602***	***$3,259,763***	***$2,896,765***	***$72,696,882***
Funds Available											
Total Funds Distributed to Date	$10,593,369.52	$7,349,366	$7,141,526	$12,606,549	$4,344,104	$12,242,900	$3,372,937	$8,889,602	$3,259,763	$2,896,765	$72,696,882
Total Funds Pending	$5,245,739.93	$8,505,666	$17,090,906	$25,027,187	$6,624,125	$15,629,444	$3,842,581	$12,118,141	$15,495,345	$2,503,235	$112,082,369
Total Funds Available for Distribution	$5,245,739.93	$8,505,666	$17,090,906	$25,027,187	$6,624,125	$15,629,444	$3,842,581	$12,118,141	$15,495,345	$2,503,235	$112,082,369
% of Total Funds Distributed	66.88%	46.35%	29.47%	33.50%	39.61%	43.92%	46.75%	42.32%	17.38%	53.64%	39.34%
% of Total Funds Distibuted by ACH											
Administration	0.78%	0.24%	0.93%			2.52%	0.02%				4.49%
Community Health Fund		1.29%				2.48%					3.77%
Health Systems and Community Capacity Building	1.15%	0.30%			0.14%	0.26%		0.71%		0.76%	3.32%
Integration Incentives	1.97%				0.05%			2.36%			4.38%
Project Management		1.37%	0.39%		0.45%	0.13%					2.35%
Provider Engagement, Participation and Implementation	4.48%	0.45%	0.61%	4.95%	2.52%	2.50%	2.37%	2.40%	0.54%	3.23%	24.04%
Provider Performance and Quality Incentives											
Reserve / Contingency Fund		0.81%				0.50%					1.30%
Shared Domain 1 Incentives	6.20%	5.63%	7.89%	12.40%	2.82%	8.45%	2.25%	6.76%	3.94%		56.34%
Total	***14.57%***	***10.11%***	***9.82%***	***17.34%***	***5.98%***	***16.84%***	***4.64%***	***12.23%***	***4.48%***	***3.98%***	***100.00%***

Attachment D: Medicaid Transformation Project Evaluation: Rapid-cycle Monitoring Report

See next page.

Medicaid Transformation Project (MTP) Evaluation

RAPID-CYCLE MONITORING REPORT

PREPARED FOR:
Washington State Health Care Authority

PREPARED BY:
Oregon Health & Science University, Center for Health Systems Effectiveness

September 28, 2018

OHSU

MTP EVALUATION
Rapid-Cycle Implementation Report

This report covers activities and findings from CHSE's evaluation of Washington's Medicaid Transformation Program (MTP) from July 1 to September 28, 2018. In this period, CHSE focused on laying groundwork for the evaluation. We submitted an application for to Washington State Institutional Review Board (WSIRB), delivered presentations to State agency and accountable community of health (ACH) partners, and gained background knowledge of MTP through meetings with State subject matter experts. We also analyzed documents to understand differences, similarities, and unique characteristics among ACHs.

KEY TAKEAWAYS

- Through document analysis, we learned that ACHs vary on important dimensions, such as governance structures, approaches to engaging partners, and the number and type of models chosen to guide their health improvement projects. For example, some ACHs have sub-regional groups that serve their boards, and some have especially well-defined mechanisms for engaing partners.

- ACH activities around value-based payment (VBP), workforce transformation, and health information technology (HIT) are in a development phase, with progress and specificity of planned activities varying across the ACHs. Notably, ACH documents lack detailed or concrete plans for VBP, and ACHs generally seem unsure of how to approach VBP. ACHs described common challenges related to expanded use of community health workers (CHWs) and electronic health records (EHRs).

- Across ACHs, there is variation in the type and number of models chosen for health improvement projects in a given area, while within ACHs there are common elements or cohesiveness across different kinds of projects.

- Long-Term Supports and Services (LTSS) and Foundational Community Supports (FCS) initiatives are largely separate from the ACH work.

Foundational activities in this period will help us launch data collection and analysis next quarter. With data from document analysis, we will refine our key informant interview guide and launch key informant interviews with State leaders, ACHs, and other stakeholders. We will also meet with HCA and DSHS to identify the full set of quantitative data needed for the evaluation and refine our provider organization survey questionnaire to assess the impact of MTP among primary care clinics and hospitals.

