Washington State Medicaid Transformation Project (MTP) demonstration
Section 1115 Waiver Annual Report (DY3) / Quarterly Report (DY3 Q4)
Demonstration Year: 3 (January 1 to December 31, 2019)
Reporting Quarter: 4 (October 1 to December 31, 2019)

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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 five-year MTP period, Washington will:

- Integrate physical and behavioral health purchasing and services to provide whole-person care.
- Convert 90 percent of Medicaid provider payments to reward outcomes instead of volume of service.
- Support providers as they adopt new payment and care models.
- Improve health equity by implementing population health strategies.
- Provide targeted services to support the state's aging populations and address social determinants of health.
- 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 Delivery System Reform Incentive Payment (DSRIP) program.
- Long-Term Services and Supports (LTSS): Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA).
- Foundational Community Supports (FCS): Community Support Services (CSS) and Supported Employment – Individual Placement and Support (IPS).
- SUD Program – Treatment Services, Including Short-term Services Provided in Residential and Inpatient Treatment Setting that Qualify as an Institution for Mental Disease (IMD).

Sunsetting Healthier Washington brand

In past reports, HCA used the term "Healthier Washington." Healthier Washington was created to show how multiple agencies and partners could work together to create a transformed health and wellness system for Washington residents. We created a brand to represent all partners and agencies, which included a logo and specific terminology, such as "Healthier Washington initiative."

Since its inception, many transformation-related projects and programs have been housed under Healthier Washington. This includes MTP and other efforts that benefit more than those enrolled in Apple Health (Medicaid). To bring clarity and consistency to our work, HCA is sunsetting the Healthier Washington brand, including use of the logo and terminology. The Healthier Washington Measures Dashboard, which is covered later in this report, will keep its name.

Although the brand is sunsetting, our transformational efforts and partnerships will not change. In addition, the concept from which Healthier Washington was founded will continue.

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.

Annual report: Demonstration Year 3

In accordance with the special terms and conditions (STCs) 76 and 42 C.F.R. § 431.428, this report summarizes the activities and accomplishments for the third year of MTP (DY3). It documents accomplishments, project status, and operational updates and challenges.

Visit the Medicaid Transformation page to learn more about HCA's Medicaid Transformation work.

Policy and administrative updates

Mental health (MH) IMD waiver

Over the course of DY3, the state continued development of the MH IMD waiver, formally referred to as the serious mental illness/serious emotional disturbance waiver. HCA plans to submit the application in the spring of 2020. 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.

Budget neutrality

HCA continued to respond to CMS requirements for budget neutrality monitoring, including adoption of the new budget neutrality monitoring tool. During DY3, HCA continued to work with CMS on corrective action plans to mitigate the projected budget neutrality exceedance over the life of MTP.

The projected exceedance is driven by unanticipated costs related to Washington's state and city minimum wage laws, and a new interpretation of federal overtime laws that took effect in late 2015. For more MTP updates, please refer to the Overall MTP development/issues section of this document.

Annual expenditures

Delivery System Reform Incentive Payment (DSRIP) program expenditures

From January 1 through December 31, 2019, all nine ACHs earned nearly $168.8 million in incentives for demonstrating completion of required project and integration milestones during DY3, including the submission of implementation plans. During DY3, Indian Health Care Providers (IHCPs) earned nearly $1.9 million for IHCP-specific projects. In addition, Medicaid managed care organizations (MCOs) earned nearly $4 million for value-based purchasing (VBP) incentives.

Table 1: DSRIP expenditures

	Q1	Q2	Q3	Q4	DY3 Total	Funding source
	January 1–March 31	April 1–June 30	July 1–September 30	October 1–December 31	January 1–December 31	Federal financial participation
ACH						
Better Health Together	$0	$17,396,295	$0	$2,573,462	$19,969,757	$9,984,879
Cascade Pacific Action Alliance	$0	$11,313,792	$0	$2,339,510	$13,653,302	$6,826,651
Elevate Health	$0	$19,109,624	$0	$2,807,412	$21,917,036	$10,958,518
Greater Columbia	$0	$21,829,660	$0	$3,275,314	$25,104,974	$12,552,487
HealthierHere	$0	$33,463,618	$0	$5,146,923	$38,610,541	$19,305,271
North Central	$0	$6,130,010	$0	$1,169,755	$7,299,765	$3,649,883
North Sound	$0	$16,820,688	$6,498,653	$3,509,265	$26,828,606	$13,414,303
Olympic Community of Health	$0	$4,705,518	$0	$935,804	$5,641,322	$2,820,661

SWACH	$0	$8,136,037	$0	$1,637,657	$9,773,694	$4,886,847
IHCP-specific projects						
Indian Health Care Providers	$0	$0	$1,862,500	$0	$1,862,500	$931,250
MCO – VBP						
Amerigroup WA	$0	$0	$0	$370,400	$370,400	$185,200
CHPW	$0	$0	$0	$668,800	$668,800	$334,400
CCW	$0	$0	$0	$509,200	$509,200	$254,600
Molina	$0	$0	$0	$1,898,000	$1,898,000	$949,000
United Healthcare	$0	$0	$0	$553,600	$553,600	$275,800

Table 2: LTSS and FCS service expenditures

	Q1	Q2	Q3	Q4	DY3 Total
	January 1–March 31	April 1–June 30	July 1–September 30	October 1–December 31	January 1–December 31
Tailored Supports for Older Adults (TSOA)	$1,669,673	$2,117,045	$1,825,341	$2,850,333	$8,462,392
Medicaid Alternative Care (MAC)	$27,638	$39,598	$38,595	$60,441	$166,272
MAC and TSOA not eligible	$25	$0	$309	$651	$985
FCS	$0	$324,645	$3,114,155	$2,494,855	$5,933,655

LTSS data annual summary

Table 3: beneficiary enrollment by program

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program from January 1, 2019 to December 31, 2019	142	1,574	3,033
Number of new enrollees in 2019 by program	109*	1,206**	1,972***
Number of new person-centered service plans in 2019 by program	23	358	877
Number of beneficiaries self-directing services under employer authority	0	0	0

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

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

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

FCS data annual summary

Reports are available on MTP resources page. These reports provide a month-by-month look at Medicaid clients enrolled in IPS and CSS since the programs began in January 2018.

Table 4: FCS client enrollment 2019*

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Supported Employment – Individual Placement and Support (IPS)	1,765	1,863	1,986	2,127	2,211	2,404	2,486	2,476	2,673	2,894	3,081	3,147
Community Support Services (CSS)	1,115	1,346	1,573	1,796	1,970	2,146	2,273	2,343	2,503	2,767	3,008	3,049
CSS and IPS	308	372	415	449	493	545	556	606	694	774	849	916
Total aggregate enrollment	**3,228**	**3,581**	**3,974**	**4,372**	**4,674**	**5,095**	**5,315**	**5,425**	**5,870**	**6,435**	**6,938**	**7,112**

*Data represents cumulative enrollment (number of individuals who had been enrolled at least one month during the life of the program). Month-to-month changes are due to client enrollment mix, not program impact. Individuals may be enrolled in both IPS and CSS.
**Enrollments for DY3 Q1-Q3 have been updated to reflect all retroactive disenrollments resulting from the end of the program's six-month authorization period.
Data source: ProviderOne

MTP evaluation

In 2018, HCA began working with an independent external evaluator (IEE), Center for Health Systems Effectiveness (CHSE) at Oregon Health and Science University. As part of their contract with HCA, CHSE is responsible for evaluating the overall success and effectiveness of MTP.

As part of their evaluation, CHSE produces a Rapid-cycle monitoring report each quarter, which highlights their quarterly activities, key findings as available from their analyses, and a summary of activities for the coming quarter. The reports also highlights the work and progress of each ACH.

Quarter 1

- CHSE applied for and received a study amendment from the Washington State Institutional Review Board. The amendment included the addition of hospital and primary practice surveys for pilot testing, and approval of interview guides.
- CHSE received the first comprehensive set of data from the state in support of quantitative analyses. Work continued in this quarter to further refine data needs for CHSE's evaluation.
- Statements of work were finalized for the SUD IMD waiver evaluation and the midpoint assessment required in the STCs for that initiative.

Quarter 2

- CHSE completed its first round of key informant interviews and initial analysis of data from those interviews.
- For the next round of key informant interviews, CHSE recruited key informants from ACHs. Site visits with three ACHs were completed.
- Initial activity began to organize administrative data from the state into an evaluation database.
- Pilot testing of hospital and primary care provider surveys was completed.

- Agreement was reached with the state on the SUD IMD waiver midpoint assessment statement of work and budget.
- The fourth rapid-cycle monitoring report included a summary of findings from the first round of key informant interviews.

Quarter 3

- CHSE completed its plan to bring both quantitative and qualitative data together for each of the evaluations' research questions.
- Approval was received from the Washington State Institutional Review Board for the CHSE final version of hospital and primary care practice surveys. The surveys were launched.
- Recruitment for survey participants was initiated.
- Key informant interviews with ACHs and ACH site visits continued.
- The detailed administrative data received from the state for quantitative analysis was organized into a relational database.
- The fifth rapid cycle monitoring report included key findings from key informant interviews, and an appendix with details of its methodologies for gathering research questions for which CHSE is charged with responding.
- Launch of hospital and health care provider survey.

Quarter 4

- CHSE began synthesizing quantitative findings for the baseline report deliverable due in March, 2020.
- Completion of ACH site visits and key informant interviews. The CHSE quantitative analysis team continued prior work on coding the data collected.
- Initial use of administrative data provided by the state to begin comprehensive quantitative analysis.
- Continuation of hospital and primary care practice surveys, with closure set for January 2020.
- The sixth rapid cycle monitoring report highlighted key findings for the first three ACHs where site visits and key informants were complete.

State legislative developments

The 105-day legislative session adjourned sine die on April 29, 2019. As anticipated, the operating budget provides continued spending authority for MTP. At the request of the Legislature, the state presented MTP updates to multiple legislative committees, and responded to targeted questions as they arose. The Legislature formally directed HCA to apply for the mental health 1115 waiver opportunity, to allow federal financial participation for Medicaid clients served by mental health IMDs.

Public forums

HCA held two public forums on Medicaid Transformation, one in Wenatchee (September 12), and the other in Vancouver (September 26). Both forums were broadcast on Facebook Live, reaching several hundred viewers in addition to local, in-person attendees. Both forums offered a time for feedback, and some audience members asked questions, shared experiences, and provided information and ideas.

Summary of public comments received during DY3

The following public comments were received during DY3, organized by program:

DSRIP program public comments

Quarter 1

Stakeholders continued to seek current information about performance measures and outcomes. The questions provided opportunities to educate stakeholders about the MTP timeline, and the lag time of

performance data. HCA has reinforced the value of the midpoint assessment and evaluation activities as ways to provide context, inform about lessons learned and early wins, and emphasize importance of local quality improvement strategies.

Quarter 2

ACHs and stakeholders continued to express the need to clarify care coordination roles within the Medicaid program. This need includes the alignment of ACH-supported activities and investments, e.g., Pathways Community Based Care Coordination, health information exchange (HIE), and Closed Loop Referral Systems.

HCA, MCOs, and ACHs will prioritize this topic for discussion in the newly formed MT Priorities Work Group. As implementation efforts are underway and new issues and opportunities are emerging, the goal is to reach a common understanding of the care coordination vision, roles, scope, levers, and investments.

