Midpoint Assessment of Washington's Section 1115 SMI/SED Amendment

ASSESSMENT REPORT

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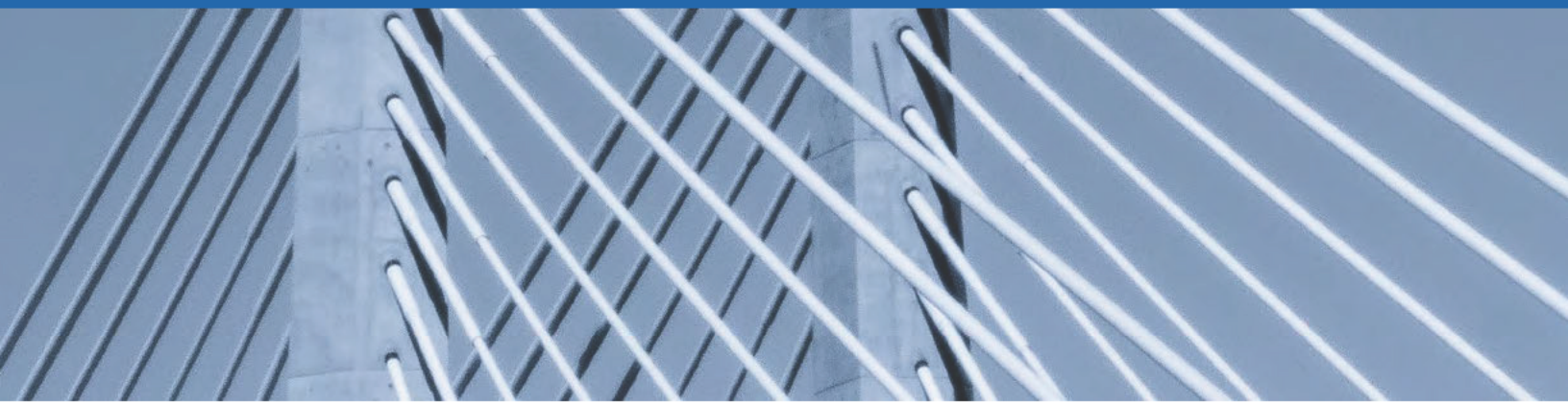
CENTER FOR HEALTH SYSTEMS EFFECTIVENESS



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Executive Summary

Overview

In November 2020, Washington obtained an amendment to its Section 1115 waiver allowing the state to receive federal financial participation for services provided to Medicaid recipients receiving short-term residential treatment for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) at an Institution for Mental Diseases (IMD). Federal funding under the amendment ("SMI waiver") is contingent on the state's progress toward a set of milestones and metrics for care delivery. The Center for Medicare & Medicaid Services (CMS) also requires Washington to conduct an independent midpoint assessment ("MPA") to examine progress in these areas, identify factors and risks affecting their achievement, and provide recommendations for state actions to support improvement.

Washington's Health Care Authority contracted with the Center for Health Systems Effectiveness at Oregon Health & Science University to complete the MPA, and this report presents its findings, assessing changes between baseline (2020) and midpoint (2021) years. These findings can help guide Washington's efforts and show how these waivers may affect individuals with SMI and SED in other states.

Summary of Findings

The state has completed the actions outlined in the Implementation Plan Protocol for implementing the SMI waiver's four milestones. A variety of measures of access, continuity of care, and early identification for SMI, assessed using administrative data, showed mixed results. For example, a measure of Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (the single Milestone 1 metric) decreased by one percentage point between 2020 and 2021, and there was no progress in the majority of metrics for Milestone 2 (Improving Care Coordination and Transitioning to Community-Based Care). However, the average length of stay for individuals in IMDs — the key metric for Milestone 3 — remained well below 30 days and decreased slightly. Most metrics for Milestone 4 (Earlier Identification and Engagement in Treatment, Including Through Increased Integration) showed improvement. Furthermore, while evidence of progress was not universal across all metrics, most changes were relatively small, and the MPA is limited in the time frame of its analysis, measuring differences between 2020 and 2021.