EVALUATION PROGRESS REPORT

Accomplishments

- We submitted an application for Washington State Institutional Review Board (WSIRB) review of the evaluation on July 12. The submission described our planned data collection and analysis activities for all evaluation aims, and included outreach materials and an interview guide for key informant interviews with State officials, ACH leaders, and partner organizations; we plan to add outreach materials and data collection instruments for provider organization surveys and interviews to the WSIRB submission by amendment. We also worked with HCA and DSHS to specify an initial set of quantitative data elements for the evaluation, which HCA submitted to WSIRB as application Appendix G on September 12.
- We delivered presentations about our plans for the evaluation to State agency staff and ACH leaders on July 16 and August 27, respectively. We believe these presentations will help build foundation for cooperation with agency staff and ACHs throughout the evaluation.
- In August, we met with State subject matter experts in the areas of VBP, HIT, workforce transformation, LTSS, and FCS to learn about these components of MTP. These meeting have helped us refine questions for key informant interviews, select metrics for quantitative analysis of LTSS and FCS, and select items for provider organization surveys.
- Led by our qualitative team, we analyzed ACHs' project plans and first round of semi-annual reports and used these documents to create an ACH "matrix" that captures key variables about ACHs and their projects. The matrix has helped us understand similarities and differences across ACHs (see Section Demonstration Progress below), and will help us formulate questions for key informant interviews. In addition, our quantitative team analyzed the semi-annual reports in order to begin identifying the target population for each ACH's projects, which has helped us document additional quantitative data needed for the evaluation (see Key Decisions and Actions below).
- We delivered a draft provider organization survey questionnaire to HCA and DSHS on September 10. The questionnaire included 15 potential items tailored to evaluating progress on MTP's VBP, HIT and workforce transformation goals.

Key Decisions and Actions

- Our quantitative team will meet with HCA and DSHS on October 12 to discuss additional quantitative data needed for the evaluation. Our goal is to agree on a comprehensive list of data elements that can be used to amend the WSIRB submission.
- We will meet with State subject matter experts on October 22 to collect feedback on the draft provider organization survey questionnaire. We plan to discuss options for the provider organization list that we will use to create the survey sample in November.
- Representatives of our team will attend the ACH Learning Symposium on Oct 24 and, meet with DSHS staff to learn about eligibility and enrollment process for MAC and TSOA benefits on Oct 25.

DEMONSTRATION PROGRESS

We analyzed project plans and semi-annual reports from each ACH, and used this information to populate a "matrix" that captures differences, similarities, and unique characteristics within and across the ACHs.

KEY FINDINGS

- ACHs vary on important dimensions, such as governance and partnerships.
  - » All ACHs have a board, staff, workgroups, and committees. Several ACHs also have sub-regional groups that serve on the board.
  - » ACHs vary in their approach to engaging partners and in the strength of their partnerships. A few ACHs have especially well-defined mechanisms for engaging partners.
- Domain 1 activities are in a development phase, with progress and specificity of planned activities varying across the ACHs.
  - » ACH documents lack detailed or concrete plans for VBP, and ACHs generally seem unsure of how to approach VBP. The primary plan cited by most ACHs is to train and educate providers on VBP.
  - » A common theme among ACHs is incorporating community health workers and peer support specialists into the healthcare workforce. ACHs note challenges or needs related to defining roles, training, and paying for CHWs through Medicaid.
  - » Some ACH regions may have more HIT expertise than others. Common HIT challenges noted by ACHs include variation in EHR platforms and interoperability of Washington's Prescription Drug Monitoring Program with EHRs.
- Across ACHs, there is variation in the type and number of models chosen for Domain 2 and 3 projects in a given area. Within most ACHs, there are common elements or cohesiveness across different kinds of projects.
- LTSS and FCS initiatives are largely separate from the ACH work. Available documents provide less detail on these initiatives than on the DSRIP work.

IMPLICATIONS FOR EVALUATION AND IMPLEMENTATION

- Document analysis and informal discussions with State agency staff have helped us identify stakeholders for semi-structured interviews and refine our interview guide. Interviews will include questions on how ACHs engage partners and work with partners to make decisions; redefinition and refinement of target populations as plans evolve; and LTSS and FCS, where less detail was available from documents.
- Given overlap in models or approaches used by ACHs, there might be opportunities to provide technical assistance to multiple ACHs, as well as opportunities to foster peer-to-peer sharing and learning.