Quarter 3

ACHs and stakeholders expressed interest in prioritizing discussions regarding sustainability and the long-term role of ACHs in the state. Through the Medicaid Transformation Priorities Work Group, there is an immediate focus on supporting operational decisions and aligned investments and actions surrounding care coordination.

Because there are two years remaining with MTP, HCA believes the current focus on care coordination vision and alignment is appropriate. There remains a desire to manage the scope and not take on too many statewide topics at once. HCA agrees with the importance of the sustainability topic and will explore opportunities to engage state and local partners on this topic in DY4.

Quarter 4

ACHs expressed some concerns regarding survey and engagement fatigue among partners in DY3 Q4. This included evaluation surveys and the independent assessor's (IA's) midpoint assessment. This is an area of concern the state remains aware of. The state will continue to streamline and coordinate survey and engagement expectations whenever possible, including the consideration of alternative methods for information gathering.

LTSS program public comments

Quarter 1-4

No comments or concerns raised during these reporting periods.

FCS program public comments

Quarter 1

- Amerigroup had one provider terminate its contract in February (Southwest Area Agency on Aging), citing the rates were not high enough to cover their costs. This is the only provider that has terminated its contract. FCS providers are required to report monthly on their capacity and outcomes, and changes to service locations, staff availability, and caseload.
- During Amerigroup's monthly question and answer session, contracted providers raised concerns about reauthorization processes, documentation standards, and the processes to request additional hours within the authorization period. Amerigroup described these processes in detail, and issued guidance on its provider website. Non-traditional providers, such as Community Action Councils, continue to learn the nuances of providing Medicaid reimbursable services and the expectations that accompany them. Amerigroup continues to report a significant amount of staff time dedicated to addressing these concerns, and providing technical assistance and training to FCS contractors.

Quarter 2

- FCS staff received a client success story of a woman who initially engaged with the program December 2018. She was considering looking for a job but was unsure because she had never

worked before. After a few months of working with an employment specialist, she interviewed for and was offered a part-time job. The employment specialist worked with another agency to secure transportation for the client to be able to maintain her job. She continues to hold her part-time employment and is working with her employment specialist to look for additional volunteer opportunities.

- Washington received inquiries from multiple states about the FCS program. Several conference calls occurred this quarter. State agencies as well as national technical assistance organizations, such as the Center for Health Care Strategies, wanted to learn more about FCS' history and launch.
- Amerigroup did not report any instances of provider grievances or appeals during this quarter. Some providers did report challenges to timely payment of submitted claims. When these challenges arise, Amerigroup is responsive to provider concerns. Contracted providers had also raised concerns about the reauthorization processes, documentation standards, and the processes to request additional hours within the authorization period, which may be affecting reimbursement for claims.
  Amerigroup described these processes in detail during their monthly question and answer session, and provided guidance on its provider website. Non-traditional providers, such as community action councils, continued to learn the nuances of providing Medicaid reimbursable services and the expectations that accompany these services. Amerigroup also reported a significant amount of staff time dedicated to addressing concerns and providing technical assistance and training to FCS contractors. There were no systemic issues at that time, although there had been some challenges resulting from provider errors in submitting claims. Other challenges may require system improvements at Amerigroup or HCA.
- Stakeholders continued to express concerns about a lack of affordable housing in both rural and urban areas. We worked with allied stakeholders to improve client access to affordable housing. DBHR staff members worked with the Department of Commerce's Housing Trust Fund team, making presentations throughout the state. The goals of these presentations were to share information and promote stronger partnerships among capital funding sources, builders, and FCS services.

Quarter 3

- Amerigroup reported no provider grievances or appeals during the quarter. No providers discontinued services during the quarter. No systemic or large-scale concerns regarding timely payment or encounter denials were reported.
- Individual providers continued to report payment and denial challenges. Amerigroup was generally responsive. To the extent that these challenges came from provider error in claims submission and other factors related to provider inexperience, HCA continued exploring providing more robust technical assistance opportunities.

Quarter 4

- FCS staff received another client success story of a veteran whose goal was to find employment and to get off benefits and be self-sufficient. He was able to obtain part-time employment in a field of his choice while working with an employment specialist. After a few months of receiving on-going supported employment services, working with his therapist, and with other support services from Veterans Affairs, the client successfully transitioned to and is maintaining full-time employment with the same employer.
- Amerigroup reported no provider grievances or appeals during the quarter. No providers discontinued services during the quarter.
- Individual providers continue to report payment and denial challenges. While Amerigroup appears generally responsive, there are providers who report that payment or denial issues are recurrent.

The FCS program administrator is working with Amerigroup to proactively communicate changes in payment processing protocols, and provide technical assistance to enable providers to more closely monitor denials. To the extent that these challenges arise from provider error in claims submission and other factors related to provider inexperience, HCA plans to offer more robust technical assistance in business modeling in 2020.

SUD IMD waiver public comments

Quarter 1-4
No comments or concerns raised during these reporting periods.

Quarterly report: October 1–December 31, 2019

This quarterly report summarizes MTP activities from the fourth quarter of 2019: October 1 through December 31. It details MTP implementation, including stakeholder education and engagement, planning and implementation, and development of policies and procedures.

Summary of quarter accomplishments

- On October 3, 2019, the state provided each ACH with a report of pay-for-performance (P4P) metrics results that set the baseline (from calendar year (CY) 2018) on which to improve. These baselines and corresponding improvement targets are the basis for P4P incentive funds in DY4 (2020).
- The American Indian Health Commission of Washington State, the tribal coordinating entity, hosted electronic health record (EHR) demonstrations by webinar for IHCPs across Washington.
- Of the new enrollees within the Long-Term Services and Supports (LTSS) program, staff have enrolled an average of 40 percent dyads and continue to focus on dyad enrollment. Year to date, the MAC and TSOA programs have served more than 6,850 participants.
- Within FCS, the total aggregate number of people enrolled in services at the end of DY3 Q3 includes 3,824 in IPS and 3,921 in CSS.
- HCA staff working on the SUD IMD waiver attended, presented, and engaged with other attendees during the annual Co-Occurring-Disorder & Treatment Washington State Conference. In addition, HCA also held provider education calls on the effectiveness of medication assisted treatment/medication for opioid use disorder. The monitoring report and workbook for the SUD IMD waiver are also included as appendices within this report.

MTP-wide stakeholder engagement

During the reporting quarter, HCA continued its stakeholder engagement efforts.

- On December 19, HCA held a webinar on FCS. The webinar focused on FCS updates, resources, tools, and technical assistance to address social determinants of health. One hundred and thirty-seven people registered, and 59 people attended this webinar.
- HCA continued to publish two monthly newsletters: the Healthier Washington newsletter (about 10,000 subscribers total), and Foundations (about 2,130 subscribers), the FCS newsletter. The Healthier Washington newsletter sunsetted at the end of the year, and will not continue in 2020. Although we sent the Healthier Washington newsletter to a large number of subscribers, we discontinued it because:
    - We are sunsetting Healthier Washington brand.
    - There was a lower percentage of subscribers actually opening and engaging with this newsletter.
    - The newsletter was not a source for new information, but rather repeated information from other HCA publications and announcements.

  NOTE: Healthier Washington newsletter subscribers will still receive announcements and other information from HCA about transformation-related efforts and activities.

HCA sent out multiple announcements about Medicaid Transformation-related activities, including the updated VBP Roadmap and Apple Health Appendix.

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 to value-based payment models. The appendix, as stipulated by the STCs, describes how MTP is supporting providers and MCOs to move along the value-based care continuum. The roadmap establishes targets for VBP attainment and related DSRIP incentives for MCOs and ACHs. MCOs earned $4 million in VBP incentives in Q4 of 2019 for meeting reporting requirements.

HCA delivered the Apple Health Appendix to CMS on September 30, 2019. In Q4, HCA also published the VBP Roadmap and Apple Health Appendix on the Paying for value page.

Validation of financial performance measures

The IA successfully completed the validation of MCO data submissions. Upon final validation of MCO performance on the VBP attainment and provider incentives metrics, the IA delivered a final report to HCA in November and sent a formal communication to each MCO describing their performance. Table 8 from the report, shown below, outlines the achievement summary of each MCO and ACH based on the data reviewed and validated by the IA.

Table 5: MCO and ACH achievement summary

		% of VBP and Provider Incentives Earned (Capitation Withhold)				
Measure	**Program**	**Amerigroup**	**CCW[1]**	**CHPW[2]**	**Molina**	**UHC[3]**
VBP	AHMC[4]	100%	100%	100%	100%	100%
	IMC	5%	100%	100%	100%	
	AHFC[5]		100%			
Provider Incentives	AHMC	83%	100%	100%	48%	42%
	IMC	0%	100%	100%	88%	
	AHFC		100%			

Legend: Achieved; Partially Achieved; Not Achieved; Not Applicable

% of VBP Earned (DSRIP Funded P4P)	
MCO	**Result**
Amerigroup	100%
CCW	100%
CHPW	100%
Molina	100%
UHC	100%

% of VBP Earned (DSRIP Funded P4P)	
ACH	**Result**
BHT[6]	100%
CPAA[7]	100%
EH[8]	100%
GC[9]	100%
HH[10]	100%
NC[11]	100%
NS[12]	100%
OCH[13]	100%
SWACH[14]	100%

[1] Coordinated Care of Washington
[2] Community Health Plan of Washington

[3] UnitedHealthcare Community Plan
[4] Apple Health Managed Care
[5] Apple Health Foster Care
[6] Better Health Together
[7] Cascade Pacific Action Alliance
[8] Elevate Health
[9] Greater Columbia ACH
[10] HealthierHere
[11] North Central ACH
[12] North Sound ACH
[13] Olympic Community of Health
[14] Southwest ACH

Statewide progress toward VBP targets

According to 2017 MCO financial performance measure data, MCOs and ACH regions are currently ahead of the annual, state-financed VBP targets. In addition to the reported financial data, HCA issued two annual VBP surveys to:

- Track health plan and provider progress toward the state's goal of paying for value.
- Identify barriers to progress.

HCA completed the analysis of the health plan and provider surveys and presented preliminary results to the ACHs on December 12, 2019. HCA has refined the survey analysis presentation and will publish the final document to the Paying for value page in Q1 2020.

Technical support and training

HCA made final edits to the VBP Resource Catalog refresh and will prepare it for publication in Q1 2020.

Upcoming activities

- Publish final Paying for Value survey report
- Begin preparations for 2020 MCO VBP validation process
- Share findings from 2019 Paying for Value survey in various settings, including ACH meetings and internal HCA meetings

Integrated managed care (IMC) progress

In 2014, the Legislature directed a transition to integrate the purchasing of medical and behavioral health services for Apple Health (Medicaid) clients through an IMC system no later than January 1, 2020. Below are IMC-related activities for Q4.

- Continued to monitor IMC implementation in the 2019 mid-adopter regions through regular participation in regional IMC workgroup meetings and through data collected for the North Sound regional Early Warning System.
- Monitored provider, MCO, and behavioral health–administrative services organization (BH-ASO) readiness activities in the on-time adopter regions (the regions scheduled to implement IMC on January 1, 2020), and provided guidance and support to ensure regions are ready for IMC implementation by January 1, 2020.
- Continued extensive stakeholder engagement with the on-time-adopter regions. This included participation in regional meetings and workgroups, development of IMC guidance documents, and regular meetings with the MCOs and future BH-ASOs to address IMC issues, concerns, and questions.