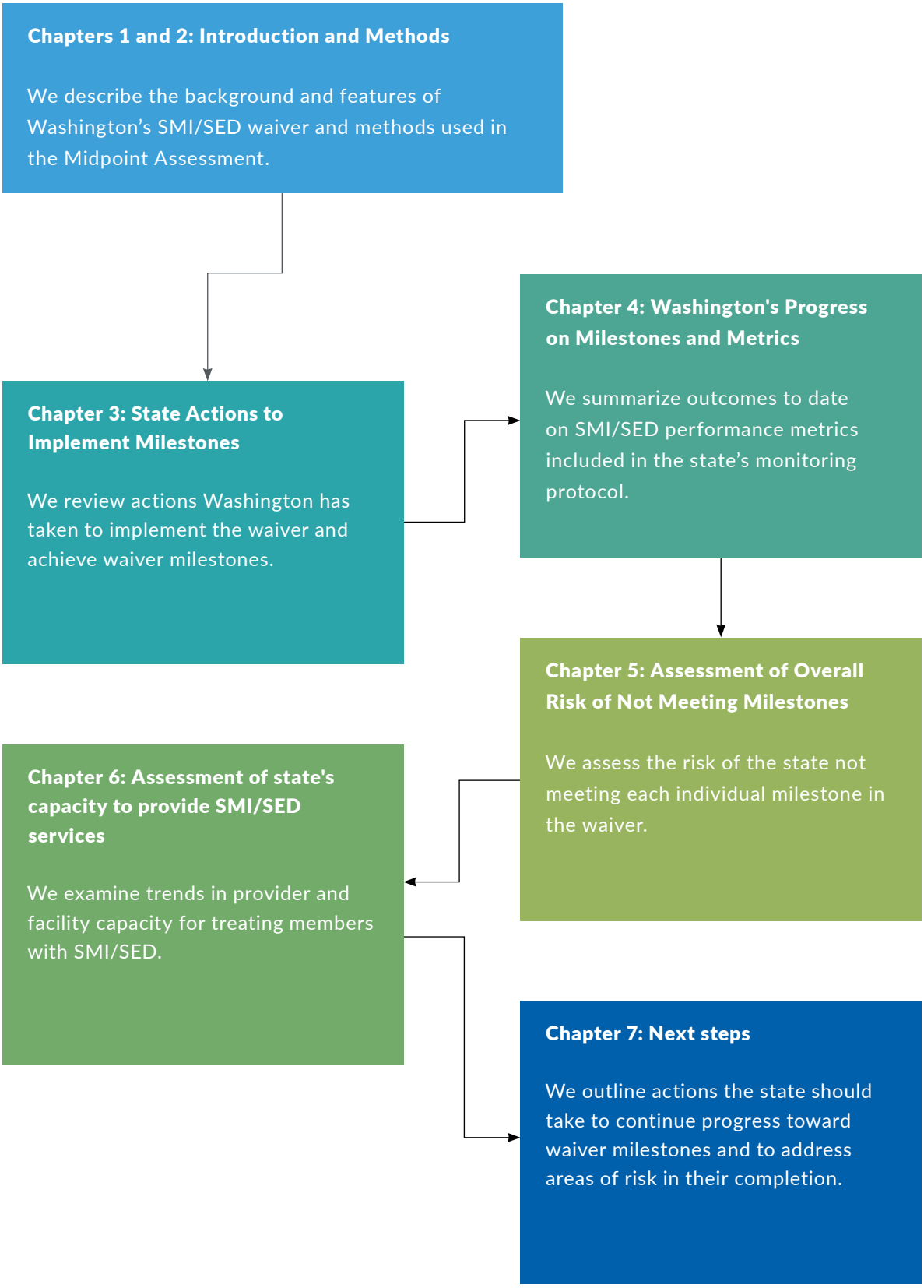
Following CMS guidelines, risk was assessed at multiple levels: implementation action items; metrics; provider availability assessments; and overall, which combined implementation actions and metrics for each milestone. We assessed action items for all milestones as "Low Risk," metrics for Milestones 1 and 2 as "High Risk," and metrics for Milestones 3 and 4 as "Low Risk." Combining these assessments, our overall assessment was "Medium Risk" for Milestones 1 and 2 and "Low Risk" for Milestones 3 and 4. In addition to the actions and metrics for the four milestones, we assessed changes in provider capacity. Generally, there was relative stability across most measures, although there appeared to be small increases in capacity among providers and small decreases in capacity among facilities. We assessed provider availability at "Medium Risk."

