Washington State Health Care Authority

Washington State Medicaid Transformation Project (MTP) demonstration

Section 1115 Waiver Quarterly Report (DY7 Q2)

Reporting quarter: 2 (April 1 to June 30, 2023)

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Introduction

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

Over the MTP period, Washington will:

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

The state will accomplish these goals through these programs:

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

Vision: a healthier Washington

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

Quarterly report: April 1 – June 30, 2023

This quarterly report summarizes MTP activities from the second quarter of 2023: April 1 through June 30. It details MTP implementation, including stakeholder education and engagement, planning and implementation, and development of policies and procedures.

Summary of quarter accomplishments

- Washington State received official approval of MTP 2.0 from CMS for an additional five years beginning on July 1, 2023.
- ACHs continue to distribute incentive funds, including $32,264,838 to 184 to partnering providers in this reporting period. The state distributed $5,000,000 in earned incentive funds to IHCP-specific project milestones.
- As of June 30, 2023, more than 15,100 clients have received services and supports from the MAC and TSOA programs. New enrollees in LTSS for this reporting period include 233 MAC dyads, 1226 TSOA dyads, and 2866 TSOA individuals. MAC and TSOA programs will continue under MTP 2.0, expanding services and care options for the eligible population.
- Within FCS, the total aggregate number of people enrolled in services as of June 30, 2023, included 6,678 in IPS and 12,892 in CSS. The total unduplicated number of enrollments at the end of this reporting period was 16,318.

MTP-wide stakeholder engagement

2023 MTP amendment request

During the reporting quarter, HCA held a formal public comment period for the **2023** MTP amendment request. **Read the announcement**. The comment period ran from April 20 through May 22. During this time, the state hosted two virtual public hearings on May 4 and May 15. Public comments received will be included as an appendix to the final amendment request, which HCA will submit to CMS next quarter. **Visit the MTP amendment page**.

Approval for 2021 MTP amendment request and federal match

During Q2, HCA announced CMS' approval of Washington's **2021** MTP amendment, including continuous enrollment for Medicaid children. **The announcement** provided updates on other MTP waiver-related activities as well, including:

- The status of MTP 2.0 and negotiations with CMS
- CMS' short extension to the current MTP wavier period

In May, Washington State also received CMS approval to receive federal match for those who aged out of the Children's Health Insurance Program (CHIP) during the public health emergency (PHE).

Approval for MTP 2.0

In June, Washington received official approval of MTP 2.0, a huge milestone in the state's Medicaid transformation efforts. **In the announcement**, HCA shared the programs approved to continue under MTP 2.0, as well as newly approved programs, pending programs, and one denied program.

HCA also began updating website language and reviewing MTP-related documents that are posted in the **MTP website section**. This work will continue into Q3 and beyond. HCA expects to share new or updated materials and webpages in the coming months.

Statewide activities and accountability

Value-based purchasing (VBP)

VBP Roadmap and Apple Health Appendix

The VBP Roadmap describes HCA's VBP goals, purchasing and delivery system transformation strategies, innovation successes to date, and plans to accelerate the transition into value-based payment models. The appendix, in accordance with the Special Terms and Conditions (STCs), describes how MTP supports providers and managed care organizations (MCOs) to move along the value-based care continuum. The roadmap establishes targets for VBP attainment and related Delivery System Reform Inventive Payment (DSRIP) incentives for MCOs and ACHs. In Q4 of 2022 and Q1 of 2023, HCA updated the annual roadmap and the VBP website.

Validation of financial performance measures

HCA contracts with Myers and Stauffer LC (MSLC) to serve as the independent assessor (IA) for MTP. In this role, the IA functions as the third-party assessor of financial measures data submitted by MCOs as part of their contracts with HCA. HCA's contracts with the five MCOs establish parameters for the VBP assessment process. These parameters include the financial performance measures, the timelines under which MCOs must submit data, and the review process, which includes third party validation. HCA met with MSLC in Q2 to begin the 2023 validation process.

Statewide progress toward VBP targets

HCA sets annual VBP adoptions targets for MCOs and ACH regions in alignment with HCA's state-financed purchasing goals. To track progress, HCA collects financial performance measure data from MCOs by ACH region through the VBP validation process and from commercial and Medicare payers through an annual Paying for Value survey. In Q2, HCA updated the template and prepared to launch the survey in Q3.

Technical support and training

No activities to report in Q2.

Upcoming activities

MCOs will complete the VBP validation templates and work with the IA to address any questions in Q3. The IA will coordinate with HCA on the analysis and final reporting of MCO progress to-date.

Health plans (including MCOs) will complete HCA's Paying for Value Survey in Q3, and HCA will analyze results in Q4.

VBP communications

During Q2, HCA finished updating the language in the **VBP website section**. Read **the announcement**. The state also prepared communications for the upcoming, annual Paying for Value survey for plans/payers. Communications included a broad announcement and instructive emails for HCA's commercial and managed care plans. The survey launches July 1. **Read the announcement**.

Integrated managed care (IMC) progress

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

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

During Q2 of 2023, HCA staff and MCO colleagues presented at the Integrated Care Conference, sponsored by the University of Washington. WA-ICA workgroup members further refined the requirements for both a lead data entity and statewide coordinating entity.

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:

- State electronic health records (EHRs)
- Crisis Call Center and related activities: 988/E2SHB 1477
- Electronic consent
- MH IMD Waiver Health IT tasks

Q2 of 2023 focused heavily on planning for the following health IT-related initiatives:

- Nationally required 988 crisis call line and, Washington State's more expansive requirements for a Crisis Call Center Hub System and BH Integrated Referral System (E2SHB 1477);
- Electronic Consent Management (ECM) solution; and
- MH IMD Health IT tasks

Activities and successes

The Health IT team spent much of the second quarter of 2023 continuing its focus on advancing multi-year initiatives involving Health IT.

Crisis Call and Response Services

The HCA 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 BH Integrated Client Referral System (E2SHB 1477).

HCA and DOH staff met face-to-face to discuss activities and timelines needed to implement the enhanced crisis call and response system required in in E2SHB 1477.

HCA and DOH staff began the analyses of responses from 11 technology vendors to the Request for Information (RFI) regarding the availability of interoperable tools to support crisis call and response services. The RFI provided information about existing tools in the marketplace, and responses will inform a planned Request for Proposals (RFP).

HCA initiated and convened the 988 State Advisory Workgroup (SAW) which includes 44 states, the District of Columbia, and two territories. The 988 SAW is a forum to discuss the implementation of 988, as well as generate clarifying questions jointly shared with Substance Abuse and Mental Health Services Administration (SAMHSA).

ECM

The ECM solution will initially focus on 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.

A contract with CodeSmart /Midato Health has been negotiated, including updated timeline, budget, and deliverables. CMS approval of the HCA planning document and the vendor contract is expected in early September and kickoff for implementation is expected in mid-September 2023. The baseline electronic consent solution is scheduled to go live in May 2024. HCA continues to meet with providers interested in being early system users.

MH IMD Waiver HIT activities

HCA completed a contract for PM services to develop a draft Health IT strategic plan for the MH IMD Waiver. The final plan will identify potential tasks, activities, and funding sources.

Community Information Exchange (CIE)

HCA is continuing to work on developing CIE for Washington State. The Health IT team is working with partners on next steps for implementing CIE to support the Community-based Care Coordination (CBCC) hubs. MTP 2.0 has provided health-related social needs (HRSN) infrastructure authority that can potentially support CIE development in addition to other infrastructure investments.

Statewide EHR as a Service

HCA contracted with McKinsey & Company (a management consulting company) in early June of 2023 to support building the statewide plan with DSHS, Department of Corrections (DOC) and Washington Technology Solutions (WaTech), with an anticipated completion date in late August 2023. Funding is contingent upon plan approval. The earliest possible implementation start would be Q3 of 2024.

In parallel, Department of Enterprise Services (DES) is working to release an RFP to establish a master contract for EHR platforms. A draft of that RFP will be provided to CMS for approval as HCA anticipates requesting an enhanced funding match.

A Planning- Advance Planning Document (P-APD) update was recently approved by CMS for the current timeline and planning efforts.

Provider Directory Application Programming Interface (API)

MyHealthButton is published in the Google and Apple application stores. HCA continues to test and work through usability issues with the app development team. Another application, **FlexPA** connects successfully to the Fast Healthcare Interoperability Resources (FHIR)server. Next steps are to ensure successful usability testing and then send out communications around its availability to potential members. HCA is waiting on additional information from OneRecord, another interested third party entity. Once they send in the requested information, they can begin the connectivity process and testing. HCA currently has 154,000 providers listed in the provider directory as of June 30, 2023.

Master Person Index (MPI) project

The Health and Human Service Coalition (Coalition) MPI initiative has established the MPI solution, created its operational governance structure, and connected two Coalition systems. The initiative supports existing system connections, while also entering an expansion phase focused on connecting numerous Coalition systems by June 2025.

WA Integrated Care Assessment Initiative (WA-ICA)

The WA-ICA Initiative involves advancing clinical integration between behavioral health and primary care practices using a practice-level self-assessment of their level of bi-directional clinical integration and providing supports to increase practices' level of clinical integration. In its approval of Washington State's MTP 2.0 application, CMS listed WA-ICA among the pended items. HCA staff and other ICA workgroup members are exploring alternative funding mechanisms to support this work.

DSRIP program implementation accomplishments

ACH project milestone achievement

Pay for reporting (P4R)

ACHs previously reported on their MTP activities, project implementation, and progress on required milestones. This is outlined in the **Project Toolkit.** P4R reports were submitted every six months, and the final **ACH P4R report** was submitted on October 7, 2022. Additional context regarding pay for performance (P4P) is included under DSRIP measurement activities.

Next steps

HCA and ACHs continue to look ahead and plan for implementation of programs approved under MTP 2.0. The two programs that are anticipated to involve ACHs most prominently include HRSN services and re-entry and pre-release services. The ACHs may also be involved in the distribution of funding to partner and facilities under HRSN infrastructure and/or re-entry planning and implementation funds.