- Gave multiple presentations about IMC to both external and internal stakeholders, where HCA described the purpose of the IMC program, the process and timeline for IMC implementation, and how HCA will continue to monitor implementation in 2020.

Health information technology (HIT)

The 2019 HIT Operational Plan includes tasks in several categories that support MTP efforts, including:

- Data and governance.
- Master Person Index (MPI) and provider directory.
- Payment models and sources.
- HIE, including enhancing the functionality of the Clinical Data Repository (CDR), registries, and tasks to expand the functionality, use, and users of the CDR.
- Engaging Tribal partners in information exchange.
- Engaging behavioral health providers in HIE.
- Supporting exchange of SUD information and consent management.
- Supporting the SUD IMD waiver and tasks related to the SUD HIT plan, including enhancements to the prescription drug monitoring program (PDMP).

During the fourth quarter of 2019, Washington State advanced its HIT Operational Plan through the following activities:

- Coordinating with Tribes and ACHs on state and national HIE resources.
- Continuing to support the HIT Plan requirements of the SUD IMD waiver.
- Engaging in meetings of the CDR Data Governance Committee that provides guidance and develops policies and processes regarding clinical and claims data and role-based access for clinical, social and claims data for purposes of the CDR, including approving the system-to-system query pilot.
- Participating in meetings (e.g., The Gravity Project) to identify consensus-based key social determinants of health data elements and support the interoperable exchange of this information.

Throughout 2019, HCA completed several initiatives to support the advancement of HIT. These include the following:

- Prioritized development of an enterprise Master Person Index.
- Recruiting a provider to pilot implementation of a query-based function for the CDR.
- Continued coordination with nine ACHs and MCOs to support Medicaid transformation activities using HIT.
- Added language to Medicaid MCO contracts to support use of HIT/HIE.
- Began implementation of Section 1003 Support Act Grant: Roadmap to Recovery, which includes a HIT focus.

During the fourth quarter of 2019, HCA worked with other state agencies and partners to develop the 2020 HIT Operational Plan, which will focus work in the following key areas:

- SUD IMD waiver and PMP enhancements.
- Mental health IMD waiver HIT items.
- Medicaid MCO contracts
- Master Person Index/provider directory.
- Continuing HIT projects.

To view the 2019 HIT Operational Plan and other related reports, visit the Medicaid HIT Plan page.

DSRIP program implementation accomplishments

ACH project milestone achievement

Semi-annual reporting

ACHs report on their MTP activities, project implementation, and progress on required milestones. This is outlined in the Project Toolkit. Semi-annual reports are submitted every six months.

Next steps

Implementation of project activities is underway across the state. ACHs will continue to inform the state about project progress by submitting updated implementation plans that reflect progress during the reporting period. ACHs will also provide updates related to how ACHs are supporting partnering providers in quality improvement.

DSRIP midpoint assessment

The STCs require an independent, midpoint assessment of DSRIP to systematically identify recommendations for improving individual ACHs and implementation of their Project Plans. Beginning in Q3, the IA initiated the midpoint assessment of DSRIP projects.

The purpose of the midpoint assessment is to:

- Provide a "point in time" assessment of progress on milestones and deliverables, as agreed to in the ACHs' Project Plans.
- Provide information to aid ACHs in correcting any midpoint difficulties and support future success.
- Provide "at-risk" project identification, guidance, and monitoring to ACHs and HCA.
- Obtain feedback from partners on whether they have the support needed to be successful.
- Gather diverse perspectives and experiences related to DSRIP.

During Q4, the IA completed midpoint assessment procedures in the remaining two ACH regions. Final midpoint assessment findings are anticipated in early January 2020 after the IA conducts a public comment period about the midpoint assessment findings.

IMC implementation milestone achievement

Under DSRIP, regions that implemented IMC prior to 2020 were eligible to earn additional incentive payments above the ACH's maximum valuation for Project Plans. Incentives earned for IMC milestones are intended to assist providers and the region with the process of transitioning to IMC. These incentives were distributed in two phases associated with progress milestones.

North Sound was the last region to implement IMC prior to 2020. Incentives associated with phase 2 achievement were distributed in July 2019 and no additional incentives were distributed during DY3 Q4.

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.

Each ACH was instrumental in promoting and encouraging provider participation in the provider 2019 Paying for Value survey, and HCA saw a record-number 148 unique provider respondents. Each ACH achieved the 2018 (DY2) regional VBP target of 50 percent based on validated MCO VBP attainment (see Table 5 referenced above).

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 $25.4 million to 311 partnering providers and organizations in support of project planning and implementation activities. The state distributed approximately $1.3 million in earned incentive funds to IHCPs in Q4 for achievement of IHCP-specific project milestones.

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

HCA and the FE implemented a change that allows ACHs to accrue interest in the FE portal, and ACHs began accruing interest in August 2019. The decision to allow interest accrual was in response to requests made by ACHs, as well as recognition that a portion of ACH earned incentives are likely to stay in the FE portal for a period of time due to allocation timelines and contract terms with partnering providers. This quarterly report includes the amount of interest earned for each ACH to date.

HCA will continue to monitor the FE portal to make sure ACHs are distributing funds to partnering providers in a timely manner.

DSRIP measurement activities

ACH project P4P improvement targets released

By selecting projects from the Project Toolkit, each ACH region must demonstrate improvement in health quality and outcomes over the course of MTP. Indicators of health quality and outcomes associated with an ACH's project plan, known as P4P metrics, determine the proportion of earned project incentives for each performance year. Data are collected and results are calculated by the state for each ACH region. Improvement target methodology and measure specifications are available in the Measurement Guide and the Medicaid Transformation metrics page.

On October 3, 2019, the state provided each ACH with a report of P4P metrics results that set the baseline (from CY 2018) on which to improve and receive incentive funds in DY4 (2020). In early November 2019, the state released ACH project P4P baselines and improvement targets. Interested stakeholders, partners, and the public can view ACH P4P metrics on the Healthier Washington Measures Dashboard, as well as in summary format (by metric and ACH) on the Medicaid Transformation metrics page.

Refresh of Healthier Washington Measures Dashboard

The updated dashboard went live on HCA's website the weekend of November 1. The update reflects the measurement period for calendar year 2018. In addition, the following changes were made from the previous release:

- Inclusion of new asthma measure (Asthma Medication Ratio)
- Updated data from Office of Financial Management to reflect 2018 population estimates
- Updates to metric documentation and dashboard layout

State measurement support

During Q4 2019, the state provided ACH staff with refreshed data products that include calendar year 2018 data. This includes products derived from data underlying the Healthier Washington Measures Dashboard, as well as more granular reports by project metric. These reports are designed to support ACHs in the identification of demographic and health risk factor characteristics associated with favorable and adverse outcomes on selected project metrics, to help inform ACH project monitoring.

HCA monitors questions about project pay-for-reporting (P4R)/P4P metrics, the Measurement Guide, and metric technical specifications. HCA continues to update documents to capture DSRIP program

development, and participate in ACH-led calls and forums to address DSRIP measurement questions. Related resources, such as the Measurement Guide, are available on the Medicaid Transformation metrics page.

DSRIP program stakeholder engagement activities

HCA continued to host weekly Transformation Alignment Calls with ACHs, state partners, and others. In addition, HCA sent out multiple announcements about ACH midpoint assessment activities and ACHs earning full credit and incentives.

DSRIP stakeholder concerns

ACHs expressed some concerns about survey and engagement fatigue among partners in DY3 Q4 related to the timing of evaluation efforts and the IA's midpoint assessment. This is an area of concern the state remains aware of and will continue to target survey and engagement whenever possible, including the consideration of alternative methods for information gathering.

Upcoming DSRIP activities

In early January 2020, the IA will submit their draft midpoint assessment report. The report assesses transformation through ACHs, a key part of the DSRIP program. The IA is responsible for independently assessing DSRIP, including the progress of transformation project activities under Initiative 1.

In January 2020, several midpoint assessment-related activities will occur:

- The public comment period for the midpoint assessment opened on January 13 and closed January 20.
- HCA hosted, with the IA presenting, a January 14 webinar on the midpoint assessment .
- The IA completed the final draft of the midpoint assessment report by the end of January.
- HCA posted the final version of the report and notified ACHs, partners, HCA leadership, and other interested parties.

Tribal project implementation activities

Primary milestone: The American Indian Health Commission of Washington State, the tribal coordinating entity, hosted electronic health record (EHR) demonstrations by webinar for IHCPs across Washington. This was a continuation of the work around EHRs that started in summer of 2019.

Secondary milestone: The Medicaid Transformation tribal liaison and members of HCA's Office of Tribal Affairs began fielding requests for individual presentations to Tribal Councils regarding the Tribal Federally Qualified Health Center (TFQHC) alternative payment methodology (APM). These presentations are required to provide Council enough information to make the decision to identify as a TFQHC.

Tribal partner engagement timeline

October 1-2: presented at the Salish region IMC conferences regarding American Indian/Alaska Native Medicaid Enrollees.

October 8: presented to Port Gamble S'Klallam Tribe on the TFQHC model.

October 9: participated in and presented at the Medicaid Transformation Learning Symposium.

October 15: participated in the North Sound Coordinating meeting, which included Tribes/IHCPs, HCA, MCOs, BH-ASOs, and ACHs.

October 18: participated in the ACH Tribal Liaison standing call.

October 24: met with the Spokane Tribe of Indians and the American Indian Community Center (AICC) regarding TFQHC.

October 25: presented on the IHCP-specific projects at the Northwest Health Law Advocate equity summit.

October 28: participated in the North Sound ACH Tribal Alignment Committee.

November 4: participated in the Great Rivers and Thurston/Mason Coordinating meeting, which included Tribes/IHCPs, the HCA, MCOs, BH-ASO and the ACH.

November 6: participated in the Governor's Indian Health Advisory Council meeting.

November 12: participated in meeting between BHT and IHCPs, including AICC and Kalispel Tribe of Indians.

November 13: participated in EHR demonstrations from athenahealth and Greenway.

November 15: participated in EHR demonstrations from Epic and NextGen.

November 18: participated in a planning meeting for behavioral health aides with Yakama Nation Behavioral Health, Northwest Portland Area Indian Health Board, and Heritage University.

November 22: hosted a webinar on the TFQHC APM for IHCPs.

December 2: participated in a meeting between BHT and Lake Roosevelt Community Health Center (associated with and located on the Colville Reservation).

December 3: participated in a meeting with Aging and Long-Term Services Agency (ALTSA) on the Health Homes programs and implications for Indian Country.

December 4: participated in a meeting with the Lower Elwha Klallam Tribe.

December 6: participated in the Governor's Indian Health Advisory Council.

December 12: presented to the CPAA Board of Directors.

December 13: participated in the ACH Tribal Liaison standing call.

December 16: participated in a meeting with Quinault Indian Nation.

December 17: participated in a meeting regarding Medicaid Transformation sustainability.

LTSS implementation accomplishments

This section summarizes LTSS program development and implementation activities from October 1 through December 31, 2019. Key accomplishments for this quarter include:

- Year to date, the MAC and TSOA programs have served more than **6,850** participants.
- The state focused on outreach over this year of the demonstration. This focus on outreach, in partnership with the Area Agency on Aging (AAA), allowed us to engage with a significant number of providers, community partners, and individuals.
- Our original goal in 2019 was to increase the dyad percentage of new enrollees to 50 percent. Of the new enrollees this year, we successfully enrolled an average of 40 percent dyads and continue to focus on dyad enrollment.