Recommendations

Based on data and findings from the MPA, we believe the following actions may improve the potential for the state to meet its goals:

- **Ensure that progress is made in using first-line psychosocial care for children and adolescents on antipsychotics.** Although a one percent drop in usage between the baseline and midpoint year may reflect changes associated with the COVID-19 Public Health Emergency, Washington will need to prioritize this measure in subsequent years to make progress on Milestone 1.
- **Ensure that progress is made on measures related to Milestone 2 (improving care coordination and transitioning to community-based care).** The state did not demonstrate progress among most measures within this milestone. However, many measures showed relatively small changes; given the context of the short time of observation, these measures may improve in subsequent years. The state made advances and met all of its actions for Milestone 2. Many of these actions (e.g., ensuring psychiatric hospitals and residential settings carry out intensive pre-discharge planning and include community-based providers in care transitions), if successful, should aid in moving Milestone 2 metrics in the intended direction.
- **Continue to monitor length of stay in IMDs.** The average length of stay for individuals in IMDs was 12 days, well below the 30-day requirement. However, this is a key metric; if the state exceeds the 30-day average length of stay, CMS will lower the threshold for reimbursement to 45 days until the average drops below 30 days.
- **Monitor the availability of institutional capacity and consider adjustments if necessary.** The IMD waiver is predicated on the notion that federal financial participation would expand residential treatment options. Although the state's capacity to provide SMI/SED services remained relatively stable between the baseline and midpoint assessment years, there were slight declines in measures of institutional capacity and residential treatment, even as the capacity of mental health practitioners showed slight increases. Continuation of this trend may necessitate a reassessment of how to expand residential and inpatient treatment in alignment with the SMI waiver.

Roadmap to the Report



Introduction

Overview

On November 6, 2020, Washington obtained approval for an amendment to its Section 1115 waiver ("Washington State Medicaid Transformation Project No. 11-W-00304") designed to help maintain and expand access for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED), with a particular focus on residential and inpatient treatment. The waiver permits the use of federal matching funds for short-term residential treatment services in an "Institution for Mental Disease" (IMD) for these populations for up to 60 days, on the condition that the average length of stay in IMDs is 30 days or less.[1,2] The implementation date was set at December 23, 2020, with the SMI waiver initially approved through June 30, 2023, and extended through June 30, 2028. The waiver applies to (a) individuals who are currently eligible under the state's Medicaid State Plan and (b) individuals eligible for Tailored Supports for Older Adults (TSOA) who are not otherwise eligible for Categorically Needy Program (CNP) or Alternative Benefits Plan (ABP) Medicaid, age 55 or older meet functional eligibility criteria for Home and Community-Based Services (HCBS) under the state plan or 1915(c), and have income up to 300% of the supplemental security benefit rate established by section 1611(b)(1) of the Act.