Overview

Washington's MTP is complex and has multiple components to track and synthesize. These include Accountable Communities of Health (ACH), Long-Term Services and Supports (LTSS), and Foundational Community Supports (FCS). Reviewing the available literature has provided the evaluation team with critical background and orientation to the MTP work. Beyond this, evaluation staff have identified key points of interest, particularly regarding the ACH work. This report discusses our work to date on document analysis and shares our general impressions and insights.

The ACHs participating in the Delivery System Reform Incentive Payment program vary on important dimensions.

Methods

The qualitative work for the MTP evaluation has, to date, focused on document analysis, which has been complemented by informal discussions with HCA and DSHS staff. We analyzed documents provided by HCA and DSHS, as well as publically available documents from state agency websites. We analyzed project plans and semi-annual reports from each ACH, and used this information to populate a "matrix." This matrix is a strategy to categorize information into groupings that are extracted from the reports and project plans, including topics such as ACH target populations for health improvement projects, project selection, ACH governance structure, Domain 1 activities, and project partners. We used this to compare ACH activities and structures across all nine ACHs. Categories were refined as our review progressed in order to distill key differences, similarities, and unique factors within and across the ACHs. We share key findings below.

Findings

There are nine ACHs in the state of Washington participating in the Delivery System Reform Incentive Payment (DSRIP) program. The ACHs vary on important dimensions. Each has a unique beneficiary population, array of partners, set of Medicaid managed care organizations (MCOs) and behavioral health organizations (BHOs), and geography. Table 1 presents a brief snapshot of some ACH characteristics.

As shown in Table 1, ACHs vary in the number of beneficiaries they serve, with the OCH serving the smallest population to HH serving the largest. There are similar MCOs serving ACH regions, with Molina present in each region, and NCACH having only two MCOs in their region; most regions have one BHO serving Medicaid beneficiaries, with the exception being CPAA, that has multiple BHOs. In addition, there is evidence of some transitions in BHO regional presence. These are all baseline characteristics that we will continue to monitor to see how these partnerships evolve and to assess how they might influence outcomes ACHs achieve.

TABLE 1. SNAPSHOT OF ACCOUNTABLE COMMUNITIES OF HEALTH

ACH*	Beneficiaries (% of total population in ACH region)	MCOs in Region†	BHOs in Region
BHT	196,000 (33%)	Molina, CHPW, UHC, Amerigroup, CC	Spokane County Regional Behavioral Health Organization (SCRBHO)
CPAA	180,000 (30%)	Molina, CHPW, UHC, Amerigroup, CC	Behavioral Health Resources, Great Rivers BHO, Sea Mar, Thurston-Mason BHO, Cowlitz Family Health Center, Valley View
GC	259,762 (13%)	Molina, CHPW, UHC, Amerigroup, CC	Greater Columbia BHO
HH	412,836 (20%)	Molina, CHPW, UHC, Amerigroup, CC	King County BHO
NCACH	94,000 (37%)	Molina, Amerigroup, CC	North Central Washington Behavioral Health
NSACH	286,760 (24%)	Molina, CHPW, UHC, Amerigroup, CC	North Sound BHO
OCH	84,000 (23%)	Molina, CHPW, UHC, Amerigroup, CC	Salish
PCACH	228,000 (27%)	Molina, CHPW, UHC, Amerigroup, CC	Optum (transitioning out in 2019)
SWACH	133,000 (26%)	Molina, CHPW, Amerigroup	Fully-integrated managed care + BH-ASO‡

*BHT – Better Health Together; CPAA – Cascade Pacific Action Alliance; GC – Greater Columbia Accountable Community of Health; HH – Healthier Here; NCACH – North Central Accountable Community of Health; NSACH – North Sound Accountable Community of Health; OCH – Olympic Community of Health; PCACH – Pierce County Accountable Community of Health; SWACH – Southwest Accountable Community of Health. †CHPW – Community Health Plan of Washington; UHC – UnitedHealthcare; CC - Coordinated Care. ‡As of April 2016, MCOs in Clark and Skamania Counties covered physical health, mental health, and substance use disorder services. Some behavioral health services, such as mental health crisis services, were provided by a behavioral health administrative services organization (BH-ASO).

GOVERNANCE

While there is variation, all ACHs have a board, staff, workgroups, and committees that collaborate. Typically, the board holds the ultimate decision making power, especially for matters regarding finances and distribution of DSRIP funds. However, in the case of NSACH, the Executive Committee has the authority of the board between board meetings for all matters except article of incorporation and bylaw amendments.