HCA temporarily suspended the taskforce that convened representatives from MCOs, ACHs, DOH, DSHS, and HCA. This taskforce will re-convene in the fall to re-engage on topics such as roles and partnership opportunities to support the re-entry and pre-release services, and HRSN services, including Community and Native Hub implementation.

Annual VBP milestone achievement by ACHs

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

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 **$32,264,838 to 184** partnering providers and organizations in support of project planning and implementation activities. The state released **$5,000,000.00** in earned incentive funds to IHCPs at the end of June 2023 for achievement of IHCP-specific project milestones. IHCP funds were available in the portal in July.

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

DSRIP measurement activities

Pay for performance (P4P)

Total DY5 P4P and High Performance Pool (HPP) incentives across ACHs totaled $42,723,776. These funds were released in June.

VBP

MCOs earned a total of eight million dollars in the final year of VBP incentives. Two of five MCOs achieved the actual target of 85 percent VBP adoption. ACHs earned a total of nearly four million dollars in VBP incentives. Four of the nine ACH regions achieved the actual target of 85 percent VBP adoption.

Statewide results

The state's DY5 statewide accountability report was approved by CMS in April. Because the state and its providers attained 84.69 percent of VBP adoption target, the state received federal financial participation (FFP) for a portion of the at-risk DSRIP funding for DY5. With this approval, the state received FFP for $13,329,127 of the $14,250,000 at-risk DSRIP funding for DY5.

DSRIP program stakeholder engagement activities

HCA continues to share pertinent information with ACHs on an ad-hoc basis. The agency shares information via email about training, grant opportunities, and events, and requests that ACHs share with their networks and community.

DSRIP stakeholder concerns

No stakeholder concerns were reported during Q2, 2023.

Upcoming DSRIP activities

HCA will continue to monitor the final distributions of ACH incentives to partnering providers through the FE portal. The final P4P payments will be released in Q2 2024, and HCA will continue to work with the ACHs, Independent Assessor, and PCG in preparation for the closeout of DSRIP incentives.

Tribal project implementation activities

Primary milestone: American Indian Health Commission, as the Tribal Coordinating Entity, submitted the final DY6 report, drawing down the final DSRIP payment for the IHCP-specific Projects.

Tribal partner engagement timeline

- April 26 and April 27: Participated in the Tribal Partners Collaborative's (TPC, a board advisory group to Better Health Together) Strategic Planning Retreat
- May 10: Participated in the TPC meeting
- May 19: Hosted the ACH Tribal Liaison call
- June 13-15: Attended the Northwest Portland Area Indian Health Board's Community Health Aide Program (CHAP) Symposium
- June 16: Hosted the ACH Tribal Liaison call

LTSS implementation accomplishments

This section summarizes LTSS program development and implementation activities from April 1 through June 30, 2023. Key accomplishments for this quarter include:

- As of June 30, 2023, more than 15, 100 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 3,927 clients.
- ALTSA continued with their annual quality assurance cycle.
- On June 30, 2023, MTP 2.0 was approved. MTP 2.0 extends current programs and authorizes development of new innovative projects, activities, and services for MTP participants. Highlights include:
    - The income limit qualification for TSOA will now be 400 percent of the federal benefit rate. This will allow for more clients to be eligible and benefit from our programs.
    - The resource standard increased to reflect six months of the current private nursing facility rate for single applicants which correspondingly increased the limit for married couples applying. Also, within this change is the ability to automatically update the resource standard each year as the nursing facility private rate is adjusted.
    - Authorized four additional services—nurse delegation, pest eradication, specialized deep cleaning, and community choice guide services.

Network adequacy for MAC and TSOA

There continues to be a shortage of paid in-home care providers for respite and personal care services at both the national and state level. The Area Agencies on Aging (AAAs) continue to engage with a variety of new providers to serve as a bridge when personal care or respite workers are in short supply. These providers are delivering services such as home delivered meals, personal emergency response systems, adult day care, and environmental modifications. Additionally, the AAAs continue to maintain and monitor existing service contracts.

Tailored Caregiver Assessment and Referral (TCARE 5.0) caregiver assessment tool was released in February 2023 and has released periodic upgrades for system compatibility.

Assessment and systems update

Work continues to move forward with Consumer Directed Employer (CDE) implementation. Consumer Direct of Washington (CDWA) is the contracted CDE provider for Washington State. CDWA will build an interface between their system and the MAC/TSOA case management system, GetCare. This interface will allow case managers to send and receive documents required by providers to support delivery of personal care and respite services for MTP participants.

Staff training

MAC and TSOA program managers for Home and Community Services (HCS) committed to providing monthly statewide training webinars on requested and needed topics during 2023. Below are the webinar trainings that occurred during this quarter:

- May 17, 2023: Estate Recovery
- June 21, 2023: Caregiver Programs Learning Collaborative: Understanding how scoring of stresses and burdens can be used to determine strategies and goals.

Upcoming webinars in Q3 include:

- July 19, 2023: Open Office Hours
- September 20, 2023: What's Lost and What's Gained as well as Resource Eligibility and After PHE Financial Review/Discussion

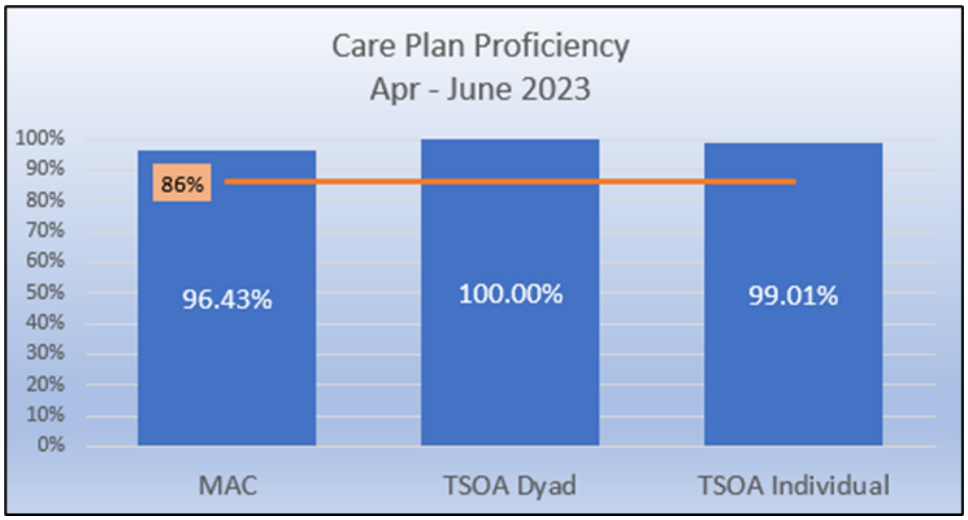
Data and reporting

Table 1: beneficiary enrollment by program

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of June 30, 2023	233	1,226	2, 866
Number of new enrollees in quarter by program	28	195	302
Number of new person-centered service plans in quarter by program	15	75	114
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	12	120	185
Number of beneficiaries self-directing services under employer authority*	0	0	0

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

Figure 1: statewide care plan proficiency to date



*The 86 percent line represents the CMS proficiency expectation.

The AAA's compliance with timely completion of care plans for enrollees continues to be outstanding.

Tribal engagement

DSHS ALTSA met with a number of tribes to discuss Medicaid services and Initiative 2 and 3 of the demonstration during Q2 2023:

- **April** – Presented MAC & TSOA information to Tribes at IPAC subcommittee. Promoted and reminded tribal members of MAC & TSOA video casting/project.
- **May** – Tribal Affairs attended Quileute Health Fair and Quinault Health Fair to share information for MAC and TSOA programs.
- **June** – Shared MAC and TSOA information with Lummi Nation during Savvy Caregiver in Indian Country training.

MAC and TSOA program information will be presented at the Tribal Fall Summit 2023.

Tribal Affairs has been building relationships with Tribal Nations while sharing services supported by Money Follows the Person Tribal Initiative (MFPTI) including MAC and TSOA. The Tribal Initiative project manager is currently compiling all

resources and information that pertain to the utilization of the grant and the services that it supports to present to unpaid caregivers in Tribal communities.

Outreach and engagement

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

Table 2: Number of outreach and engagement activities held by AAA

	April	May	June
Community presentations and information sharing	70	76	26

The volume and type of outreach activities held by the AAA continue to fluctuate.

Quality assurance

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?

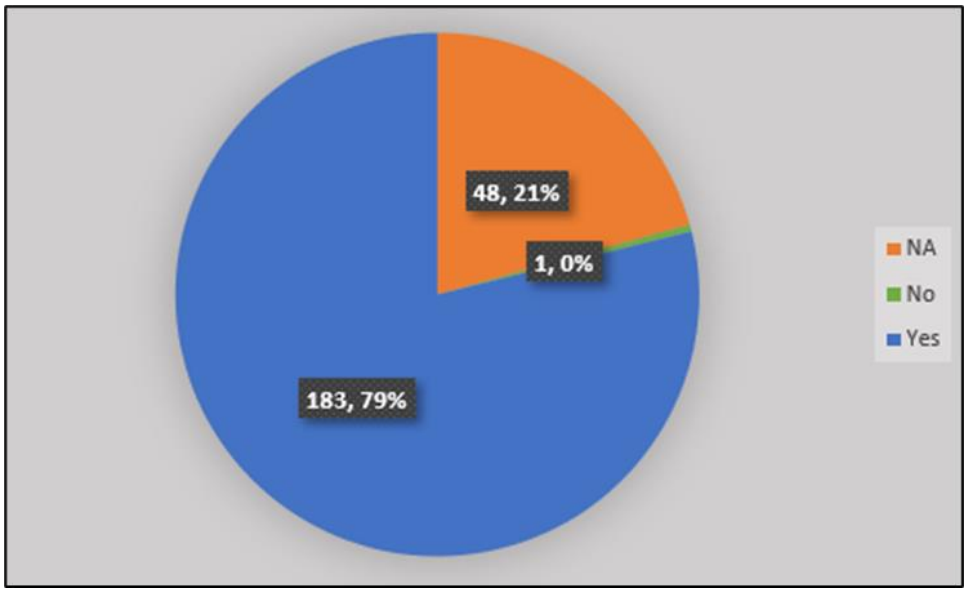


Figure 3: Question 2a: did the client remain eligible after the PE period?