Table 6: new clients by region and program

Network adequacy for MAC and TSOA

The programs continue to struggle with system-wide workforce challenges, as there continues to be a shortage of Home Care workers available to provide respite and personal care services. The state continues to engage in workforce development efforts on multiple fronts.

To mitigate this ongoing shortage, the state is looking at flexibility in allowing new provider types to offer less skilled services. The state continues to monitor network adequacy and availability of services and provider types across the state. One of the main areas of focus are Adult Day Health and Adult Day Care contracts for respite.

Transportation has been a challenge over the course of the demonstration because of the waiver language that states the individual must be transported to a contracted service. The state is seeking a waiver amendment to allow service funds to be used more broadly to transport program recipients. TSOA clients have requested to use their limited benefits for transportation to medical services and to access community services, such as congregate meal programs.

Assessment and systems update

ALTSA, part of DSHS, has started the planning and development of integrating GetCare, the primary client management system, and TCARE, the caregiver assessment tool, to streamline the workflow for case managers by eliminating redundant data entry and allow more efficient data collection from each system.

Staff training

MAC and TSOA program managers for ALTSA committed to providing monthly statewide training webinars on requested and needed topics during 2019. Below are the webinar trainings that occurred during this quarter:

- **October 16:** overview of caseload management reports available in GetCARE system to aid in tracking due dates of screenings and assessments.
- **November 21:** review functionality of creating service authorizations, supplies, and environmental modifications; warm hand off protocols and seamless transitions.

Upcoming webinars include:

- **January 6, 2020:** MTP Quality Assurance Webinar – review all the CMS Quality Assurance questions regarding the MAC and TSOA program and the purpose of each question.

Data and reporting

Table 7: beneficiary enrollment by program

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of December 31, 2019	108	1092	2208
Number of new enrollees in quarter by program	21*	284**	511***
Number of new person-centered service plans in quarter by program	5	73	213
Number of beneficiaries self-directing services under employer authority	0	0	0

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

The state continues to monitor and assist AAAs with compliance in timely completion of care plans for enrollees.

Outreach and engagement

The outreach events, in coordination with the AAAs, continued in community services offices into October and November:

- **October 3:** Colville outreach event
- **October 25:** Wenatchee outreach event
- **October 28:** Newport outreach event
- **November 19:** Moses Lake outreach event
- **November 20:** Spokane Maple outreach event
- **November 20:** Spokane Trent outreach event

These events provided greater exposure of the programs, and there was a heightened awareness by clients because of the posters displayed in these offices, as well as targeted mailings sent to potential participants. The state mailed thousands of postcards in advance of the events in an effort to reach individuals who may need and be eligible for MAC or TSOA services.

At some of the events, individuals brought the invitations with them and either needed help for themselves, for someone they were caring for, or looking to be a caregiver. Some that attended were looking at what their options may be in the future.

Hospital association and medical clinic outreach events continued this quarter as well:

- **November 4:** Longview Hospital and medical clinic outreach event
- **November 7:** King County Hospital and medical clinic outreach event. This event was a great success because attendees requested additional presentations by the AAA's for these areas. In addition, a second hospital event has been scheduled for March of 2020.
- **December 10:** statewide webinar for hospitals and clinic outreach
- **November 18:** Nisqually Tribe vendor event, made contact with multiple clients who are caregivers, resulting in a call later asking more about the caregiver programs.
- **December 2:** Nisqually Healing House presentation about MAC and TSOA to facility staff
- **December 17:** Nisqually Healing House attended open house and provided information and answered questions regarding the MAC and TSOA programs

Table 8: outreach and engagement activities by AAA

	October	November	December
	Number of events held		
Community presentations and information sharing	**31**	**8**	**2**

Outreach activities occurred in a variety of settings, such as Community Resource Offices, hospital events, community resource fairs, hospital social worker meetings, MCO meetings, public library events, senior centers, and 55+ housing communities. The state also shared publications, send out mailings, posted ads in local newspapers and on the radio, and held support groups, training and workshops for Q4.

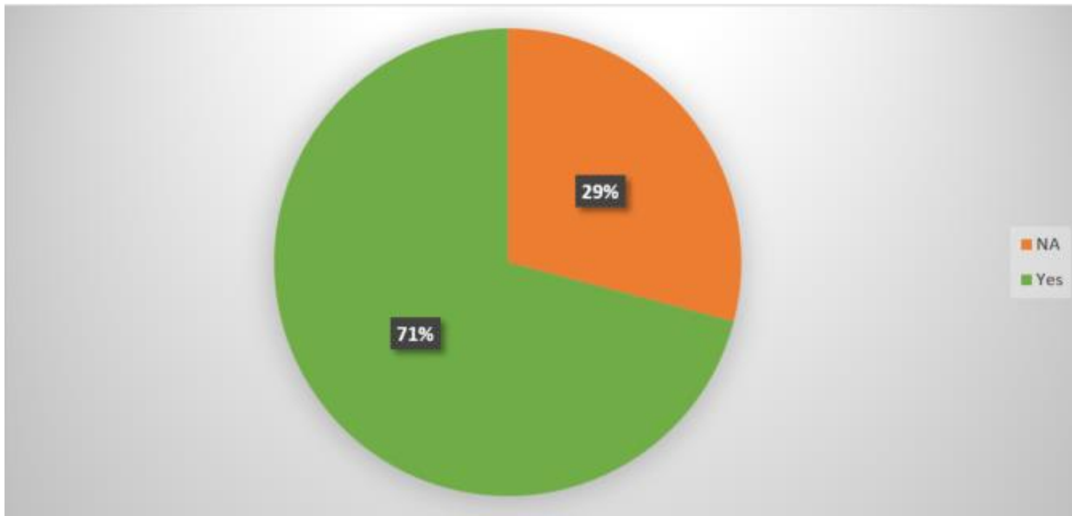
ALTSA met with a number of Tribes to discuss Medicaid services and Initiative 2 and 3 of MTP. Below are the activities, from October 1 through December 31, 2019:

- Completed contract negotiations with Lummi Nation and Spokane Tribe of Indians to expand Tribal subject matter expertise about respite services and increase Tribal staff ability to assist with MAC/TSOA and other respite program referrals. A contract has been sent to Tribal Council for review and signature. Respite and Traumatic Brain Injury trainings are scheduled for the Q1 of 2020.
- Meeting with Makah Tribe to discuss LTSS, Tribal respite navigator services including MAC/TSOA on October 1.
- Meeting with Port Gamble S'Klallam Tribe to discuss TLTSS, Tribal respite navigator services including MAC/TSOA on October 9.
- Meeting with Samish Nation to discuss LTSS, Tribal respite navigator services including MAC/TSOA on October 11.
- Meeting with Lummi Nation to discuss LTSS, Tribal respite navigator services including MAC/TSOA on October 25.
- Meeting with Squaxin Island Tribe to discuss LTSS, Tribal respite navigator services including MAC/TSOA on October 30.
- Annual Tribal Initiative Summit. Workshop on MAC/TSOA was given to approximately 140 attendees on October 31.
- 7.01 planning meeting with Spokane Tribe. Discussion of respite services contract discussed on November 18.
- Meeting with American Indian Community Center to discuss infrastructure analysis for LTSS delivery, including respite services, MAC/TSOA on November 19.
- Meeting with Confederated Tribes of the Colville Reservation to discuss LTSS, Tribal respite navigator services including MAC/TSOA on November 20.
- 7.01 planning meeting with Puyallup Tribe. Discussion of respite services, including MAC/TSOA was included on December 30.

Quality assurance

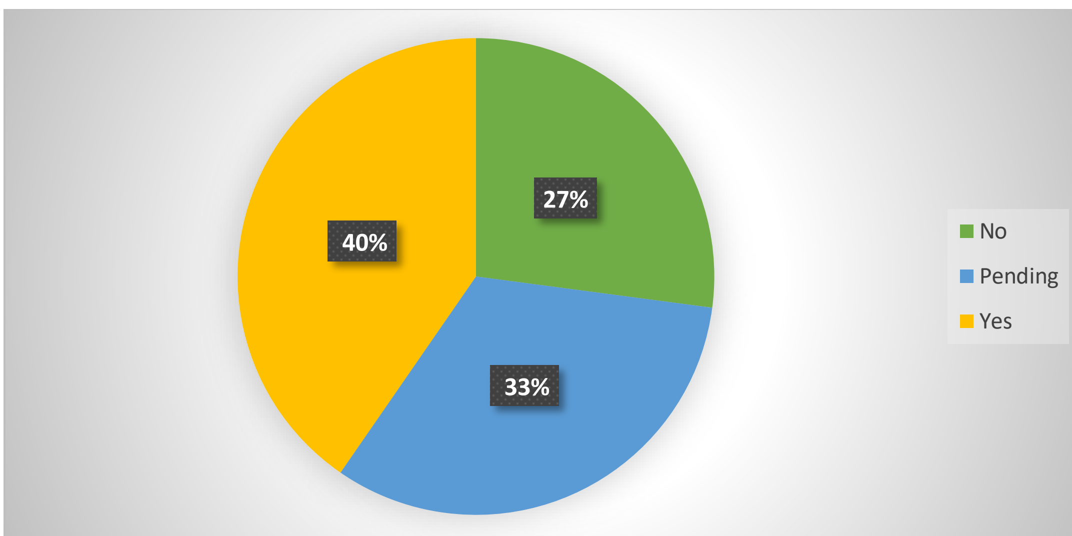
Results of the quarterly presumptive eligibility (PE) quality assurance review

Table 9: Question 1: was the client appropriately determined to be nursing facility level of care eligible for PE?



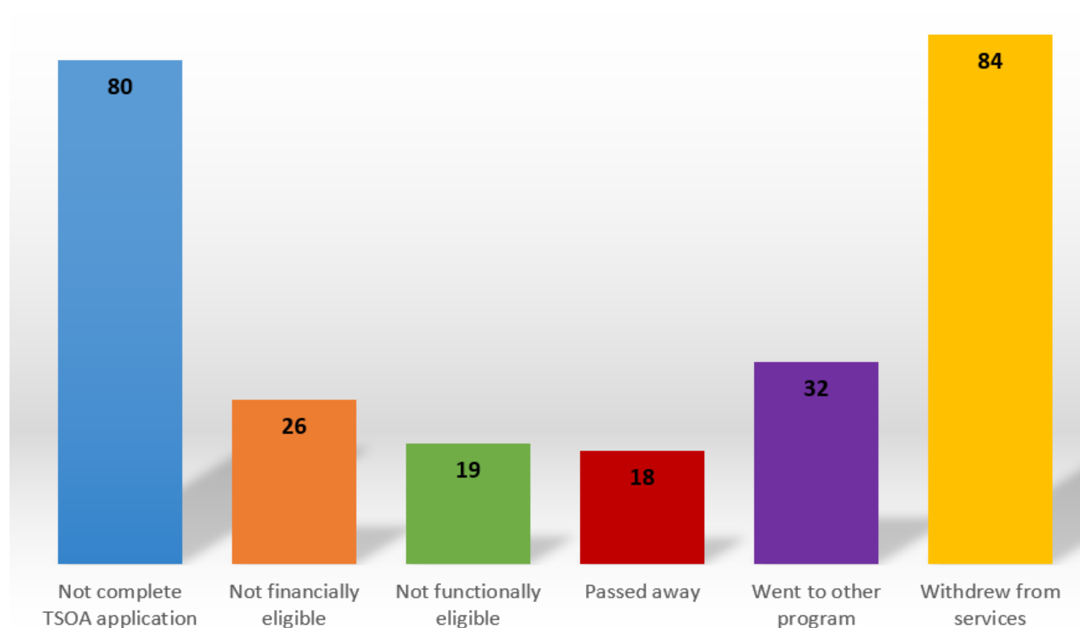
Note: the N/A represents clients who were part of the last quarter's review and the response to question #1 was "yes" but the response to question #2a was "pending".