Treatment in residential or inpatient settings may be necessary for individuals experiencing a psychiatric emergency. These settings offer opportunities for safety, stabilization, and the possibility of starting or adjusting medication, while also facilitating the coordination of interdisciplinary clinical teams and informal support networks.[3,4] Nationally, the lack of inpatient bed availability has been linked to increased emergency department (ED) visits for mental health conditions.[5] Many individuals are "boarded" in the emergency department, with some reports suggesting that patients with acute psychiatric conditions may remain in the ED for 3 to 5 days or even longer.[6] This practice of boarding has created significant challenges for hospitals, leading to concerns about patient safety and negative outcomes. The lack of inpatient bed availability has been associated with homelessness[7,8] and increased incarceration of persons with SMI.[9-11]

Despite the apparent need for more residential services, support for care in these settings has been limited in the Medicaid program. Since 1965, federal law has prohibited the use of federal Medicaid matching funds for services provided to Medicaid enrollees ages 21 through 64 in facilities with the IMD designation, defined as facilities with more than 16 beds that specialize in mental health or substance use disorder treatment. This rule significantly limited the scope of inpatient psychiatry treatment available to Medicaid enrollees.

The IMD exclusion for enrollees with SMI has been the source of considerable debate. Those who support the repeal of the exclusion point out that it is inconsistent with the 2008 federal Mental Health Parity and Addiction Equity Act (MHPAEA).[9] They argue that Medicaid enrollees require access to the full spectrum of mental health care, including inpatient treatment,[12,13] and that IMDs offer a better alternative to emergency department boarding.[6,14,15] Conversely, proponents of the exclusion contend that the primary issue is the dearth of community-based services and that revoking the IMD rule would undermine those services in favor of inpatient care.[16] Thus, the IMD waiver includes requirements that states enhance their support of community-based services.

In 2018, the Centers for Medicare & Medicaid Services (CMS) provided states the option to pursue Section 1115 demonstration waivers that removed the IMD exclusion. The waivers allow for federal matching funds for short-term residential treatment services in an IMD for adults with SMI and children with SED for up to 60 days, on the condition that the average length of stay in IMDs is 30 days or less. (If the statewide average length of stay exceeds 30 days, the maximum length of stay receiving federal matching funds is reduced to 45 days. If subsequent annual monitoring reports demonstrate that the statewide average length of stay is 30 days or less, the state may resume claiming payments for short-term stays of up to 60 days.) These “SMI waivers” were similar to waivers that removed the IMD exclusion for substance use disorders (“SUD waivers”), including the SUD waiver approved for Washington in 2018.

Approval of Washington’s SMI waiver provides expenditure authority for all Medicaid state plan services, including a continuum of services to treat SMI and SED. Federal funding under the waiver is contingent on the state's progress toward a set of milestones for care delivery. Progress will be evaluated based on an implementation plan (SMI Implementation Plan Protocol) and a set of performance targets (SMI Monitoring Protocol) agreed upon between the state and CMS. In addition, CMS required Washington to conduct an independent midpoint assessment ("MPA") of the SMI waiver to examine progress on milestones and performance targets, including factors affecting their achievement and the risk of not meeting them. Washington's Health Care Authority (HCA) contracted with the Center for Health Systems Effectiveness (CHSE) at Oregon Health & Science University (OHSU) to complete the MPA. This report presents its findings.

Washington's Dynamic Behavioral Health System

Washington's SMI waiver is just one part of a large set of changes that affect the state's behavioral health system. These include:

- **Washington's transition to "Integrated Managed Care,"** or IMC, initiated in 2016, with all MCOs and counties financially integrating behavioral and physical health care by January 2020.
- **Washington's Section 1115 Waiver,** the Medicaid Transformation Plan (MTP), effective January 2017. Under MTP, Washington state created nine regional Accountable Communities of Health (ACHs) to convene local stakeholders, identify collaboration opportunities, and coordinate regional health transformation efforts. The ACH regions largely mirrored the former Behavioral Health Organization (BHO) regions and had strong ties to the successors of the BHOs, Washington’s behavioral health administrative service organizations (BH-ASOs), which were established to coordinate crisis mental health services in their regions. ACHs were charged with carrying out a variety of Health Improvement Projects, including some that had the potential to directly or indirectly affect individuals with mental health conditions, including Project 2A (Bi-Directional Integration of Physical and Behavioral Health Care); Project 2B (Community-Based Care Coordination); Project 2C (Transitional Care); and Project 2D (Diversion Interventions).
- **Organizational changes among state agencies responsible for the administration and management of behavioral health benefits.** On July 1, 2018, Washington's Department of Social and Health Services' (DSHS) Division of Behavioral Health and Rehabilitation (DBHR), the agency overseeing behavioral health rule-making and provider licensing, was dissolved. Responsibility for licensing and certification of behavioral health providers was transferred to the Department of Health (DOH), while staffing and behavioral health rule-making responsibilities were transferred to HCA and DOH, placing DBHR, which includes the State Mental Health Authority and State Substance-Abuse Authority, with the Medicaid Single State Agency. These changes were intended to facilitate delivery system integration and reduce administrative costs.

- **The initiation of Washington's SUD waiver**, which went into effect on July 17, 2018. The SUD waiver's expenditure authority covers SUD treatment services provided under Washington's Medicaid state plan to individuals in an IMD, including outpatient services, intensive outpatient services, residential treatment, medically supervised withdrawal management, and medications for opioid use disorder (MOUD).
- **The COVID-19 Public Health Emergency (PHE)**, which disrupted health care broadly, and may have shifted the delivery of some mental health services from a preponderance of in-person visits to greater use of telehealth.[17]
- **The introduction of the 988 hotline**, designated by the Federal Communications Commission (FCC) on July 16, 2022, to serve as the national three-digit dialing code for the National Suicide and Crisis Lifeline. The hotline was expected to increase the use of crisis services across states, with operators counseling callers and potentially dispatching mobile crisis services.
- **House Bill 1477**, establishing centralized mental health crisis resources and allocating approximately $500M to improve behavioral health services.
- **House Bill 5444**, in 2014 Federal litigation, often referred to as "Trueblood" after the initial plaintiffs' advocate's name, challenged unconstitutional delays in competency evaluation and restoration services for incarcerated individuals awaiting trial. As a result, the state entered a settlement agreement which included requirements to provide competency evaluations within 14 days and competency restoration services within seven days of court orders. E2SSB 5444 codified the state's responses. Additionally the many millions of dollars in fines levied against the state were ultimately ordered to be used to fund programs that keep class members out of jail; creating a Trueblood Diversion Workgroup, and funding multiple projects statewide intended to divert persons with mental illness from unnecessary incarceration to timely treatment interventions.

Box 1.1: The IMD Exclusion

An IMD is defined as "a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." (Social Security Act §1905(i)) IMDs are generally licensed or accredited facilities that specialize in providing psychiatric, psychological, or SUD treatment services.

Since 1965, the IMD exclusion prohibited state Medicaid programs from obtaining federal matching funds to pay for IMD services. The policy was intended to support a shift from institutionalized care to community-based treatment for mental illness while establishing states as the primary payer for inpatient mental health services. The exclusion applies to services provided to Medicaid beneficiaries between the ages of 21 and 64 but does not preclude states from receiving federal Medicaid funding for services provided in facilities that do not meet the definition of an IMD, such as facilities with 16 or fewer beds. In 2016, CMS amended the rules for Medicaid managed care such that states' capitation payments to managed care entities for enrollees admitted to an IMD qualified for full federal matching as long as the IMD length of stay did not exceed 15 days in a calendar month.