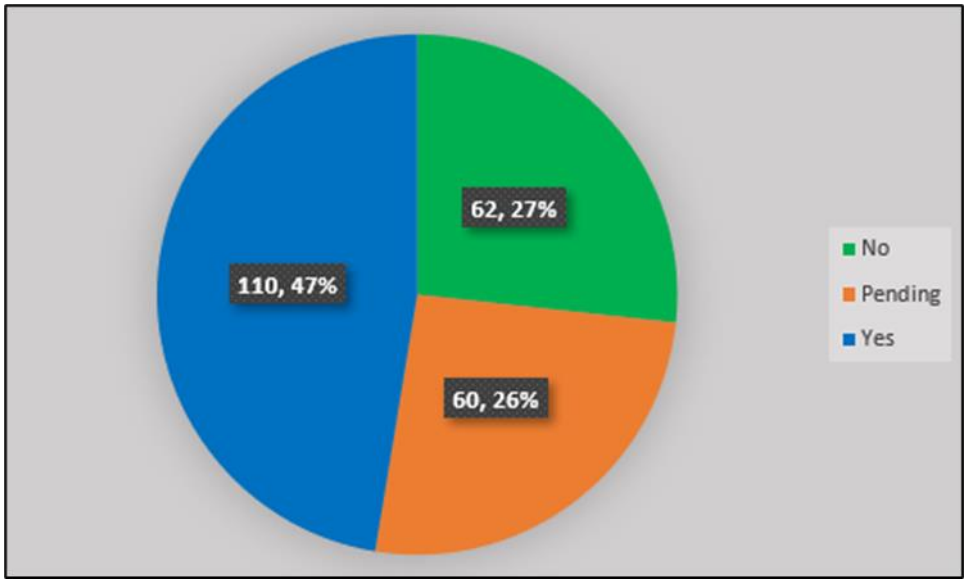
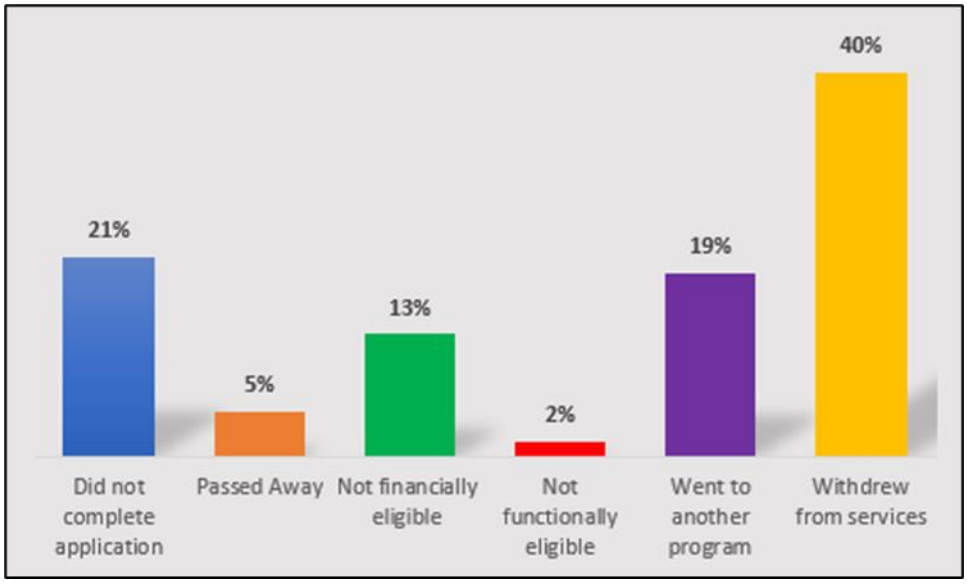


Figure 4: Question 2b: if "No" to question #2a, why?

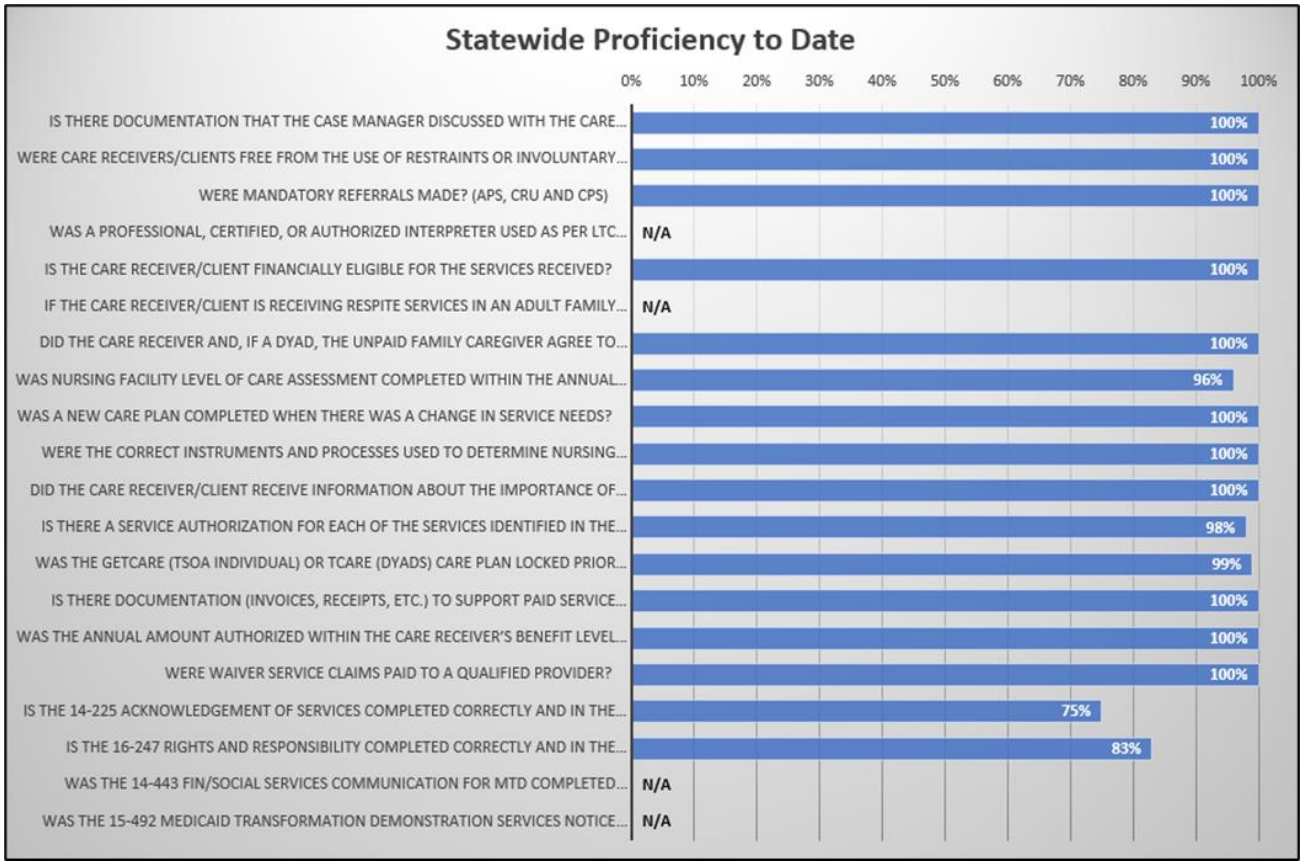


2023 quality assurance results to date

HCS's 2023 Quality Assurance cycle began in January, and it is expected to conclude in November 2023. The statewide compliance review of the twenty MAC and TSOA performance measures is conducted with all 13 AAAs. An identical review process is applied in each AAA Planning and Service Area (PSA), using the same quality assurance tool and the same performance measures.

The Quality Assurance team reviews a statistically valid sample of case records. The sample size in 2023 is 353 cases. The methodology used is the same for the state's 1915(c) waivers and meets the CMS requirements for sampling. Each AAA's sample was determined by multiplying the percent of the total program population in that area by the sample size.

Figure 5: statewide proficiency to date



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

State rulemaking

ALTSA finalized the rule making process this quarter to modify Washington Administrative Code (WAC) related to proposed new MAC and TSOA services requested in MTP 2.0, as well as the proposed expanded definition for transportation (to include accessing community resources).

Upcoming activities

- Implementation of new services approved under MTP 2.0.
- Continuation on infrastructure development regarding Consumer Direct Employer implementation.

LTSS stakeholder concerns

No stakeholder concerns were noted during this quarter.

FCS implementation accomplishments

The FCS program provides evidence-based supportive housing and supported employment services to eligible Medicaid clients. This section summarizes development and implementation activities from April 1 through June 30, 2023. Key accomplishments for the quarter include:

Total aggregate number of people enrolled in FCS services at the end of DY7 Q2:

- CSS: 12,892
- IPS: 6,678

There were 199 providers under contract with Amerigroup at the end of DY7 Q2, representing 536 sites throughout the state.

Note: CSS and IPS enrollment totals include 3,252 participants enrolled in both programs. The total unduplicated number of enrollments at the end of this reporting period was 16,318.