Table 10: Question 2a: did the client remain eligible after the PE period?



Note: "Pending" means the client was still in PE period during the quality assurance review.

Table 11: Question 2b: if "No" to question #2a, why?



2019 quality assurance results to date

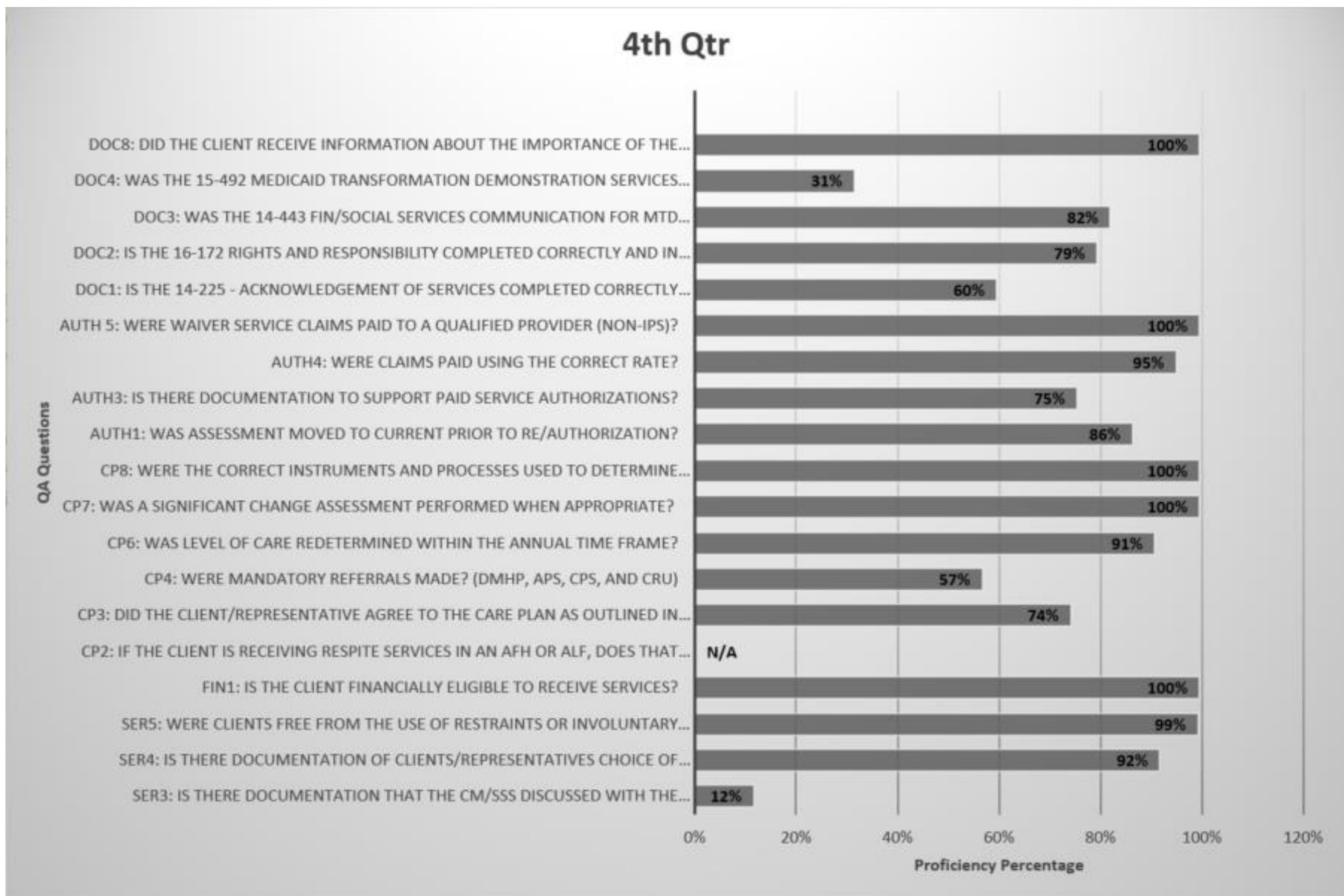
The 2019 audit cycle for Home and Community Services' Quality Assurance unit was from January–October 2019. The statewide compliance review was conducted with all 13 AAAs. An identical review process is used in each AAA Planning and Service Area (PSA), using the same quality assurance tool and the same 19 questions. (See set of quality assurance questions.) The quality assurance team reviews a statistically valid sample of case records. This quarter the sample size was 956 cases.

This methodology is the same one used for the state's 1915(c) waivers and meets the CMS requirements for sampling. Each PSA's sample was determined by multiplying the percent of the total program population in that area by the sample size.

This quarter, the QA questions were reviewed and the language changed so it matched with the MAC and TSOA language and will begin to be implemented in January 2020. In addition, a question and answer webinar is scheduled the first week of January to go over the changes in the working of the questions.

The comparison chart below reflects the statewide proficiency to date for each of the audit questions.

Table 12: statewide proficiency to date



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

State rulemaking

There was no rulemaking activity for the MAC and TSOA programs during this reporting period.

Upcoming activities

- MAC and TSOA trainings will continue each month on various topics.
- Outreach for 2020 will be focused around medical provider outreach and Tribal outreach, including:
    - A hospital event with King and Snohomish County on March 26, 2020.
    - A Tribal Summit in Eastern Washington in spring 2020.

LTSS stakeholder concerns

There were no stakeholder concerns raised during this reporting period.

FCS implementation accomplishments

This section summarizes the FCS program development and implementation activities from October 1 through December 31, 2019. Key accomplishments for the quarter include:

- Total aggregate number of people enrolled in FCS services at the end of DY3 Q4:
    - CSS: 3,824
    - IPS: 3,921

- There were 135 providers under contract with Amerigroup at the end of DY3 Q4, representing 376 sites throughout the state.

Note: CSS and IPS enrollment totals include 867 participants enrolled in both programs. The total unduplicated number of enrollments at the end of Q4 was 6,871.

Network adequacy for FCS

Table 13: FCS provider network development

	October		November		December	
FCS service type	Contracts	Service locations	Contracts	Service locations	Contracts	Service locations
Supported Employment – Individual Placement Support (IPS)	33	69	33	69	33	69
Community Support Services (CSS)	17	32	16	31	17	33
CSS and IPS	83	269	84	273	85	274
Total	**133**	**370**	**133**	**374**	**135**	**376**

Client enrollment

Table 14: FCS client enrollment

	October	November	December
Supported Employment – Individual Placement and Support (IPS)	2,893	3,077	3,054
Community Support Services (CSS)	2,765	2,992	2,950
CSS and IPS	745	845	867
Total aggregate enrollment	**6,403**	**6,914**	**6,871**

Data source: RDA administrative reports
Please note that all December data is preliminary, and may represent undercounts.

Table 15: FCS client risk profile

		Meet HUD homeless criteria	Avg. PRISM risk score	Serious mental illness
October	IPS	476 (13%)	1.02	2,784 (77%)
	CSS	883 (25%)	1.63	2,515 (72%)
November	IPS	518 (13%)	1.02	3,033 (77%)
	CSS	981 (26%)	1.63	2,792 (73%)
December	IPS	541 (14%)	1.02	3,040 (78%)
	CSS	970 (25%)	1.63	2,782 (73%)

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)
Note: month-to-month changes are due to client enrollment mix, not program impact
Data source: RDA administrative reports

Table 16: FCS client risk profile continued

		Medicaid only enrollees*	MH treatment need	SUD treatment need	Co-occurring MH + SUD treatment need flags
October	IPS	3,061	2,892 (94%)	1,673 (55%)	1,596 (52%)
	CSS	2,821	2,635 (93%)	2,143 (76%)	2,019 (72%)
November	IPS	3,303	3,099 (94%)	1,786 (54%)	1,697 (51%)
	CSS	3,091	2,872 (93%)	2,326 (75%)	2,184 (71%)
December	IPS	3,304	3,093 (94%)	1,791 (54%)	1,697 (51%)
	CSS	3,070	2,845 (93%)	2,308 (75%)	2,162 (70%)

Data source: RDA administrative reports
*Does not include individuals who are dual enrolled.

Table 17: 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
October	IPS	3,061	327 (11%)	2,464 (80%)	911 (30%)	260 (8%)
	CSS	2,821	419 (15%)	2,028 (72%)	1,138 (40%)	333 (12%)
November	IPS	3,303	339 (10%)	2,572 (78%)	947 (29%)	271 (8%)
	CSS	3,091	453 (15%)	2,155 (70%)	1,203 (39%)	364 (12%)
December	IPS	3,304	338 (10%)	2,487 (75%)	922 (28%)	262 (8%)
	CSS	3,070	455 (15%)	2,030 (66%)	1,140 (37%)	339 (11%)

(Aging CARE assessment in last 15 months)
Data source: RDA administrative reports
*Does not include individuals who are dual enrolled.

Table 18: FCS client Medicaid eligibility

		CN blind/disabled (Medicaid only & full dual eligible)	CN aged (Medicaid only & full dual eligible)	CN family & pregnant woman	ACA expansion adults	CN & CHIP children
October	IPS	1,080 (30%)	91 (3%)	376 (10%)	1,982 (54%)	109 (3%)
	CSS	1,381 (39%)	221 (6%)	336 (10%)	1,551 (44%)	21 (1%)
November	IPS	1,163 (30%)	99 (3%)	406 (10%)	2,141 (55%)	113 (3%)
	CSS	1,477 (38%)	254 (7%)	367 (10%)	1,715 (45%)	24 (1%)
December	IPS	1,173 (30%)	94 (2%)	404 (10%)	2,139 (55%)	111 (3%)
	CSS	1,493 (39%)	251 (7%)	372 (10%)	1,680 (44%)	21 (1%)

ACA = Affordable Care Act
CHIP = Children's Health Insurance Program
CN = categorically needy
Data source: RDA administrative reports

Quality assurance and monitoring activity

Training, technical assistance, stakeholder involvement, and information sharing around FCS continued this quarter, including the following activities:

- HCA, ALTSA, and Amerigroup provided direct technical assistance to individual agencies statewide.
- HCA hosted 15 webinars this quarter, presenting to more than 950 attendees.

- HCA and ALTSA presented information about FCS at four state conferences (NAMI, Co-Occurring Disorder and Treatment, Medicaid Transformation Learning Symposium, Conference on Ending Homelessness).
- HCA held two fidelity reviewer trainings on the IPS and Permanent Supportive Housing (PSH) fidelity models in December. The fidelity reviewer training events prepare agencies for fidelity reviews as well as promoting a learning collaborative approach to continuous quality improvement activities.
- HCA also conducted five fidelity reviews this quarter of contracted FCS providers, two on the evidence-based practice PSY model, and three on the IPS model. In addition to FCS staff, 14 contracted agencies participated in the fidelity reviews.