Another notable difference between ACHs is the use of "sub-organizations." OCH, BHT, and NCACH have sub-regional groups that serve the board. OCH has Natural Communities of Care (NCC), entities that are considered partners in care delivery for Medicaid beneficiaries based on geographical proximity, referral patterns, and service agreements (i.e., county). BHT has several groups, referred to as the Spokane and Rural Collaboratives. Each collaborative has a unique charter, governance structure, and decision making process. Each of these organizations has been tasked with developing a transformation plan, including a framework for individual partner plans. NCACH has Coalitions for Health Improvements (CHIs) located in Chelan-Douglas, Grant, and Okanogan counties. CHIs engage regional partners on behalf of NCACH and inform the board. Each CHI has a voting representative on the board.

ENGAGEMENT AND PARTNERSHIP EFFORTS

The project plans and semi-annual reports contain descriptions of partners from sectors

Value-based payment, workforce transformation, and population health management are in a development phase.

including social services, clinical and medical, hospital, behavioral health, housing, transportation, governmental, criminal justice, and many others. ACHs vary in their approaches to engaging partners and the strength of their partnerships at the baseline. For instance, a few ACHs have more defined mechanisms for engaging partners than others. One example is OCH's Natural Communities of Care (NCC), which was described earlier. Each of the participating providers in the NCC will develop a change plan describing expected workflow and how clinics may be reconfigured to support this work. HH's Community/Consumer Voice Committee (CCV) is a good example of consumer and community engagement. The CCV is where community members and beneficiaries have a seat at the table and work closely with the governing board and project teams to provide input.

The evaluation team would like to learn more about how each ACH engages partners through interviews. Since MTP is emphasizing community engagement and ground-up changes to improve health, it is important to track where communities start in terms of their partnerships, how they work to engage partners, and how they operate to make decisions and implement change (i.e., how they get things done).

Regarding Domain 1 activities, ACHs are still in an early phase of this work. Progress and the specificity of planned activities vary across the ACHs for value-based payment (VBP), workforce transformation, and population health management (HIT/HIE). Additionally, all ACHs have participated in distributing surveys for each of the Domain 1 activities, including involvement with the HCA survey. These surveys and other collaboration between ACHs and their partners provide evidence of initial conditions (strengths, challenges, and needs) with regard to VBP, workforce, and HIT/HIE. Most ACHs have dedicated workgroups or task forces to address each of the Domain 1 categories.

VALUE-BASED PAYMENT

The project plans or semi-annual reports do not contain detailed or concrete plans on VBP. Most ACHs are working with payers and MCOs in their region to establish thinking and collaboration on VBP models. ACH leaders are also working with partners on how to define value, and how to assign risk from small providers to MCOs. The primary plan cited by most ACHs is to train and educate providers on VBP, although ACHs generally seem unsure of how to approach VBP.

WORKFORCE TRANSFORMATION

A common theme among ACHs is incorporating community health workers (CHWs) and peer support specialists into the healthcare workforce. This may be in part due to the adoption of the Pathways HUB model, which emphasizes the potential of CHWs and peer support in care delivery and access. However, a couple of ACHs noted that there are challenges with defining a CHW's role and what appropriate training would look like. Relatedly, ACH leaders noted that there are professional licensure and certification barriers that may be preventing some of the workforce—including CHWs and behavioral health providers—from being involved to their full potential. This is noted especially where there are gaps in the workforce, such as with. Most ACHs noted the need or desire to have more CHWs, including ideas for CHW training and working toward making it possible to pay CHWs through Medicaid.

POPULATION HEALTH/HEALTH INFORMATION TECHNOLOGY OR EXCHANGE

About half of the ACHs have mentioned using EDIE, the Emergency Department Information Exchange platform. The EDIE allows tracking of emergency department visits, highlighting those who visit the emergency department frequently. High frequency utilizers of emergency departments are a target population of several project categories used by several ACHs. ACH leaders have surveyed their regions on their use of and resources for HIT/HIE to better understand existing efforts, gaps, and variation within their regions.

Some regions may have more HIT and HIE expertise than others. For instance, Olympic Community of Health has piloted an information technology tool called "The Commons," which connects health information of shared patients between a primary care provider and a substance use disorder provider. Developing this kind of tool requires developing the trusting partnership on which data sharing must necessarily be based. Regions that have developed such partnerships may be better positioned to implement HIT/HIE plans.