Network adequacy for FCS

Table 3: 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)	36	77	36	77	35	76
Community Support Services (CSS)	24	60	24	60	24	60
CSS and IPS	135	395	137	397	140	400
Total	**195**	**532**	**197**	**534**	**199**	**536**

Client enrollment

Table 4: FCS client enrollment

	April	May	June
Supported Employment – Individual Placement and Support (IPS)	3,198	3,337	3,426
Community Support Services (CSS)	8,793	9,477	9,640
CSS and IPS	2,889	3,159	3,252
Total aggregate enrollment	**14,880**	**15,973**	**16,318**

Data source: RDA administrative reports

Table 5: FCS client risk profile

		Met HUD homeless criteria	Avg. PRISM risk score	Serious mental illness
April	IPS	719 (12%)	.94	4,251 (70%)

May	CSS	2,511 (21%)	1.17	7,287 (62%)
	IPS	757 (12%)	1.04	4,547 (70%)
June	CSS	2,672 (21%)	1.28	7,967 (63%)
	IPS	780 (12%)	.81	1,573 (24%)
	CSS	2,709 (21%)	1.01	2,984 (23%)

HUD = Housing and Urban Development

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

Table 6: FCS client risk profile continued

		Medicaid only enrollees*	MH treatment need	SUD treatment need	Co-occurring MH + SUD treatment needs flags
April	IPS	5,102	4,664 (91%)	3,093 (61%)	2,895 (57%)
	CSS	9,809	8,681 (89%)	7,124 (73%)	6,487 (66%)
May	IPS	5,477	4,991 (91%)	3,305 (60%)	3,095 (57%)
	CSS	10,640	9,406 (88%)	7,667 (72%)	6,996 (66%)
June	IPS	5,614	5,098 (91%)	3,370 (60%)	3,144 (56%)
	CSS	10,895	9,599 (88%)	7,785 (71%)	7,089 (65%)

Data source: RDA administrative reports

*Does not include individuals who are dual enrolled.

Table 7: FCS client service utilization

		Medicaid only enrollees*	Long-term Services and Supports	Mental health services	SUD services (received in last 12 months)	Care + MH or SUD services
April	IPS	5,102	603 (12%)	3,589 (70%)	1,865 (37%)	503 (10%)
	CSS	9,809	914 (9%)	5,981 (61%)	4,258 (43%)	760 (8%)
May	IPS	5,477	645 (12%)	3,720 (68%)	1,985 (36%)	525 (10%)
	CSS	10,640	970 (9%)	6,260 (59%)	4,540 (43%)	792 (7%)
June	IPS	5,614	684 (12%)	3,703 (66%)	1,999 (36%)	541 (10%)
	CSS	10,895	1,029 (9%)	6,218 (57%)	4,532 (42%)	819 (8%)

(Aging CARE assessment in last 15 months)

Data source: RDA administrative reports

*Does not include individuals who are dual-enrolled.

Table 8: FCS client Medicaid eligibility

		CN blind/disabled (Medicaid only & full dual eligible)	CN aged (Medicaid only & full dual eligible)	CN family & pregnant woman	ACA expansion adults (nonadults presumptive)	Adults (nonadults presumptive) ACA expansion adults (SSI presumptive)	CN & CHIP children
April	IPS	1,774 (29%)	141 (2%)	662 (11%)	2,656 (44%)	671 (11%)	181 (3%)
	CSS	3,425 (29%)	581 (5%)	1,434 (12%)	4,368 (37%)	1,754 (15%)	117 (1%)
May	IPS	1,853 (29%)	154 (2%)	718 (11%)	2,858 (44%)	716 (11%)	195 (3%)
	CSS	3,636 (29%)	631 (5%)	1,578 (12%)	4,754 (38%)	1,902 (15%)	132 (1%)
June	IPS	1,937 (29%)	164 (2%)	734 (11%)	2,915 (44%)	737 (11%)	187 (3%)
	CSS	3,719 (29%)	658 (5%)	1,627 (13%)	4,750 (37%)	2,000 (16%)	132 (1%)

ACA = Affordable Care Act

CHIP = Children's Health Insurance Program

CN = categorically needy

Data source: RDA administrative reports

Quality assurance and monitoring activity

During Q2, FCS staff collaborated with the TPA to oversee FCS enrollment and participation. 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 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.

With the PHE ending and regular Medicaid enrollments resuming by the end of Q1, FCS experienced an increase in reconnections, disenrollments, and changes in the number of enrolled participants in Q2. Although the manual enrollment process may be time-consuming, it provides deeper insight into enrollment trends among specific FCS providers while allowing HCA to monitor for inconsistencies or data discrepancies.

FCS training staff have successfully conducted several fidelity reviews of contracted FCS providers. These reviews were performed virtually or in a hybrid format over a period of two or more days, with review teams consisting of HCA staff and other FCS providers. To foster greater collaboration across systems, FCS training staff also engage fidelity reviewers from other state agencies, such as the Division of Vocational Rehabilitation. Fidelity reviews were conducted consistently and frequently throughout Q2.

The FCS team conducted two comprehensive fidelity reviewer trainings, which were divided into two sessions. One session centered on supported employment, while the other session 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. It is worth noting that

the fidelity reviews adopt a collaborative learning approach. Additionally, FCS providers can receive incentives through SAMHSA block grant funds if they choose to become reviewers or host a review.

Lastly, FCS will be hosting the second Permanent Supportive Housing (PSH) Fidelity Certification training in the third quarter. The content will once again be delivered by a national technical assistance organization that actively supports the work of FCS, Advocates for Human Potential. The training will be facilitated by both the supportive housing trainers, who will offer comprehensive assistance and share community-specific examples of successful PSH implementation. In a previous training, the FCS team successfully graduated 11 staff members who acquired vital PSH fidelity knowledge and are now actively contributing to the expansion of reviews throughout Washington. The FCS team aspires to certify the same number of individuals or more during the upcoming second iteration of this training.

Other FCS program activity

The FCS team presented two conference sessions at the 2023 Corporation for Supportive Housing (CSH) Summit in Philadelphia, PA, which was held May 31–June 2, 2023:

1. At the Intersection of Affordable Housing and Behavioral Health: Foundational Community Supports
2. Creating Opportunities to Receive and Implement Tenant Feedback

During these sessions, the FCS team shared information about FCS supported employment and supportive housing services with attendees from across the country representing housing and property development, service providers, community leaders, government staff, researchers, people with lived experience, and others.

HCA continues to maintain an ongoing monthly workgroup with the DSHS ALTSA team and Research, Data and 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 CSS providers, coordinated by King County, the most populous county in Washington State. These meetings offer housing providers in the county the opportunity to share experiences, exchange ideas, and learn from one another about effective practices when administering FCS benefits.

Furthermore, in partnership with the DSHS 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. Towards the end of 2022, FCS provided a funding opportunity that agencies could apply for, aiming to enhance access to housing and/or employment services for eligible participants. The FCS team looks forward to offering this opportunity to agencies again in Q3 and Q4. Funding will be allocated to 10 additional agencies throughout the state using federal block grants from SAMSHA. Each agency will allocate resources to support individuals who, at a minimum, face challenges related to substance use.

Upcoming activities

Medicaid Academy: In Q3 and Q4, FCS will be offering a condensed version of the Medicaid Academy as well as a budgeting series. These courses are specifically designed for prospective and current FCS providers. The target audience includes executive leads, fiscal/finance leads, programmatic leads, and quality improvement leads within respective agencies. The information presented in these academies will primarily benefit agencies who have not yet established themselves as Medicaid billing providers, those encountering challenges with Medicaid billing, and those wishing to bill Medicaid for CSS and IPS services.

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 Q3 and Q4 in addition to the FCS team's traditional Supportive Housing Institute.

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

Additionally, there is a plan to expand the Housing and Essential Needs (HEN) program to provide up to 9 months of additional rental support as a bridge period for IPS-enrolled individuals. It is worth noting that around 30 percent of IPS enrollees already receive assistance from the HEN program through a referral.

FCS program stakeholder engagement activities

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

Table 9: Number of FCS program stakeholder engagement activities held

	April	May	June
Training and assistance provided to individual organizations	100	98	125
Community and regional presentations and training events	6	8	13
Informational webinars	12	7	11
Stakeholder engagement meetings	8	4	1
Total activities	**126**	**117**	**150**

During Q2, there was a notable rise in training and assistance activities aimed at supporting individual organizations. Webinars have been organized to provide comprehensive information, education, and resource coordination for FCS providers catering to individuals seeking assistance with housing and employment services. These webinars seek to equip them with necessary resources and support. Q2 topics included:

- Braiding resources to collaboratively develop and strengthen housing and services
- Addressing the barriers to concurrent Supported Employment and Supportive Housing Service Provision
- Landlord Mitigation Fund Updates
- Bending, but not breaking: Healthy grieving and building resilience
- Using success stories as a method to encourage and support career goals
- Preparing for Initial Interactions and Introductions with employers
- SSDI Title II Benefits
- Utilizing motivational interviewing in Supported Employment: Listening for Change Talk
- Dispelling myths about individuals not wanting to work
- Prepare initial interactions and introductions with employers
- Benefit planning basics and resources

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. In response, HCA is offering additional technical assistance to support providers in adopting best practices and aligning with other Medicaid billing processes. The Medicaid Academy also offers a dedicated session on billing and documentation for those interested.

FCS stakeholders have been seeking information on the status of the waiver renewal and the plans for the continuation of services. This has been especially prevalent among new providers who are interested in developing FCS services and programs within their agencies. FCS Stakeholders have also been inquiring how and when the new approvals related to the 1115 waiver will be implemented. The FCS team plans to offer a webinar update in Q3 and inform the Advisory Council of the implementation steps.

FCS agencies have been actively providing feedback and insights on the integration of FCS services with Apple Health and Homes initiatives. 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, 2023. Accomplishments for the quarter include:

The legislature concluded its 2023 session during this quarter and a special legislative session was required to pass a new permanent law in the wake of the 2021 State v. Blake Washington Supreme Court decision that struck down prior drug possession laws.

This resulted in the passage of 5536 which concerns-controlled substances, counterfeit substances, and legend drug possession and treatment.

The bill added resources for diversion and treatment including:

- Opioid Treatment Program Rural Access and Expansion
- $36.6 million from the state general fund to expand efforts to provide opioid use disorder (OUD) medication in city, county, regional, and tribal jails.
- $7 million from the state general fund to provide support for new and established clubhouses throughout the state.
- $3.2 million from the state general fund to establish and expand 23-hour crisis relief centers distributed to an equivalent number of crisis services providers in Western Washington and Eastern Washington.
- $2.5 million from the state general fund—$5 million total funds—to provide ongoing grants to Law Enforcement Assisted Diversion (LEAD) programs.
- $1.8 million from the state general fund—$3.6 million total funds—to provide ongoing grants for Arrest and Jail Alternative programs.