Other FCS program activity

The Kalispel Tribe became FCS' first Tribal partner contracting to provide IPS services this quarter. One other Tribe is in process and will likely begin providing FCS services in early 2020.

During this quarter, Yakima Housing Authority (YHA) became our first contracting Housing Authority (HA) partner. We will offer close technical support to YHA, with the expectation to develop template policies and procedures that may be utilized by other HAs interested in becoming FCS providers.

Finally, we are pleased to report that Cascade Pacific Action Alliance ACH is working with HCA and the Washington State Dept. of Commerce to braid FCS with other funding sources to develop a robust coordinated care model within their region.

We view Tribes, HAs and ACHs as important partners in braiding IPS and CSS with other resources to achieve strong participant outcomes, and to leverage investment in FCS services effectively.

Upcoming activities

- HCA staff are presenting and/or participating in these upcoming conferences:
  - 2020 State of Reform Conference on January 9, 2020
  - National Housing First Partners Conference from March 17-19, 2020
  - Region X Community Action Conference in May 2020
  - 2020 International IPS Learning Community Annual Meeting in May 2020
- HCA is looking to increase the number of SUD treatment facilities in the FCS network through incentive grants in DY4 Q1. Funding for the incentive grants are provided by braiding Substance Abuse Mental Health Services Administration block grant funding for SUD agencies to develop the capacity to deliver FCS services.
- HCA is working with its five national technical assistance contractors to provide webinars and in-person trainings focused on business models, best practices, and policies and procedures to create targeted assistance for housing authorities, grant-based organizations, and other non-traditional providers.

FCS program stakeholder engagement activities

During the reporting quarter, staff from HCA, ALTSA, and Amerigroup supported a variety of stakeholder engagement activities.

Table 19: FCS program stakeholder engagement activities

	October	November	December
	Number of events held		
Training and assistance provided to individual organizations	42	44	26

Community and regional presentations and training events	8	15	15
Informational webinars	6	5	6
Stakeholder engagement meetings	7	7	8
Total activities	**63**	**71**	**55**

Training and technical assistance activities for individual organizations continued during this reporting period. Webinars inform, educate, and coordinate resources for FCS providers serving people who need housing and employment services, resources, and support. DY3 Q4 topics included:

- Integrating Supported Employment with Coordinated Entry
- Integration and Collaboration of Supported Employment and Behavioral Health
- Self-directed Job Search
- Transition from Grant Business Model to Medicaid Reimbursement Business Model
- Supervisor Training
- Job Development and Time Management
- Forensic Peer Bridging and FCS
- Documenting IPS Fidelity
- Healthcare for Workers with Disabilities – WA's Medicaid Buy-in Program

FCS stakeholder concerns

Amerigroup reported no provider grievances or appeals during the quarter. No providers discontinued services during the quarter.

Individual providers continue to report payment and denial challenges. While Amerigroup appears generally responsive, there are providers who report payment or denial issues as recurrent. The FCS program administrator is working with Amerigroup to proactively communicate changes in payment processing protocols, and provide technical assistance to enable providers to more closely monitor denials. To the extent that these challenges arise from provider error in claims submission and other factors related to provider inexperience, HCA plans to offer more robust technical assistance in business modeling in 2020.

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 October 1 through December 31, 2019. Accomplishments for the quarter include:

- Staff member presented on the Meds-First + Care Navigation model of care and its outcomes at the 34th annual Co-Occurring-Disorder & Treatment Washington State Conference. (This well-established conference had more than 640 registrants.)
- Evaluation team engaged providers and consumers at the Washington State Co-Occurring Disorder and Treatment Conference and began listening sessions.

- Hosted provider education calls on the effectiveness of medication assisted treatment (MAT) services—including outreach to youth providers. NOTE: HCA is moving away from the term "MAT" and using "medication for opioid use disorder (MOUD)".

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:

- **Milestone 3c:** requirements that residential treatment facilities offer MAT/MOUD on-site or facilitate access off-site.
  - **Update:** MCO contracts for January 2020 now in effect include language for this requirement. Work continued on enlisting Department of Health to participate in updating provider Washington State Administrative Code (WAC) requirements. Implementation of WAC changes is on schedule following multiple high-level meetings with Department of Health (DOH) leadership.
- **Milestone 6:** the state will require residential and outpatient providers to improve coordination between levels of care. A sub-workgroup was formed and meets regularly. HCA expects to have the requirement in the July 1, 2019, managed care contracts.
  - **Update:** MCO contracts for January 2020 are now in effect with this requirement. HCA WAC language currently meets this milestone; DOH will factor these expectations into current rulemaking projects.

SUD HIT plan requirements

During the fourth quarter of 2019, Washington State advanced its HIT Operational Plan including work to support the SUD IMD waiver HIT plan requirements:

HCA coordinated internally and with DOH to support implementation of the HIT Plan requirements related to the PDMP and related requirements using funds made available through the Partnership Act/SUPPORT Act. This year, DOH connected the PDMP to both national interstate sharing hubs (PDMP interconnect and RxCheck) and is currently sharing data in 30 states, DC, Puerto Rico and the Military Health System. The state also began a security review of OneHealthPort Single Sign-on to determine if it can be used by PDMP and other programs, which will greatly ease the use for the PDMP.

Using funds made available through the Partnership Act/SUPPORT Act, HCA began developing a consent management pilot, including developing a Request for Proposal for project management support. HCA is currently exploring options for additional contractor support to complete the pilot in 2020.

Evaluation design

There were no updates during this reporting period.

Monitoring protocol

There were no updates during this reporting period.

Upcoming activities

HCA will work on updating the Washington Administrative Code.

Quarterly expenditures

The following table reflects quarterly expenditures for DSRIP, LTSS, and FCS during DY3 (2019).

Table 20: DSRIP expenditures

	Q1	Q2	Q3	Q4	DY3 Total	Funding source
	January 1–March 31	April 1–June 30	July 1–September 30	October 1–December 31	January 1–December 31	Federal financial participation
ACH						
Better Health Together	$0	$17,396,295	$0	$0	$17,396,295	$8,698,148
Cascade Pacific Action Alliance	$0	$11,313,792	$0	$0	$11,313,792	$5,656,896
Elevate Health	$0	$19,109,624	$0	$0	$19,109,624	$9,554,812
Greater Columbia	$0	$21,829,660	$0	$0	$21,829,660	$10,914,830
HealthierHere	$0	$33,463,618	$0	$0	$33,463,618	$16,731,809
North Central	$0	$6,130,010	$0	$0	$6,130,010	$3,065,005
North Sound	$0	$16,820,688	$6,498,653	$0	$23,319,341	$11,659,671
Olympic Community of Health	$0	$4,705,518	$0	$0	$4,705,518	$2,352,759
SWACH	$0	$8,136,037	$0	$0	$8,136,037	$4,068,019
IHCP-specific projects						
Indian Health Care Providers	$0	$0	$1,862,500	$0	$1,862,500	$931,250

Table 21: LTSS and FCS service expenditures

	Q1	Q2	Q3	Q4	DY3 Total
	January 1–March 31	April 1–June 30	July 1–September 30	October 1–December 31	January 1–December 31
Tailored Supports for Older Adults (TSOA)	$1,669,673	$2,117,045	$1,825,341	$0	$5,612,059
Medicaid Alternative Care (MAC)	$27,638	$39,598	$38,595	$0	$105,831
MAC and TSOA not eligible	$25	$0	$309	$0	$334
FCS	$0	$324,645	$3,114,155	$0	$3,438,800

Financial and budget neutrality development issues

Financial

The State Auditor's Office completed their routine audit on MTP expenditures and did not have any findings to report for SFY19 (July 2018 – June 2019 period).

HCA has developed a process for mapping SUD IMD expenditures on the CMS-64 waiver forms and will be reported on the CMS-64 FFY20/Quarter 1 form.

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. November 2019 and December 2019 for non-expansion adults are forecasted caseload figures from CFC. SUD member months are based on the state's ProviderOne system. At this time, SUD member month's data is only available through September 2019.

Table 22: member months eligible to receive services

Calendar month	Non-expansion adults only	SUD Medicaid disabled	SUD Medicaid non-disabled	SUD newly eligible	SUD American Indian/Alaska Native
Jan-17	376,343	0	0	0	0
Feb-17	375,234	0	0	0	0
Mar-17	374,734	0	0	0	0
Apr-17	373,544	0	0	0	0
May-17	373,052	0	0	0	0
Jun-17	372,926	0	0	0	0
Jul-17	372,000	0	0	0	0
Aug-17	371,708	0	0	0	0
Sep-17	370,427	0	0	0	0
Oct-17	370,203	0	0	0	0
Nov-17	370,002	0	0	0	0
Dec-17	369,989	0	0	0	0
Jan-18	370,006	0	0	0	0
Feb-18	368,573	0	0	0	0
Mar-18	368,401	0	0	0	0
Apr-18	367,161	0	0	0	0
May-18	367,525	0	0	0	0
Jun-18	366,826	0	0	0	0
Jul-18	366,570	2	3	11	8
Aug-18	365,995	6	1	18	17
Sept-18	365,014	3	3	11	18
Oct-18	365,015	4	3	9	24
Nov-18	364,559	2	1	17	27
Dec-18	363,994	4	4	12	15
Jan-19	363,951	4	18	65	22
Feb-19	362,214	13	23	110	27
Mar-19	361,871	7	25	96	29
Apr-19	361,412	6	29	92	35
May-19	360,907	4	29	82	42
June-19	360,143	5	25	57	31
Jul-19	360,599	2	22	57	34
Aug-19	360,165	1	29	28	32
Sep-19	359,730	10	32	77	26
Oct-19	359,200	0	0	0	0
Nov-19	358,773	0	0	0	0
Dec-19	358,586	0	0	0	0
Total	13,197,352	73	247	742	387

Budget neutrality

HCA adopted CMS's budget neutrality monitoring tool and has been using Performance Management Database and Analytics system to upload quarterly spreadsheets. Conversations with CMS continued regarding the projected budget neutrality exceedance over the life of MTP. This exceedance is due to unanticipated LTSS wage increases in recent years.

Designated state health programs (DSHP)

HCA procured a contract with Myers & Stauffer to perform an independent audit on DSHP expenditures.

Overall MTP development and issues

Operational/policy issues

Implementation activities are underway for all initiatives. There are no significant operational or policy issues to report for this quarter, with the exception of the context provided in the budget neutrality section regarding ongoing corrective action planning.

Consumer issues

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

MTP evaluation

In 2018, HCA began working with the IEE, CHSE at Oregon Health and Science University. As part of their contract with HCA, CHSE is responsible for evaluating the overall success and effectiveness of MTP. As part of their evaluation, CHSE produces a rapid-cycle monitoring report each quarter, which highlights the work and progress of each ACH.

Highlights from the latest rapid-cycle report (December 31, 2019)

CHSE submitted the sixth rapid-cycle monitoring report on December 31, 2019, in compliance with their timeline of contracted deliverables.