The option to pursue IMD waivers for SUD services was announced in 2015. More than 30 states have adopted these waivers. The option to pursue IMD waivers for SMI and SED was announced in 2018. One important difference in these waivers is that SUD waivers have an expectation that average length of stay is less than 30 days, whereas this constraint is more binding for SMI waivers. Specifically, if the average length of stay for individuals with SMI or SED exceeds 30 days, the maximum length of stay permissible for federal matching funds decreases from 60 days to 45 days until the state can subsequently show that its statewide average length of stay has dropped to 30 days or less. Approximately ten states have adopted SMI/SED waivers, and at least six have applications pending.[18]

The SMI Amendment

Washington's SMI amendment ("SMI waiver") went into effect on December 23, 2020. The waiver's expenditure authority covers SMI and SED treatment services provided under Washington's Medicaid state plan to individuals in an IMD, including outpatient services, intensive outpatient services, residential treatment, and crisis services. The state is required to achieve a statewide average length of stay of 30 days or less for SMI treatment in residential settings, subject to monitoring through a set of performance measures. Washington must also comply with budget neutrality requirements.

Milestones

To obtain federal funding under the SMI/SED waiver, Washington agreed to demonstrate progress on a set of four milestones and two additional topics identified by CMS:

1. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Improving Care Coordination and Transitioning to Community-Based Care
3. Increasing Access to Continuum of Care, Including Crisis Stabilization Services
4. Earlier Identification and Engagement in Treatment, Including Through Increased Integration
5. Financing Plan
6. Health IT Plan

Exhibit 1.1 below describes the milestones in further detail. The state outlined its strategic approach and implementation plan for achieving these milestones in the SMI Implementation Plan Protocol.

Exhibit 1.1: SMI Waiver Milestones

1

Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings

1a. Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid.

1b. Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements.

1c. Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay.

1d. Compliance with program integrity requirements and state compliance assurance process.

1e. State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions.

1f. Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.

2

Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care

2a. Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning and include community-based providers in care transitions.

2b. Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.

2c. State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through the most effective means possible, e.g., email, text, or phone call within 72 hours post-discharge.

2d. Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission.

2e. Other state requirements/policies to improve care coordination and connections to community-based care.

3

Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services

3a. Conducting annual assessments of the availability of mental health providers, including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and Federally Qualified Health Centers (FQHCs) offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports.

3b. Strategies to improve state tracking of the availability of inpatient and crisis stabilization beds.

3c. State requirement that providers use a widely recognized, publicly available patient assessment tool to determine the appropriate level of care and length of stay.

3d. Other state requirements/policies to improve access to a full continuum of care.

Exhibit 1.1: SMI Waiver Milestones

4

Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration

4a. Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported employment and supported programs.

4b. Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SMI/SED and linkages to treatment.

4c. Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SMI/SED.

4d. Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people.

5

Milestone 5: Financing Plan

5a. Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, and observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.

5b. Increase availability of ongoing community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.