The legislation requires that HCA develop payment structures by January 1, 2025, for health engagement hubs (hubs), defined as all-in-one locations where people who use drugs can access a range of medical, harm reduction, treatment, and social services. Hubs must be open to youth and adults, provide referrals or access to methadone and other medications for opioid addiction, and function as a patient-centered medical home by offering cost-effective patient-centered care including wound care, provide harm reduction services and supplies, and provide linkages to housing, transportation, and support services. Hubs may not provide supervised injection services. HCA must direct Medicaid managed care organizations to adopt a value-based bundled payment methodology in contracting with hubs and other opioid treatment programs, to the extent permitted by federal law. HCA must make sufficient funding available to ensure that a hub is available within a two-hour drive for all communities, and that there is one health engagement hub available per 200,000 residents in Washington State.

Creating Education and Employment Pathways. HCA must establish a grant program for programs designed to provide persons recovering from SUDs with employment opportunities, with priority given to programs that engage with Black, Indigenous, persons of color, and other historically underserved communities.

Providing a Statewide Directory of Recovery Services. Subject to funding, HCA must collaborate with DOH and the Department of Social and Health Services to expand the Washington Recovery Helpline and the Recovery Readiness Access Tool to provide a dynamically updated, statewide behavioral health treatment and recovery support services mapping tool, including a robust resource database and referral system, to facilitate the connection between individuals and facilities which are currently accepting new referrals.

Streamlining Substance Use Disorder Treatment Intakes. HCA must convene a work group to recommend changes to intake, screening, and assessment for SUD services by December 1, 2023, with the goal of shortening the intake process

and broadening the workforce capable of processing SUD intakes. HCA must include providers, payors, and people who use drugs in the work group, and other individuals recommended by HCA.

Implementation plan

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

- No changes occurred in this period.

SUD Health IT plan requirements

See the sections on Crisis Call and Response services, ECM, and MH IMD Waiver HIT activities under the **Health IT activities and successes subheading**.

Evaluation design

No changes occurred in this period.

Monitoring protocol

No changes occurred in this period.

Upcoming activities

No upcoming activities.

MHIMD waiver implementation accomplishments

The legislature concluded its 2023 session during this quarter, passing their final budget on April 22, 2023, which will provide nearly two billion dollars of spending for MH initiatives, including:

- $25 million state ($26.4 million total) to establish a taskforce and five hospital pilot programs specifically to address challenges faced with discharging patients from acute care and post-acute care capacity.
- $250,000 state for a hospital discharge assessment study to evaluate the impact of requiring functional assessments prior to discharge from acute care hospitals.
- $17.4 million state ($34.8 million total) to continue the long-term care rapid response nursing team program in fiscal year 2024. This program provides staffing teams for long-term care facilities facing workforce shortages and helps address hospital capacity issues.
- $10.9 million state ($13 million total) for institutional transitions to help Medicaid patients transition from acute care hospitals, state hospitals and community psychiatric hospitals into settings in the community with more appropriate levels of care:
- $3.3 million state ($6.7 million total) for community placement incentives: includes specialty dementia care slots, community stability slots and discharge coordination.
- $1.8 million state for non-citizen long-term care (LTC) slots: adds 10 long-term care slots for individuals transitioning out of acute care hospitals who are ineligible for Medicaid as non-citizens.
- $14.8 million state ($52.1 million total) to rebase psychiatric per diem rates paid to hospitals to ensure the rates reflect the appropriate percentage of cost for each hospital.
- $1.1 million state ($7.5 million total) to maintain the Intensive Outpatient and Partial Hospitalization Pilot program (IOP/PHP) pilot sites and expand to a statewide children's benefit in CY 2024.
- $6.3 million state ($6.5 million total) to support pediatric patients stuck in hospitals through a care coordinator within the Office of the Governor and a rapid care team composed of representatives from multiple agencies, including Department of Children, Youth, and Families (DCYF) as designated by HB 1580 (Children in Crisis).
- $3.8 million state ($4.9 million total) for youth inpatient navigators to help families and caregivers identify alternate, temporary solutions when a long-term inpatient bed is not available due to bed capacity or geography issues.
- $3.5 million state ($6.9 million total) to increase children's long-term inpatient program (CLIP) bed rates.
- $23.8 million state for the University of Washington (UW) 90/180 inpatient beds. The agency will pay the UW Behavioral Health Teaching Facility for long-term inpatient beds.
- $10.3 million total for UW short-term behavioral health beds. The agency will pay the UW Behavioral Health Teaching Facility for short-term beds.
- $16.4 million state ($35.7 million total) operating costs for 15 behavioral health facilities that were funded in prior capital budgets.
- $95.3 million state ($267.7 million total) for a BH Medicaid community-based provider rate increase beginning Jan. 1, 2024. The amount reflects a 15 percent increase for services by behavioral health organizations paid through the Medicaid MCOs. The House budget specifies that these rate increases are for non-hospital providers.
- $55.7 million state for a 15 percent rate increase for non-Medicaid/state only services. This is intended to address regional behavioral health service needs that cannot be paid for with Medicaid funds including designated crisis responders, involuntary treatment hearing court costs and services to low-income individuals who are not eligible for Medicaid.
- $3.5 million state ($9 million total) for rate enhancement for all hospital and non-hospital facilities serving civil conversion patients except those whose rates are set at 100 percent of their most recent Medicare cost report. These civil conversion patients are patients who have not been restored to competency to stand trial for criminal charges.
- $1.7 million total for expenses associated with credentialing, inspections, assistance, and program administration for licensed psychiatric beds.

- $12,359,000 of the general fund—state appropriation for fiscal year 2024, $12,359,000 of the general fund—state appropriation fiscal year 2025, and $23,444,000 of the general fund—federal appropriation is provided solely for the authority and behavioral health entities to continue to contract for implementation of high intensity programs for assertive community treatment (PACT) teams.
- $3,520,000 of the general fund—federal appropriation is provided solely for the authority to maintain a pilot project to incorporate peer bridging staff into BH regional teams that provide transitional services to individuals returning to their communities.

Implementation plan

No changes occurred in this period.

MH Health IT plan requirements

Activities are found in the **SUD Health IT plan requirements section**.

Evaluation design

No changes occurred in this period.

Monitoring protocol

No changes occurred in this period.

Upcoming activities

No upcoming activities.

Quarterly expenditures

The following table reflects quarterly expenditures for DSRIP, LTSS, and FCS during DY7 (2023). **MCOs earned $8,000,000** and **ACHs earned $46,682,377** for ACH and VBP Incentives.

Table 10: DSRIP expenditures

	Q1 (January 1–March 31)	Q2 (April 1–June 30)	Q3 (July 1–September 30)	Q4 (October 1–December 31)	DY7 Total (January 1–December 31)	Funding source: Federal financial participation
Better Health Together	0	$5,514,444			$5,514,444	$2,757,222
Cascade Pacific Action Alliance	0	$3,553,253			$3,553,253	$1,776,627
Elevate Health	0	$4,401,665			$4,401,665	$2,200,833
Greater Health Now (formerly Greater Columbia)	0	$6,730,054			$6,730,054	$3,365,027
HealthierHere	0	$10,911,877			$10,911,877	$5,455,939
Thriving Together North Central Washington (formerly North Central)	0	$2,252,070			$2,252,070	$1,126,035
North Sound	0	$7,705,759			$7,705,759	$3,852,880
Olympic Community of Health	0	$2,113,025			$2,113,025	$1,056,513
SWACH	0	$3,500,230			$3,500,230	$1,750,115
Indian Health Care Providers	0	0			$ 0	$ 0

Table 11: MCO-VBP expenditures

MCO-VBP	Q1 (January 1–March 31)	Q2 (April 1–June 30)	Q3 (July 1–September 30)	Q4 (October 1 – December 31)	DY7 Total (January 1–December 31)
Amerigroup WA	0	1,362,405.00			1,362,405.00
CHPW	0	1,272,727.00			1,272,727.00
CCW	0	938,784.00			938,784.00
Molina	0	2,946,142.00			2,946,142.00
United Healthcare	0	1,479,942.00			1,479,942.00

Table 12: LTSS and FCS service expenditures

	Q1 (January 1–March 31)	Q2 (April 1–June 30)	Q3 (July 1–September 30)	Q4 (October 1–December 31)	DY7 Total (January 1–December 31)
Tailored Supports for Older Adults (TSOA)	$5,171,456	$6,189,650			11,361,106.68
Medicaid Alternative Care (MAC)	$159,264	$579,071			738,334.86
MAC and TSOA not eligible	$259.28	0.0			259.28
FCS	$7,950,523	$7,705,120			$15,655,643.00

Financial and budget neutrality development issues

Financial

Below are the counts of member months eligible to receive services under MTP. Member months for non-expansion adults are updated retrospectively, based on the current caseload forecast council (CFC) medical caseload data.

The agency recently migrated to a new database, and we were not able to transition the data query from the old database in time to pull SUD and serious mental illness (SMI) member months for this quarter. We anticipate updating the member months in next quarter's report.