Recent accomplishments and key activities during this reporting period include:

- **Data synthesis:** CHSE began synthesizing quantitative and qualitative findings for the March 2020 baseline report. Analysts from CHSE's qualitative and quantitative team held multiple meetings together. Facilitated discussions with the combined teams is enabling each team to acquire an in-depth understanding of the analytic process of the other. Future analysis and alignment of findings across the teams will be used to adjust data collection and interpretation.
- **Key informant interviews:** from May to November 2019, the CHSE qualitative team conducted 60 interviews with ACH stakeholders through a process of site visits in all nine ACH regions. The quantitative analysis team continues to code the data collected. They will be preparing "case" summaries for each ACH, along with longer summaries that capture structured details across a set of dimensions.
- **Administrative data analysis:** during the last reporting period, CHSE began using administrative data provided by HCA and DSHS' Research and Data Analysis (RDA) to begin in-depth quantitative analyses. They are currently designing data displays for the March 2020 baseline report.
- **Hospital and Primary Care Practice surveys:** CHSE continued to contact hospitals and primary care practices using multiple methods to increase survey response. The deadline to close the survey was extended from November 2019 to January 2020.
- **ACH Comparison across dimensions:** In the fifth rapid-cycle monitoring report, CHSE focused on early findings from interviews with key informants. Building on that, this report highlights the first three ACHs where CHSE conducted interviews and site visits: SWACH, CPAA, and OCH. The report compares these ACHs on the following dimensions:
    - Organizational history
    - Involvement with IMC implementation
    - Approach to change and health improvement projects
    - Approach to addressing social determinants of health

- Relationship with Tribes
- Relationship with MCOs
- Expected activity during next reporting period (January 1–March 31, 2020):
- Continued synthesis of quantitative and qualitative data
- Closure of hospital and health provider survey and initiation of survey analysis
- Round 2 key informant interviews (February – July 2020)
- Submission of baseline report (March 2020)
- The sixth rapid-cycle monitoring report will be available on the Medicaid Transformation resources page in early 2020.

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, Q4 2019
- Attachment C: 1115 SUD Demonstration Monitoring Workbook – Part A
- Attachment D: 1115 SUD Demonstration Monitoring Report – Part B
- Attachment E: LTSS quality assurance questions

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	Kelli Emans	Integration Unit Manager, DSHS	360-725-3213
FCS program	Melodie Pazolt	BH Programs and Recovery Support Services Section Manager, DBHR	360-725-0487
SUD IMD waiver	David Johnson	Federal Programs Manager, DBHR	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, Q4 2019

This table shows all funds earned and distributed through the FE portal through December 31, 2019.

	Total	Better Health Together	Cascade Pacific Action Alliance	Elevate Health (Pierce County ACH)	Greater Columbia	HealthierHere	North Central	North Sound	Olympic Community of Health	SWACH	IHCP-specific projects
Funds earned by ACH											
2A: bi-directional integration of physical and behavioral health through care transformation	$182,487,454	$20,675,302	$14,768,072	$22,554,874	$30,468,869	$47,879,649	$6,741,948	$18,607,771	$7,633,957	$13,157,011	$0
2B: community based care coordination	$66,347,176	$14,214,272	$10,153,052	$15,506,477	$0	$0	$4,635,087	$12,792,842	$0	$9,045,446	$0
2C: transitional care	$48,126,938	$0	$5,999,530	$0	$12,377,977	$19,451,107	$2,738,915	$7,559,409	$0	$0	$0
2D: diversion interventions	$13,399,620	$0	$0	$0	$0	$0	$2,738,915	$7,559,409	$3,101,297	$0	$0
3A: addressing the opioid use public health crisis	$22,810,938	$2,584,414	$1,846,010	$2,819,360	$3,808,608	$5,984,957	$842,744	$2,325,973	$954,245	$1,644,626	$0
3B: reproductive and maternal/child health	$6,407,782	$0	$2,307,512	$0	$0	$0	$0	$2,907,464	$1,192,806	$0	$0
3C: access to oral health services	$2,460,162	$0	$0	$0	$0	$0	$0	$1,744,477	$715,685	$0	$0
3D: chronic disease prevention and control	$45,621,862	$5,168,825	$3,692,017	$5,638,720	$7,617,217	$11,969,912	$1,685,487	$4,651,943	$1,908,490	$3,289,252	$0
Integration incentives	$68,111,492	$8,301,872	$0	$9,321,788	$10,183,916	$14,888,792	$5,781,980	$10,831,088	$0	$8,802,056	$0
VBP incentives	$2,700,000	$300,000	$300,000	$300,000	$300,000	$300,000	$300,000	$300,000	$300,000	$300,000	$0
IHCP-specific projects	$12,841,500	$0	$0	$0	$0	$0	$0	$0	$0	$0	$12,841,500
Bonus pool/high-performance pool	$6,308,649	$0	$1,455,842	$0	$0	$0	$1,455,842	$1,941,123	$1,455,842	$0	$0
Interest accrual	$630,446	$66,863	$28,473	$60,849	$103,847	$192,710	$43,655	$60,770	$8,329	$64,949	$0
TOTAL	**$478,254,018**	**$51,311,548**	**$40,550,508**	**$56,202,067**	**$64,860,434**	**$100,667,128**	**$26,964,573**	**$71,282,269**	**$17,270,650**	**$36,303,341**	**$12,841,500**
Funds distributed by ACH											
Administration	$19,424,545	$1,637,366	$335,891	$3,900,000	$1,556,500	$6,117,866	$0	$4,709,204	$14,081	$1,153,636	$0
Community health fund	$15,894,169	$2,929,314	$2,358,557	$4,000,000	$1,395,202	$0	$0	$4,688,179	$0	$522,917	$0
Health systems and community capacity building	$27,923,456	$5,217,701	$1,307,788	$6,335,393	$2,590,667	$463,690	$1,451,239	$8,242,011	$110,000	$1,654,966	$550,000
Integration incentives	$19,446,907	$2,930,000	$0	$4,745,933	$6,393,858	$4,680,375	$58,422	$553,320	$0	$85,000	$0
Project management	$4,933,561	$0	$1,903,385	$0	$890,500	$0	$590,746	$1,329,035	$196,000	$23,896	$0
Provider engagement, participation, and implementation	$79,859,581	$9,929,222	$7,564,164	$3,895,200	$6,103,384	$11,858,815	$2,832,722	$16,654,873	$7,937,734	$1,669,167	$11,414,300
Provider performance and quality incentives	$23,425,341	$0	$4,641,774	$10,405,953	$1,390,539	$1,663,417	$1,373,482	$0	$0	$3,950,177	$0
Reserve/contingency fund	$2,404,473	$0	$1,474,098	$0	$0	$0	$0	$930,375	$0	$0	$0
Shared domain 1 incentives	$87,005,581	$9,570,614	$8,700,558	$10,440,669	$12,180,782	$19,141,229	$4,350,278	$13,050,838	$3,480,224	$6,090,391	$0
TOTAL	**$280,317,615**	**$32,214,217**	**$28,286,215**	**$43,723,147**	**$32,501,432**	**$43,925,391**	**$10,656,888**	**$50,157,835**	**$11,738,039**	**$15,150,150**	**$11,964,300**
Funds available											
Total funds distributed to date	$280,317,615	$32,214,217	$28,286,215	$43,723,147	$32,501,432	$43,925,391	$10,656,888	$50,157,835	$11,738,039	$15,150,150	$11,964,300
Total funds available for distribution	$197,911,403	$19,072,331	$12,264,293	$12,478,920	$32,359,002	$56,741,737	$16,307,685	$21,124,434	$5,532,611	$21,153,191	$877,200
% of total funds distributed	58.62%	62.83%	69.76%	77.80%	50.11%	43.63%	39.52%	70.37%	67.97%	41.73%	93.17%
% of total funds distributed by ACH											
Administration	6.93%	5.08%	1.19%	8.92%	4.79%	13.93%	0.00%	9.39%	0.12%	7.61%	0.00%
Community health fund	5.67%	9.09%	8.34%	9.15%	4.29%	0.00%	0.00%	9.35%	0.00%	3.45%	0.00%
Health systems and community capacity building	9.96%	16.18%	4.62%	14.49%	7.97%	1.06%	13.62%	16.43%	0.94%	10.92%	4.60%
Integration incentives	6.94%	9.09%	0.00%	10.85%	19.67%	10.66%	0.55%	1.10%	0.00%	0.56%	0.00%
Project management	1.76%	0.00%	6.73%	0.00%	2.74%	0.00%	5.54%	2.65%	1.67%	0.16%	0.00%

Provider engagement, participation, and implementation	28.50%	30.88%	26.74%	8.91%	18.78%	27.00%	26.58%	33.20%	67.62%	11.02%	95.40%
Provider performance and quality incentives	8.36%	0.00%	16.41%	23.80%	4.28%	3.79%	12.89%	0.00%	0.00%	26.07%	0.00%
Reserve/contingency fund	0.86%	0.00%	5.21%	0.00%	0.00%	0.00%	0.00%	1.85%	0.00%	0.00%	0.00%
Shared domain 1 incentives	31.04%	29.69%	30.76%	23.88%	37.48%	43.58%	40.82%	26.02%	29.65%	40.20%	0.00%
TOTAL	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Attachment C: 1115 SUD Demonstration Monitoring Workbook – Part A

This is the first workbook submitted as part of the CMS approved SUD Monitoring Protocol. This workbook contains historical reporting on the baseline reporting period (07/01/2017–06/30/2018) through the first year of waiver implementation (07/01/2018–06/30/2019). Per CMS' instructions, a separate tab was created for each quarter of reporting (see table below).

As discussed with CMS, the state is not reporting on CY2017 baseline rates for four established quality metrics at this time. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment; Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence; Follow-up after Emergency Department Visit for Mental Illness and Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD must be reported using a previous version of HEDIS® specifications that are no longer implemented in the state's analytic environment.

CMS has delayed reporting on these metrics until the next reporting period to allow the state to re-implement the previous specifications. CMS approved state-specific deviations for three other established quality metrics. CY2017 rates are reported for Use of Opioids at High Dosage in Persons without Cancer; Concurrent Use of Opioids and Benzodiazepines; and Continuity of Pharmacotherapy for Opioid Use Disorder given that the state is using a modified version of the specifications.

Table 23: tabs for each quarter of reporting

Tab Name	Type of reporting for sud imd waiver	Calendar dates for reporting period	CMS-constructed monthly metric measurement periods	CMS-constructed annual metric measurement periods	Established quality metric measurement periods
Report - metrics reporting	Current waiver reporting period	10/01/2019 – 12/31/2019	04/01/2019 – 06/30/2019	07/01/2018 – 06/30/2019	N/A
Report - metrics reporting - A	Baseline reporting period	01/01/2018 – 03/31/2018	07/01/2017 – 09/30/2017	N/A	N/A
Report - metrics reporting - B	Baseline reporting period	04/01/2018 – 06/30/2018	10/01/2017 – 12/31/2017	N/A	01/01/2017 – 12/31/2017*
Report - metrics reporting - C	Baseline reporting period	07/01/2018 – 09/30/2018	01/01/2018 – 03/31/2018	N/A	N/A
Report - metrics reporting - D	Baseline reporting period	10/01/2018 – 12/31/2018	04/01/2018 – 06/30/2018	07/01/2017 – 06/30/2018	N/A
Report - metrics reporting - E	Waiver reporting period	01/01/2019 – 03/31/2019	07/01/2018 – 09/30/2018	N/A	N/A
Report - metrics reporting - F	Waiver reporting period	04/01/2019 – 06/30/2019	10/01/2018 – 12/31/2018	N/A	01/01/2018 – 12/31/2018

Report - metrics reporting - G	Waiver reporting period	07/01/2019 – 09/30/2019	01/01/2019 – 03/31/2019	N/A	N/A

*Some established quality metrics not reported for the CY2017 at this time.