There are a number of challenges related to HIT/HIE noted in these ACH documents. While many providers and health system administrators reported that they use an electronic health record (EHR), there is typically variation in which platform they use. Several ACH leaders noted in their project plans or semi-annual reports that this variation creates barriers to exchanging health information. North Central ACH leaders noted a lack of interoperability of the prescription monitoring program (PMP) with EHRs. Having a PMP that functions with EHR platforms may be useful to ACH projects.

PROJECT SELECTION AND IMPLEMENTATION STRATEGIES

Guiding principles for this work, such as health equity, access to care, and quality of care, are embedded in the projects and requirements of the ACH work. However, a couple of ACHs have unique plans in this area. North Sound ACH is using the guiding principle of "Targeted Universalism." This is described as identifying a common or "universal" goal, then identifying any barriers to this goal experienced by specific groups. The ACH tasks themselves with tailoring goals for these specific groups to achieve or reach the purported goal. Pierce County ACH is planning to develop a "playbook" with a list of guidelines, policies, procedures, protocols, and compilation of evidence-based practices that will assist and guide partners during the demonstration period.

Table 2 presents details on project selection and prior or current experience in project areas by ACH. The number of projects selected by each ACH ranged from four to eight, with five ACHs selecting four projects, three selecting six projects, and one selecting all eight projects. Of note is that all ACHs selected project 3D: Chronic Disease Prevention and Control, a non-required project. NSACH, which has committed to all eight projects, is taking a holistic approach, where projects are not discreet activities, but are addressed through four initiatives: Care Coordination, Care Transformation, Care Integration, and Capacity Building. PCACH also organizes their project by a system of change rather than viewing them as separate initiatives. OCH, SWACH, BHT, and HH have some aspects of cohesiveness between projects that they have explicitly discussed.

As Table 2 shows, all ACHs are planning work on behavioral health, addressing the opioid crisis and better management of chronic care. In most areas selected, ACHs have prior experience and are leveraging this for experience in their MTP work. We have reviewed the project plans to identify what the AHCs describe that they propose to do. We understand that what actually happens can be quite different, and for good reason, and we will be monitoring this evolution.

TABLE 2. PROJECT SELECTION BY ACCOUNTABLE COMMUNITY OF HEALTH

ACH*	2A Behavioral Health Integration	2B Care Coordination	2C Transitional Care	2D Diversion Intervention	3A Addressing the Opioid Crisis	3B Reproductive, Maternal, and Child Health	3C Oral Health Access	3D Chronic Disease
BHT	X	X			X			X
CPAA	X	X	X		X	X		X
GC	X		X		X			X
HH	X		X		X			X
NCACH	X	X	X	X	X			X
NSACH	X	X	X	X	X	X	X	X
OCH	X		X		X	X	X	X
PCACH	X	X			X			X
SWACH	X	X			X			X

Note: Blue highlighting indicates prior or existing experience in a project area or chosen model for that project area, explicitly stated in project plans or semi-annual reports. *BHT – Better Health Together; CPAA – Cascade Pacific Action Alliance; GC – Greater Columbia Accountable Community of Health; HH – Healthier Here; NCACH – North Central Accountable Community of Health; NSACH – North Sound Accountable Community of Health; OCH – Olympic Community of Health; PCACH – Pierce County Accountable Community of Health; SWACH – Southwest Accountable Community of Health.

In addition, for each of the selected projects, ACHs listed the models or approaches they plan to use. Across ACHs, there was variation in model choice, including the type and number of models chosen to frame and direct their efforts. Some ACHs have selected models for project partners, while others are giving project partners more choice and flexibility in the model or approach that guides their work. Some ACHS have yet to identify specific guiding models. Table 3 presents common models selected by the ACHs.