Table 13: Member months eligible to receive services

Calendar month	Non-expansion adults only	SUD Medicaid disabled	SUD Medicaid non-disabled	SUD newly eligible	SUD AI/AN	SMI Medicaid Disabled IMD	SMI Medicaid non-disabled IMD	SMI Newly eligible IMD	SMI AI/AN
Jan-17	376,299	0	0	0	0	0	0	0	0
Feb-17	375,195	0	0	0	0	0	0	0	0
Mar-17	374,723	0	0	0	0	0	0	0	0
Apr-17	373,574	0	0	0	0	0	0	0	0
May-17	373,119	0	0	0	0	0	0	0	0
Jun-17	373,022	0	0	0	0	0	0	0	0
Jul-17	372,109	0	0	0	0	0	0	0	0
Aug-17	371,843	0	0	0	0	0	0	0	0
Sep-17	370,577	0	0	0	0	0	0	0	0
Oct-17	370,383	0	0	0	0	0	0	0	0
Nov-17	370,213	0	0	0	0	0	0	0	0
Dec-17	370,239	0	0	0	0	0	0	0	0
Jan-18	370,278	0	0	0	0	0	0	0	0
Feb-18	368,902	0	0	0	0	0	0	0	0
Mar-18	368,709	0	0	0	0	0	0	0	0
Apr-18	367,449	0	0	0	0	0	0	0	0
May-18	367,812	0	0	0	0	0	0	0	0
Jun-18	367,090	0	0	0	0	0	0	0	0
Jul-18	366,833	5	19	91	10	0	0	0	0

Aug-18	366,234	8	17	95	44	0	0	0	0
Sept-18	365,237	4	19	80	44	0	0	0	0
Oct-18	365,235	4	22	93	47	0	0	0	0
Nov-18	364,767	3	27	93	34	0	0	0	0
Dec-18	364,217	4	17	96	23	0	0	0	0
Jan-19	364,142	34	133	411	37	0	0	0	0
Feb-19	362,461	31	115	391	40	0	0	0	0
Mar-19	362,113	42	144	398	45	0	0	0	0
Apr-19	361,644	56	136	473	38	0	0	0	0
May-19	361,125	43	125	483	49	0	0	0	0
June-19	360,366	65	150	573	54	0	0	0	0
Jul-19	360,793	65	197	676	55	0	0	0	0
Aug-19	360,367	66	243	744	49	0	0	0	0
Sep-19	359,922	75	214	779	44	0	0	0	0
Oct-19	359,409	73	237	884	36	0	0	0	0
Nov-19	358,545	81	190	812	44	0	0	0	0
Dec-19	358,870	58	213	940	51	0	0	0	0
Jan-20	359,316	32	129	531	44	0	0	0	0
Feb-20	359,322	24	125	478	44	0	0	0	0
Mar-20	361,014	33	133	484	45	0	0	0	0
Apr-20	364,507	42	109	383	21	0	0	0	0
May-20	366,952	25	97	376	29	0	0	0	0
Jun-20	369,749	46	157	553	46	0	0	0	0
Jul-20	372,413	25	84	335	32	0	0	0	0
Aug-20	375,214	51	218	711	38	0	0	0	0
Sep-20	377,400	65	208	680	46	0	0	0	0
Oct-20	379,393	26	93	373	43	0	0	0	0
Nov-20	380,268	54	185	762	27	0	0	0	0
Dec-20	381,715	66	192	827	26	89	58	264	5

Jan-21	382,859	41	131	563	31	242	170	799	17
Feb-21	382,879	25	89	298	18	275	196	876	11
Mar-21	384,165	21	85	318	25	293	239	952	15
Apr-21	385,454	25	97	369	15	267	234	844	18
May-21	386,608	31	85	313	26	278	263	871	16
Jun-21	387,628	17	32	157	21	305	227	878	16
Jul-21	389,227	25	104	368	20	272	179	605	17
Aug-21	391,255	19	91	322	20	250	176	564	14
Sep-21	392,688	16	86	326	15	241	177	604	14
Oct-21	394,029	16	81	273	11	256	199	620	18
Nov-21	395,958	14	77	301	14	248	226	608	27
Dec-21	396,580	7	45	221	13	237	221	625	15
Jan-22	398,190	1	15	66	7	238	237	625	22
Feb-22	399,480	15	97	367	8	221	250	599	24
Mar-22	401,039	18	116	409	3	236	240	672	23
April-22	403,219	22	105	358	20	198	169	459	16
May-22	404,663	3	13	62	11	285	263	691	17
Jun-22	406,907	30	110	401	26	282	218	654	12
Jul-22	408,973	21	91	367	17	239	128	506	9
Aug-22	411,735	24	117	484	16	255	219	685	8
Sep-22	413,132	4	28	152	13	236	199	576	10
Oct-22	415,090	0	12	34	16	77	46	192	6
Nov-22	417,399	26	105	355	15	279	227	694	5
Dec-22	420,007	8	34	168	3	236	173	591	3
Jan-23	422,038					73	30	150	0
Feb-23	424,224								
Mar-23	427,559								
April-23	428,734								
May-23	424,591								

Jun-23	413,913								
Total	**29,761,302**	**1,635**	**5,794**	**21,657**	**1,569**	**6,108**	**4,964**	**16,204**	**358**

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 had an independent audit performed on DSHP claims for calendar year 2021 (DY5). The audit was finalized in June 2023 with no findings. **Read the report.**

Overall MTP development and issues

Operational/policy issues

No operational or policy issues were identified in Q2 2023. Washington State continued to work with the legislature on many bills and budget provisos in support of MTP 2.0 programs and goals. MTP 2.0 expenditure authority was approved as anticipated in the final state budget. The state will continue to work with the legislature to request new expenditure authority for programs not previously requested, including pending MTP 2.0 amendment requests.

Consumer issues

Washington 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. Stakeholders and consumers were relieved to receive the announcement of MTP 2.0 approval on June 30, 2023.

MTP evaluation

The MTP Independent External Evaluator's (IEE) quarterly rapid cycle report was delivered on June 13, 2023, in compliance with the contracted deliverable timeline. This report covers April 1 through June 30, 2023. It presents findings regarding Washington State's Medicaid system performance through March 2022 including key performance indicators in 10 measurement domains as well as an examination of equity and disparities among specific populations within measurement domains. The report is available on the **HCA website**.

Quantitative analysis of Medicaid data

The quantitative team obtained and analyzed administrative data, including Medicaid enrollment, encounters, and claims through March 2022.

Qualitative analysis of Medicaid data

The qualitative team is currently

- Actively sampling for and recruiting BH provider organization interviewees, tailoring interview guides, developing a codebook, and conducting interviews concurrently with data analysis.
- Continuing to analyze previously collected qualitative data. These ongoing analyses will be documented in the final evaluation report.
- Actively coding and analyzing data from the final round of ACH interviews.
- Meeting weekly to listen to audio recordings, analyze transcripts, and refine the codebook.

The qualitative team also completed, submitted, and received the Washington State Institutional Review Board (WSIRB) approval to begin actively sampling and recruiting participants to better understand the impact of the SMI/SED (serious mental illness/severe emotional disturbance) initiative.

Key findings from the latest rapid-cycle report

We have completed a full year of reporting since the March 2020 stay-at-home order was issued in Washington in response to the COVID-19 Public Health Emergency (PHE). The impact on several health outcomes was stark: rates of well-child visits, periodontal care, and cancer screenings demonstrated predictable declines across all member categories. Measures improved in the third and fourth quarters of 2021, with rates of in-person well-care for children approaching pre-PHE rates. This is also the first reporting period in which we see an improvement in statewide employment rates since the onset of the PHE.

We previously reported a dramatic downward trend in the use of emergency department and acute hospital care. We are now seeing a reversal in that trend, with rates of emergency department visits higher than the previous year. Most notably, members with severe mental illness received care in the emergency department at a rate three times that of the statewide average.

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

Summary of changes in Medicaid system performance

Better

- The rate of employment for Medicaid members improved over this measurement period to 49.7 percent, up 4.3 percentage points from the previous year.
- The rate of prescriptions for controller medication for asthma improved 7.5 percentage points over the previous year.
- Access to well-care visits for members ages 3 to 21 and well-child visits for children ages 3 to 11 improved over the previous year.
- Periodontal exams and preventive or restorative dental services for adults demonstrated continued improvements over the previous year.

Mixed

- Although there were improvements to well-care visits, other metrics of access to primary and preventive care and prevention and wellness declined during this period, with rates of breast cancer screening falling by 2.6 percentage points and immunizations for children falling 4.1 percentage points compared with the previous year.
- Rates of care obtained in emergency departments and acute hospital settings varied widely among members of different racial and ethnic groups. Asian, Native Hawaiian and Pacific Islander, and Hispanic members were significantly less likely to receive care in these settings, while American Indian and Alaska Native (AI/AN), Black, and White members were much more likely to receive care in these locations than the statewide average.

Worse

- There are significant racial and ethnic disparities in access to care for substance use disorders. Black members accessed opioid use disorder (OUD) treatment at rates 12.2 percentage points lower than the state average and 30-day follow-up after an ED visit for alcohol or drug use at a rate 11.1 percentage points lower than the state average.
- AI/AN populations received breast cancer screening at a rate 12.9 percentage points lower than the statewide average.

Upcoming IEE activities

The IEE qualitative team will continue recruiting, conducting interviews, and meeting weekly to analyze data for behavioral health provider organization interviews. The team will continue to recruit participants and analyze survey data to better understand the impact of the SMI/SED initiative. The findings from these interviews and surveys will be reported in the final evaluation report.

Summary of additional resources, enclosures, and attachments

Additional resources

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

Summary of attachments

- Attachment A: **state contacts**
- Attachment B: **Financial Executor Portal Dashboard, Q2 2023**
- Attachment C: **designated state health programs (DSHP)**
- Attachment D: **1115 SUD Demonstration Monitoring Workbook – Part A**
- Attachment E: 1115 SUD Demonstration Monitoring Report – Part B
- Attachment F: **1115 SMI/SED Demonstration Monitoring Workbook – Part A**
- Attachment G: 1115 SMI/SED Demonstration Monitoring Report – Part B

Attachment A: state contacts

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

Area	Name	Title	Phone
MTP and quarterly reports	Chase Napier	Manager, Medicaid Transformation	360-725-0868
DSRIP program	Chase Napier	Manager, Medicaid Transformation	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

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, Q2 2023

View this table on the HCA website, which shows all funds earned and distributed through the FE portal through June 30, 2023.

Attachment C: designated state health programs (DSHP)

View the report on the HCA website.

Attachment D: 1115 SUD Demonstration Monitoring Workbook – Part A

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

Attachment E: 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 Number of beneficiaries with an SUD diagnosis remains stable as well as the number of individuals receiving treatment, and SBIRT assessments.

Receipt of outpatient substance use disorder treatment is down slightly while residential/inpatient TX numbers remain steady. Rates of withdrawal management are consistent and MAT rates stable.

While there was a slight increase in initiation of alcohol and other drug treatment, engagement decreased slightly.

While the opioid use rate is stable, the overall number has decreased dramatically. The rate of concurrent use of opioids and benzodiazepines continues to decrease. Additionally, while the rate saw a modest decrease, the absolute number of individuals decreased substantially.