NOTE: The full workbook will be submitted as a separate attachment to CMS. A public workbook (which does not contain the full workbook) is available on the HCA website.

Attachment D: 1115 SUD Demonstration Monitoring Report – Part B

1. Title Page for the State's SUD Demonstration or SUD Components of Broader Demonstration

State	*Washington State*
Demonstration name	*Washington State Medicaid Transformation Project No. 11-W-00304/0*
Approval date for demonstration	*January 9, 2017*
Approval period for SUD	*July 1, 2018-December 31, 2021*
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.

2. Executive Summary

• While the absolute number of Medicaid beneficiaries treated in an IMD for SUD increased slightly, the overall average length of stay in an IMD decreased for both individuals with an SUD diagnosis and individuals with an OUD diagnosis.

• The number of providers authorized to prescribe MOUD increased rapidly between SFY2018 and SFY2019.

• Overall, the rate of emergency department utilization for SUD in Washington remained relatively stable from July 2017 through June 2019. However, the rate for persons with a diagnosis of OUD shows a downward trend over the same time.

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 Medicaid beneficiaries with a substance use disorder (SUD) diagnosis in a given month almost doubled from the initial baseline month (July 2017) to the most recently reported month (June 2019). This increase is primarily driven by an increase in the number of Medicaid beneficiaries with an opioid use disorder (OUD) diagnosis. Even though the absolute number of Medicaid beneficiaries with an SUD/OUD diagnosis increased, the proportion of Medicaid beneficiaries in the various subpopulations (age breakouts, dually eligible for Medicaid/Medicare, pregnant, involved in the criminal justice system) remained stable.	04/01/2019 – 06/30/2019	#3: Medicaid beneficiaries with SUD diagnosis (monthly)
	While the number of Medicaid beneficiaries with a SUD diagnosis in a given month almost double between the initial baseline month to the most recent month, the number of Medicaid beneficiaries with an SUD diagnosis in a given ***year*** had a less dramatic increase. The number of Medicaid beneficiaries with an SUD diagnosis in a given year increased by about 6,000 persons between SFY2018 and SFY2019. As with the monthly count, this increase is primarily driven by an increase in the number of Medicaid beneficiaries with an OUD diagnosis.	07/01/2018 – 06/30/2019	#4: Medicaid beneficiaries with SUD diagnosis (annual)
	Between SFY2018 and SFY2019, there was a small increase in the number of Medicaid beneficiaries treated in an IMD for SUD. Once again, this increase is primarily driven by an increase in the number of Medicaid beneficiaries treated in an IMD with an OUD diagnosis.	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.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
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 Medicaid beneficiaries with an SUD diagnosis who received any form of SUD treatment in a given month increased over 25% from the initial baseline month (July 2017) to the most recently reported month (June 2019).	04/01/2019 – 06/30/2019	#6: Any SUD Treatment
	While the absolute number of Medicaid beneficiaries who received an SBIRT screening is low, there is a four-fold increase in use of the SBIRT from the initial baseline month (July 2017) to the most recently reported month (June 2019). Research within the state has highlighted some barriers to billing for SBIRT, including but not limited to staff turnover and uncertainty around reimbursement.	04/01/2019 – 06/30/2019	#7: Early Intervention

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
	The number of Medicaid beneficiaries who received an outpatient SUD services increased by more than 4,000 individuals from the initial baseline month (July 2017) to the most recently reported month (June 2019). The proportion of outpatient service use among Medicaid beneficiaries in the various subpopulations (age breakouts, dually eligible for Medicaid/Medicare, pregnant, involved in the criminal justice system) remained stable. However, the proportion of outpatient service utilization among Medicaid beneficiaries with an OUD diagnosis increased from 49.53 percent to 59.31 percent.	04/01/2019 – 06/30/2019	#8: Outpatient Services
	The absolute number of Medicaid beneficiaries who received a residential or inpatient service remained stable from the initial baseline month (July 2017) to the most recently reported month (June 2019). The proportion of service utilization among most subpopulations fluctuates from one month to the next, but overall remains consistent. There is a slight overall increase in the proportion of residential and inpatient service utilization among Medicaid beneficiaries with an OUD diagnosis.	04/01/2019 – 06/30/2019	#10: Residential and Inpatient Services
	Use of withdrawal management services increased from the initial baseline month (July 2017) through December 2018 and decreased in use since then to levels consistent with the initial baseline month.	04/01/2019 – 06/30/2019	#11: Withdrawal Management
	The use of medication assisted treatment (MAT) steadily increased from the initial baseline month (July 2017) to the most recently reported month (June 2019). This is largely driven by the increased in the number of Medicaid beneficiaries with opioid use disorder utilizing MAT.	04/01/2019 – 06/30/2019	#12: Medication Assisted Treatment
	While the absolute number of Medicaid beneficiaries treated in an IMD for SUD increased slightly, the overall average length of stay in an IMD decreased for both individuals with an SUD diagnosis and individuals with an OUD diagnosis.	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.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
2.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) Planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g. outpatient services, intensive outpatient services, medication assisted treatment, services in intensive residential and inpatient settings, medically supervised withdrawal management) ☐ ii) SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and medication assisted treatment services provided to individuals in IMDs			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 1			
☒ The state has no implementation update to report for this reporting topic.			
3.2 Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)			
3.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 2			
☒ The state has no trends to report for this reporting topic.			
☐ The state is not reporting metrics related to Milestone 2.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
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.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
4.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards ☐ ii) State review process for residential treatment providers' compliance with qualifications standards ☐ iii) Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 3			
☒ The state has no implementation update to report for this reporting topic.			
☒ The state is not reporting metrics related to Milestone 3.			
5.2 Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)			
5.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4	The number of providers authorized to provide substance use disorder services (including outpatient, residential and inpatient, and withdrawal management) increased by almost 100 providers between SFY2018 and SFY2019. Note that this does not specifically include providers authorized to prescribe medication for opioid use disorder (MOUD), however providers authorized to provide SUD services may also by authorized to provide MOUD. See the monitoring workbook Data and report	07/01/2018 – 06/30/2019	#13: SUD provider availability

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
	The number of providers authorized to prescribed medication for opioid use disorder (MOUD) increased rapidly between SFY2018 and SFY2019.	07/01/2018 – 06/30/2019	#14: SUD provider availability – MAT
☐ The state has no trends to report for this reporting topic.			
5.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ Planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 4			
☒ The state has no implementation update to report for this reporting topic.			
6.2 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)			
6.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 5	No trends to report for the Initiation and Engagement of AOD treatment (only one measurement year available).		
	Use of opioids at high dosages in persons without cancer decreased slightly between SFY2018 and SFY2019.	01/01/2018 – 12/31/2018	#18: Use of Opioids at High Dosage in Persons without Cancer (modified by State)

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
	Concurrent use of opioids and sedatives decreased by almost 3 percentage points between SFY2018 and SFY2019.	01/01/2018 – 12/31/2018	#21: Concurrent Use of Opioids and Benzodiaze-pines (modified by State)
	While the absolute number of individuals receiving and maintaining a pharmacotherapy treatment for opioid use disorder increased, the overall proportion of individuals remaining on pharmacotherapy decreased between SFY2018 and SFY2019. The State is exploring clinical care related factors that affect adherence to pharmacotherapy, including type of provider/program and the starting dose of the medication.	01/01/2018 – 12/31/2018	#22: Continuity of Pharma-cotherapy for Opioid Use Disorder (modified by State)
☐ The state has no trends to report for this reporting topic.			
6.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD ☐ ii) Expansion of coverage for and access to naloxone			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 5			
☒ The state has no implementation update to report for this reporting topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
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	No trends to report for Follow-Up after Emergency Department Use for Alcohol or Other Drug Dependence or for Mental Illness (only one measurement year available).		
☒ 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	No trends to report for Statewide Fatal Drug Overdoses (only one measurement year available).		
	The percentage of Medicaid beneficiaries, 12 years of age and older, with a substance use disorder treatment need identified within the past two years, who received at least one qualifying substance use disorder treatment during the measurement year increased by 3 percentage points between SFY2018 and SFY2019.	07/01/2018 – 06/30/2019	Q2: Substance Use Disorder Treatment Penetration Rate

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
	The FCS program started halfway through the first measurement year. As expected, the percentage of Medicaid beneficiaries with a substance use disorder related inpatient or residential treatment stay within the past two years, who enrolled in at least one FCS service, was very low during the first measurement year (SFY2018). However, during the second measurement year (SFY2019), almost 4% of Medicaid beneficiaries with an SUD related inpatient or residential treatment stay enrolled in at least one FCS service during the measurement year.	07/01/2018 – 06/30/2019	Q3: Foundational Community Supports Beneficiaries with Inpatient or Residential SUD Services
☐ The state has no trends to report for this reporting topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
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.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
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	Overall, the rate of emergency department utilization for SUD in WA remained relatively stable from July 2017 through June 2019. However, the rate for persons with a diagnosis of OUD shows a downward trend over the same time.	04/01/2019 – 06/30/2019	#23: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries
	Overall, the rate of inpatient stays for SUD in WA increased slightly from July 2017 to June 2019. However, the rates for persons with a diagnosis of OUD appear to be on a downward trend over the same time.	04/01/2019 – 06/30/2019	#24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries
	Readmissions among beneficiaries with SUD remained stable from SFY2018 to SFY2019.	07/01/2018 – 06/30/2019	#25: Readmissions Among Beneficiaries with SUD
	No trends to report for Overdose Deaths count or rate (only one measurement year available).		
	No trends to report for Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD (only one measurement year available).		
☐ 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.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
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 as a whole. Describe the current 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.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
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.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
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 SUD evaluation is on track. The state does not anticipate any barriers in achieving the goals and timeframes agreed to in the STCs at this point in time.*		
☐ 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.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
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.			

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

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

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

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

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

Attachment E: LTSS quality assurance questions

1. SER 3: Is there documentation that the CM/SSS discussed with the client/representative his/her choices of available programs/services, settings, and providers?
2. SER 4: Is there documentation of clients/representatives choice of available programs/services, settings, and providers?
3. SER 5: Were clients free from the use of restraints or involuntary seclusion?
4. FIN 1: Is the client financially eligible for the services received?
5. CP 2: If the client is receiving respite services in an AFH or ALF, does that facility have the specialty designation required to meet the needs of the client?
6. CP 3: Did the client/representative agree to the care plan as outlined in the LTC Manual?
7. CP 4: Were mandatory referrals made? (DMHP, APS, CPS, and CRU)
8. CP 6: Was level of care re-determined within the annual time frame?
9. CP 7: Was a significant change assessment performed and service plan updated when appropriate?
10. CP 8: Were the correct instruments and processes used to determine participant level of care?
11. AUTH 1: Was assessment moved to current prior to re-authorization?
12. AUTH 3: Is there documentation to support paid service authorizations?
13. AUTH 4: Were claims paid using the correct rate?
14. AUTH 5: Were waiver service claims paid to a qualified provider (non-IPs)?
15. DOC 1: Is the 14-225 - Acknowledgement of Services completed correctly and in the file?
16. DOC 2: Is the 16-172 Rights and Responsibility completed correctly and in the file?
17. DOC 3: Was the 14-443 Fin/Social Services Communication for MTD completed correctly and in the file?
18. DOC 4: Was the 15-492 Medicaid Transformation Demonstration Services Notice completed correctly and in the file?
19. DOC 8: Did the client receive information about the importance of the flu vaccine at the time of all face-to-face assessments?