TABLE 3. COMMON MODELS SELECTED BY ACHS (BY PROJECT)

Project	Common Models
2A: Bi-Directional Integration of Physical and Behavioral Health	Bree Collaborative, Collaborative Care Model
2B: Community-Based Care Coordination	Pathways Community HUB Model
2C: Transitional Care	Care Transitions Intervention Model, Peer Bridger Program, Interventions to Reduce Acute Care Transfers
2D: Diversions Interventions	ER is for Emergencies, Community Paramedicine Model
3A: Addressing the Opioid Use Public Health Crisis	CDC/AMDG Interagency Guidelines, Six Building Blocks, Prevention, Treatment, Overdose Prevention, Recovery
3B: Reproductive and Maternal and Child Health	One Key Question, Bright Futures, CDC's Recommendations to Improve Preconception Health and Health Care
3C: Access to Oral Health Services	Mobile Dental Hygiene in Community Settings, Oral Health Delivery Framework, Increase oral health access points
3D: Chronic Disease Prevention and Control	Chronic Care Model (complemented by disease specific interventions such as CDC diabetes prevention, Million Hearts Campaign)

ASSESSMENTS

Each ACH has discussed in their project plans and semi-annual reports that they have conducted their own surveys and assessments multiple times, including most recently the Current State Assessments. ACHs had their own approaches to how to assess the current efforts and resources in their regions, and there is variation in the type and amount of assessment that has been conducted. Many of these assessments sought to understand readiness for change in a particular area (e.g., fully integrated managed care, VBP, HIT/HIE, workforce transformation) and the organization's or region's current efforts in a particular area (e.g., physical and behavioral health integration, HIE/HIT, fully-integrated managed care, and general assessments of capacity and gaps in efforts). It appears that ACHs are attempting to leverage this information to target regional gaps and needs, and to leverage and build on existing efforts, where they exist. It will be interesting to understand what they learned from these assessments and how they are using this information to identify needs and mobilize to address them.

TARGET POPULATIONS

All of the ACHs have identified target populations, or have laid out plans to identify target populations, for each of their selected project areas. There is variation among ACHs in their selection of target populations, but there are some populations that are common across several or most of the ACHs. Table 4 presents common and noteworthy target populations by project.

TABLE 4. COMMON AND NOTABLE TARGET POPULATIONS ACROSS SELECTED PROJECTS

Project	Common Models*
2A: Bi-Directional Integration of Physical and Behavioral Health	• All Medicaid beneficiaries (comorbidities) • Additional risk or at-risk factors such as homelessness
2B: Community-Based Care Coordination	• High-risk pregnancy or other risk factors • Jail transition (BHT) • ED visits in past 12 months (NCACH)
2C: Transitional Care	• Transitioning between acute care to housing • Individuals who are homeless or do not have stable housing • Multiple or preventable ED visits
2D: Diversions Interventions	• Accessing ED care for non-emergent needs • Individuals released from jail (OCH)
3A: Addressing the Opioid Use Public Health Crisis	Beneficiaries with: • SUD/OUD or at risk for developing • Multiple ED visits • Overdosed • Opioid prescription (or chronic use)
3B: Reproductive and Maternal and Child Health	• Men and women of reproductive age • Pregnant women and mothers • Those with SUD • Those who have suffered abuse, trauma, or ACE
3C: Access to Oral Health Services	• Adults and children with limited access to oral health care • Pregnant women • Chronic conditions or high service utilization • Beneficiaries who are homeless
3D: Chronic Disease Prevention and Control	Beneficiaries with: • One or more chronic conditions • Under or over utilize health services • Care access barrier • Behavioral health concerns

*BHT – Better Health Together; CPAA – Cascade Pacific Action Alliance; GC – Greater Columbia Accountable Community of Health; HH – Healthier Here; NCACH – North Central Accountable Community of Health; NSACH – North Sound Accountable Community of Health; OCH – Olympic Community of Health; PCACH – Pierce County Accountable Community of Health; SWACH – Southwest Accountable Community of Health.

LONG-TERM SERVICES AND SUPPORTS AND FOUNDATIONAL COMMUNITY SUPPORTS

Importantly, the LTSS and FCS initiatives are largely separate from the ACH work and are operated by different agencies, including DSHS and Area Agencies on Aging. We have few documents available to us documenting details about these initiatives. While we have been able to speak with HCA and DSHS staff about these programs at a high level, enabling us to learn more about eligibility and services provided through these new offerings, more discussion is needed to develop a detailed understanding of the efforts in these areas. Interviews will be especially helpful to connect with and learn from state and regional leaders who are involved in the work.

Next Steps

Through document analysis we have developed a greater depth of understanding of MTP and each initiative. Part of our work in the document analysis was to keep a list of people and organizations intimately involved in MTP work. We will use our findings to identify key stakeholders for semi-structured interviews, and to tailor our interview protocol to each key informant's expertise and areas of knowledge. We look forward to beginning interviews with State and ACH leaders once the WSIRB application is approved.