The rate of follow-up after an emergency department visit for mental illness has decreased over the prior measurement year but remains above the baseline year rate. The rate of emergency department utilization for SUD has remained consistent across the measurement period. A few subpopulations, such as among those with an opioid use disorder (OUD) diagnosis, saw a slight increase in ED utilization for SUD, but the rates remain within the range of prior measurement periods.

As with ED utilization for SUD, inpatient stays for SUD have remained consistent across the measurement period, with a slight increase in IP utilization for SUD among those with an OUD diagnosis.

Please note these measurement periods occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.

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 number of beneficiaries with an SUD diagnosis in a given month has remained stable over the last several months. The pattern is consistent for all subpopulation reporting. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#3: Medicaid beneficiaries with SUD diagnosis (monthly)
	Not reported this quarter.	07/01/2018 – 06/30/2019	#4: Medicaid beneficiaries with SUD diagnosis (annual)
	Not reported this quarter.	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 who received any SUD treatment has remained consistent during the measurement period and is similar to the utilization rates from prior quarters. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#6: Any SUD Treatment
	The number of individuals who received an SBIRT assessment has remained consistent during the measurement period and is similar to the utilization rates from prior quarters. There was a slight uptick in SBIRT use in December 2022, however it is within the range of prior quarters. Research within the state has highlighted some barriers to billing for SBIRT, including but not limited to staff turnover and uncertainty around reimbursement. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#7: Early Intervention
	The number of individuals who received outpatient SUD treatment has decreased slightly during the measurement period. Note: This measurement period occurred during the COVID-19 pandemic. The	04/01/2019 – 06/30/2019	#8: Outpatient Services

	impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.		
	The number of individuals who received residential and inpatient SUD treatment has remained consistent during the measurement period and is similar to the utilization rates from prior quarters. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#10: Residential and Inpatient Services
	The number of individuals who received withdrawal management has remained consistent during the measurement period and is similar to the utilization rates from prior quarters. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#11: Withdrawal Management
	The number of individuals who received medication assisted treatment has remained consistent during the measurement period and is similar to the utilization rates from prior quarters. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#12: Medication Assisted Treatment
	Not reported this quarter.	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: **☐ 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.	Not reported this quarter.	07/01/2018 – 06/30/2019	#13: SUD provider availability

☒ The state has no trends to report for this reporting topic.	Not reported this quarter.	07/01/2018 – 06/30/2019	#14: SUD provider availability – MAT
5.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ Planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care.**			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 4.			
☒ The state has no implementation update to report for this reporting topic.			
6.2 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)			
6.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 5.	The rate of initiation of AOD treatment has remained stable, with a slight, but within range, increase over the last measurement year. The rate of engagement of AOD treatment has slightly decreased over the last measurement year but remains higher than the baseline year. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2017 – 12/31/2017	#15: Initiation and Engagement of Alcohol and Other Drug Treatment
	The rate of use of opioids at high dosage in persons without cancer has remained stable. However, the overall number of individuals has decreased dramatically. Note: This measurement period occurred	01/01/2018 – 12/31/2018	#18: Use of Opioids at High Dosage

	during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.		in Persons without Cancer (modified by State)
	The rate of concurrent use of opioids and benzodiazepines continues to decrease. In addition, while the rate saw a modest decrease, the absolute number of individuals decreased substantially. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2018 – 12/31/2018	#21: Concurrent Use of Opioids and Benzodiazepines (modified by State)
☐ The state has no trends to report for this reporting topic.	Not reported this quarter due to data issue.	01/01/2018 – 12/31/2018	#22: Continuity of Pharmacotherapy for Opioid Use Disorder (modified by State)
6.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD.** **☐ ii) Expansion of coverage for and access to naloxone.**			
☒ The state has no implementation update to report for this reporting topic.			

☐ The state expects to make other program changes that may affect metrics related to Milestone 5.			
☐ The state has no implementation update to report for this reporting topic.			
7.2 Improved Care Coordination and Transitions between Levels of Care (Milestone 6)			
7.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 6.	The rate of follow-up after an emergency department visit for AOD has increased over the prior measurement year. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2017 – 12/31/2017	#17(1): Follow-Up after Emergency Department Visit for Alcohol or Other Drug Dependence
	The rate of follow-up after an emergency department visit for mental illness has decreased over the prior measurement year but remains above the baseline year rate. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2017 – 12/31/2017	#17(2): Follow-Up after Emergency Department Visit for Mental Illness
☐ The state has no trends to report for this reporting topic.			
7.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ Implementation of policies supporting beneficiaries' transition from residential and**			

inpatient facilities to community-based services and supports.			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 6.			
☒ The state has no implementation update to report for this reporting topic.			
8.2 SUD Health Information Technology (Health IT)			
8.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its Health IT metrics.			
☒ The state has no trends to report for this reporting topic.	Not reported this quarter.	07/01/2017 – 06/30/2018	Q1: PDMP Statewide Fatal Drug Overdoses – All, All Opioids, Heroin, Prescription Opioids (excluding synthetic opioids), Synthetic Opioids (not Methadone)
	Not reported this quarter.	07/01/2018 – 06/30/2019	Q2: Substance Use Disorder Treatment

			Penetration Rate
	Not reported this quarter.	07/01/2018 – 06/30/2019	Q3: Foundational Community Supports Beneficiaries with Inpatient or Residential SUD Services
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 rate of emergency department utilization for SUD has remained consistent across the measurement period. A few subpopulations, such as among those with an OUD diagnosis, saw a slight increase in ED utilization for SUD, but the rates remain within the range of prior measurement periods. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#23: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries
	As with ED utilization for SUD, inpatient stays for SUD has remained consistent across the measurement period, with a slight increase in IP utilization for SUD among those with an OUD diagnosis. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries
	Not reported this quarter.	07/01/2018 – 06/30/2019	#25: Readmissions Among Beneficiaries with SUD

	Not reported this quarter due to data issue.	07/01/2017 – 06/30/2018	#26: Overdose Deaths (count)
	Not reported this quarter due to data issue.	07/01/2017 – 06/30/2018	#27: Overdose Deaths (Rate)
	Not reported this quarter due to data issue.	01/01/2017 – 12/31/2017	#40: Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD.
☐ The state has no trends to report for this reporting topic.			
9.2.2 Implementation Update			
☐ The state expects to make other program changes that may affect metrics related to other SUD-related metrics.			
☒ The state has no implementation update to report for this reporting topic.			
10.2 Budget Neutrality			
10.2.1 Current status and analysis			
☐ If the SUD component is part of a broader demonstration, the state should provide an analysis of the SUD-related budget neutrality and an analysis of budget neutrality. Describe			

the status of budget neutrality and an analysis of the budget neutrality to date.
10.2.2 Implementation Update
☐ The state expects to make other program changes that may affect budget neutrality
☒ The state has no implementation update to report for this reporting topic.
11.1 SUD-Related Demonstration Operations and Policy
11.1.1 Considerations
☐ States should highlight significant SUD (or if broader demonstration, then SUD-related) demonstration operations or policy considerations that could positively or negatively affect beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.
☒ The state has no related considerations to report for this reporting topic.
11.1.2 Implementation Update
Compared to the demonstration design and operational details, the state expects to make the following changes to:

☐ **i) How the delivery system operates under the demonstration (e.g., through the managed care system or fee for service).** ☐ **ii) Delivery models affecting demonstration participants (e.g., Accountable Care Organizations, Patient Centered Medical Homes).** ☐ **iii) Partners involved in service delivery.**
☒ **The state has no implementation update to report for this reporting topic.**
☐ **The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities.**
☒ **The state has no implementation update to report for this reporting topic.**
☐ **The state is working on other initiatives related to SUD or OUD.**
☒ **The state has no implementation update to report for this reporting topic.**
☐**The initiatives described above are related to the SUD or OUD demonstration (States should note similarities and differences from the SUD demonstration).**
☒ **The state has no implementation update to report for this reporting topic.**
12. SUD Demonstration Evaluation Update
12.1. Narrative Information

☐ **Provide updates on SUD evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. See report template instructions for more details.**
☒ **The state has no SUD demonstration evaluation update to report for this reporting topic.**
☐ **Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.**
☐ **The state has no SUD demonstration evaluation update to report for this reporting topic.**
☐ **List anticipated evaluation-related deliverables related to this demonstration and their due dates.**
☒ **The state has no SUD demonstration evaluation update to report for this reporting topic.**
13.1 Other Demonstration Reporting
13.1.1 General Reporting Requirements
☐ **The state reports changes in its implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol.**
☐ **The state has no updates on general requirements to report for this reporting topic.**

☐ **The state anticipates the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes.**
☒ **The state has no updates on general requirements to report for this reporting topic.**
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ **i) The schedule for completing and submitting monitoring reports.** ☐ **ii) The content or completeness of submitted reports and/or future reports.**
☒ **The state has no updates on general requirements to report for this reporting topic.**
☐ **The state identified real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation**
☒ **The state has no updates on general requirements to report for this reporting topic.**
13.1.2 Post-Award Public Forum
☐ **If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual report.**
☒ **No post-award public forum was held during this reporting period and this is not an annual**

report, so the state has no post-award public forum update to report for this topic.
14.1 Notable State Achievements and/or Innovations
14.1 Narrative Information
❒ Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD (or if broader demonstration, then SUD related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.
☒ The state has no notable achievements or innovations to report for this reporting topic.

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

> *The IET-AD, FUA-AD, FUM-AD, and AAP measures (metrics #15, 17 (1), and 17 (2), and 32) are Healthcare Effectiveness Data and Information Set ("HEDIS®") measures that are owned and copyrighted by the National Committee for Quality Assurance ("NCQA"). NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications.*
>
> *The measure specification methodology used by CMS is different from NCQA's methodology. NCQA has not validated the adjusted measure specifications but has granted CMS permission to adjust. Calculated measure results, based on the adjusted HEDIS specifications, may be called only "Uncertified, Unaudited HEDIS rates."*

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

Attachment F: 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 G: 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

While the number of children and adolescents on antipsychotics who are receiving first-line psychosocial care increased from 2021 to 2022, the overall rate decreased. The rate of unplanned readmissions following psychiatric hospitalization has decreased.

The rate of medication continuation following inpatient psychiatric discharge has remained stable. The number of those ages 6-17 who received follow-up care within 30 and 7 days of hospitalization for mental illness has increased slightly. However, the overall rate has decreased. The number of those ages 18+ who received follow-up care within 30 and 7 days of hospitalization for mental illness has increased slightly. However, the overall rate has decreased.

Both the number and the overall rate of those who received follow-up care within 30 and 7 days of an emergency department visit for alcohol and other drug abuse has increased. Both the number and the overall rate of those who received follow-up care within 30 and 7 days of an emergency department visit for mental illness has decreased.

The utilization rate of inpatient mental health services has remained consistent with prior months. The utilization rate of intensive outpatient and partial hospitalization mental health services has remained consistent with prior months.

The utilization rate of outpatient mental health services has remained consistent with prior months.

The utilization rate of ED based mental health services has increased slightly compared with prior months but is within the range seen in earlier months.

The utilization rate of telehealth based mental health services has remained consistent with prior months. The utilization rate of any mental health services has remained consistent with prior months.

In IMDs, the overall average length of stay and the average length of stay less than or equal to 60 days has decreased slightly. The average length of stay for stays greater than 60 days has increased slightly. There has been an increase in the number of beneficiaries with SMI/SED treated in an IMD for mental health. We expect this increase to be due to a combination of factors including:

Added capacity in 2019 with the opening of new IMDs, however none were running at full capacity until 2020.

This increased capacity was unlikely to be fully utilized due to COVID-19 and the associated impacts on both beneficiaries and workers.

The significant increase from 2021 to 2022 is likely indicative of the facilities be able to operate at full capacity.

The number of beneficiaries with SMI/SED in a given month has remained consistent. The number of beneficiaries with SMI/SED has increased over the past year.
The rate of access to preventive/ambulatory health services for Medicaid beneficiaries with SMI has increased.
The overall number of children and adolescents on antipsychotics who receive metabolic monitoring has remained stable. However, the overall rate has decreased slightly.

The rate of follow-up care for adult Medicaid beneficiaries who are newly prescribed an antipsychotic medication has decreased slightly. However, the overall number of those receiving follow-up care has remained consistent.

The total cost associated with non-inpatient or residential services has increased since the baseline year (CY2020), but the costs associated with the most recent measurement year are lower than the prior year.

The total cost associated with inpatient or residential services has increased since the baseline year (CY2020), but the costs associated with the most recent measurement year are lower than the prior year.

The per cap cost associated with non-inpatient or residential services has increased since the baseline year (CY2020), but the per cap costs associated with the most recent measurement year are lower than the prior year.
The number of grievances has remained consistent with the prior quarter. The number of appeals is lower compared to the prior quarter but within the range seen in earlier quarters. The number of critical incidents has remained consistent with the prior quarter.
Please note these measurement periods occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.

The total cost associated with IMD services has increased each year since the baseline year (CY2020).

The per cap cost associated with IMD services increased slightly from the baseline year (CY2020) to CY2021, but has decreased below the baseline per cap costs in CY2022. The number of individuals who are receiving mental health treatment has increased, while the overall rate has remained consistent.
The number and rate of Foundational Community Support beneficiaries with inpatient or residential mental health services has increased.

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.	While the number of children and adolescents on antipsychotics who are receiving first-line psychosocial care increased from 2021 to 2022, the overall rate decreased. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2020-12/31/2020	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)
☐ The state has no metrics trends to report for this reporting topic.			
1.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) The licensure or accreditation processes for participating hospitals and residential settings** **☐ii) The oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements** **☐ iii) The utilization review process to ensure beneficiaries have access to the appropriate**			

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

			Health Care (PMH-20)
	The rate of unplanned readmissions following psychiatric hospitalization has decreased. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2020-12/31/2020	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)
	The rate of medication continuation following inpatient psychiatric discharge has remained stable. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2020-12/31/2020	Medication Continuation Following Inpatient Psychiatric Discharge
	The number of those ages 6-17 who received follow-up care within 30 and 7 days of hospitalization for mental illness has increased slightly. However, the overall rate has decreased. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2020-12/31/2020	Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH)
	The number of those ages 18+ who received follow-up care within 30 and 7 days of hospitalization for mental illness has increased slightly. However, the overall rate has decreased. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2020-12/31/2020	Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)
	Both the number and the overall rate of those who received follow-up care within 30 and 7 days of an emergency department visit for alcohol	01/01/2020-12/31/2020	Follow-up After

	and other drug abuse has increased. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.		Emergency Department Visit for Alcohol and Other Drug Abuse (FUA-AD)
	Both the number and the overall rate of those who received follow-up care within 30 and 7 days of an emergency department visit for mental illness has decreased. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2020-12/31/2020	*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 utilization rate of inpatient mental health services has remained consistent with prior months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2021-06/01/2021	Mental Health Services Utilization - Inpatient
	The utilization rate of intensive outpatient and partial hospitalization mental health services has remained consistent with prior months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2021-06/01/2021	Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization
	The utilization rate of outpatient mental health services has remained consistent with prior months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt	04/01/2021-06/01/2021	Mental Health Services

	of these services is unknown. Any changes in trends should be interpreted with caution.		Utilization - Outpatient
	The utilization rate of ED based mental health services has increased slightly compared with prior months but is within the range seen in earlier months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2021-06/01/2021	Mental Health Services Utilization - ED
	The utilization rate of telehealth based mental health services has remained consistent with prior months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2021-06/01/2021	Mental Health Services Utilization - Telehealth
	The utilization rate of any mental health services has remained consistent with prior months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2020-12/31/2020	Mental Health Services Utilization - Any Services
	The overall average length of stay and the average length of stay less than or equal to 60 days has decreased slightly. The average length of stay for stays greater than 60 days has increased slightly. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2020-12/31/2020	Average Length of Stay in IMDs
	The overall average length of stay and the average length of stay less than or equal to 60 days has decreased slightly. The average length of stay for stays greater than 60 days has increased slightly. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2020-12/31/2020	Average Length of Stay in IMDs (IMDs receiving FFP only)
	There has been an increase in the number of beneficiaries with SMI/SED treated in an IMD for mental health. We expect this increase to be due to a combination of factors including:	01/01/2020-12/31/2020	Beneficiaries With SMI/SED Treated in an

	- Added capacity in 2019 with the opening of new IMDs, however none were running at full capacity until 2020. - This increased capacity was unlikely to be fully utilized due to COVID-19 and the associated impacts on both beneficiaries and workers. - The significant increase from 2021 to 2022 is likely indicative of the facilities being able to operate at full capacity. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	IMD for Mental Health
☐ **The state has no trends to report for this reporting topic.**		
3.2.2 Implementation Update		
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ **i) State requirement that providers use an evidenced-based, publicly available patient assessment tool to determine appropriate level of care and length of stay** ☐ **ii) Other state requirements/policies to improve access to a full continuum of care including crisis stabilization**		
☒ **The state has no implementation update to report for this reporting topic.**		
☐ **The state expects to make other program changes that may affect metrics related to Milestone 3.**		
☒ **The state has no implementation update to report for this reporting topic.**		
4.2 Earlier Identification and Engagement in Treatment, Including Through Increased Integration (Milestone 4)		
4.2.1 Metric Trends		

☒ **The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4.**	The number of beneficiaries with SMI/SED in a given month has remained consistent. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2022-6/30/22	Count of Beneficiaries With SMI/SED (monthly)
	The number of beneficiaries with SMI/SED has increased over the past year. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2020-12/31/2020	Count of Beneficiaries With SMI/SED (annually)
	Not currently reported due to data issue.		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 has increased. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2020-12/31/2020	Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI
	The overall number of children and adolescents on antipsychotics who receive metabolic monitoring has remained stable. However, the overall rate has decreased slightly. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2020-12/31/2020	Metabolic Monitoring for Children and Adolescents on

			Antipsychotics
	The rate of follow-up care for adult Medicaid beneficiaries who are newly prescribed an antipsychotic medication has decreased slightly. However, the overall number of those receiving follow-up care has remained consistent. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2020-12/31/2020	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an 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.**	Not currently reported due to data issue.		Community Based Psychiatric Hospitals Using HIT for Discharge Summaries
	The number of individuals who are receiving mental health treatment has increased, while the overall rate has remained consistent.	01/01/2020-12/31/2020	Mental Health Treatment Penetration Rate
	Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2020-12/31/2020	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 percent related to other SMI/SED-related metrics.**	The total cost associated with non-inpatient or residential services has increased since the baseline year (CY2020), but the costs associated with the most recent measurement year are lower than the prior year. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2020-12/31/2020	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential
	The total cost associated with inpatient or residential services has increased since the baseline year (CY2020), but the costs associated with the most recent measurement year are lower than the prior year. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2020-12/31/2020	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential
	The per cap cost associated with non-inpatient or residential services has increased since the baseline year (CY2020), but the per cap costs associated with the most recent measurement year are lower than the prior year. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2020-12/31/2020	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential

	The per cap cost associated with inpatient or residential services has increased since the baseline year (CY2020), but the per cap costs associated with the most recent measurement year are lower than the prior year. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2020-12/31/2020	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential
	The number of grievances has remained consistent with the prior quarter. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2022-6/30/22	Grievances Related to Services for SMI/SED
	The number of appeals is lower compared to the prior quarter but within the range seen in earlier quarters. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2022-6/30/22	Appeals Related to Services for SMI/SED
	The number of critical incidents has remained consistent with the prior quarter. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2022-6/30/22	Critical Incidents Related to Services for SMI/SED
	The total cost associated with IMD services has increased each year since the baseline year (CY2020). Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2022-6/30/22	Total Costs Associated With Treatment for Mental Health in an IMD Among

			Beneficiaries With SMI/SED
	The per cap cost associated with IMD services increase slightly from the baseline year (CY2020) to CY2021, but has decreased below the baseline per cap costs in CY2022. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	01/01/2020-12/31/2020	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.