6

Milestone 6: Health IT Plan

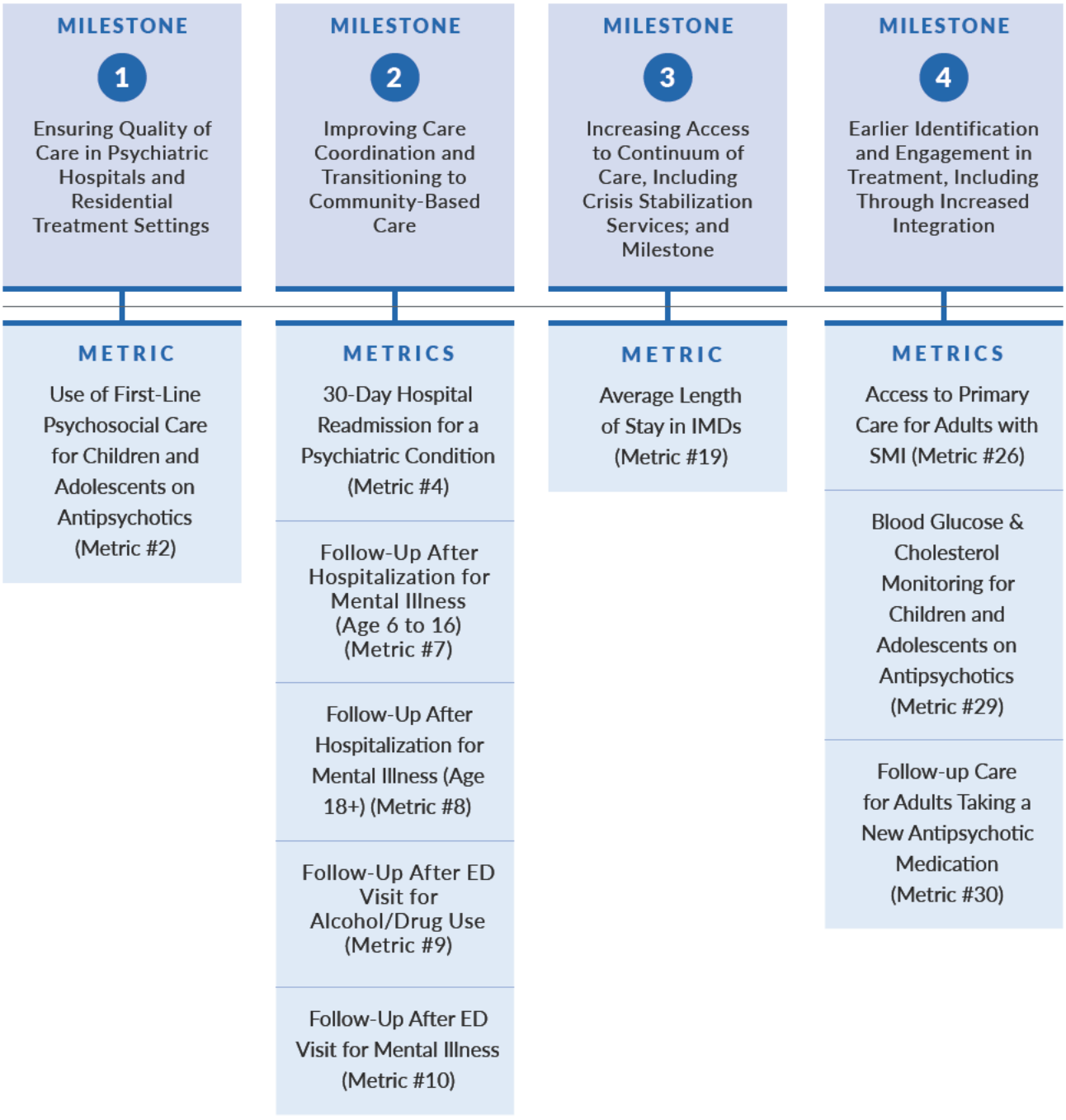
6a. The state must confirm sufficient health IT infrastructure/ecosystem at every appropriate level (i.e., state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration.

6b. The state must confirm the SMI/SED Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan.

6c. The state must confirm it intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)2 and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts.

Required Monitoring Metrics

CMS selected 10 critical metrics across the four demonstration milestones. This report assesses progress on these metrics between the demonstration baseline (calendar year 2020) and midpoint (calendar year 2021).



Midpoint Assessment

HCA agreed to provide CMS with an independent midpoint assessment of the SMI component of its 1115(a) waiver. The assessment is required to include the following components:

- An examination of state progress toward meeting each milestone, including whether the state progressed according to the timeframe approved in the demonstration implementation plan, and demonstrated progress toward closing the gap between baseline and target each year in monitoring metrics, as outlined in the state's approved monitoring protocol.
- A determination of factors that affected state achievement towards meeting milestones and monitoring metric targets to date, identification of factors likely to affect future performance in meeting milestones and targets not yet met, and discussion about the risk of possibly missing those milestones and metrics targets.
- An assessment of whether the state is on track to meet its budget neutrality requirements, including recommendations for adjustments in the state's implementation plan or to factors that the state can influence that will support improvement, if necessary.
- If applicable, modifications to the state's implementation plan, financing plan, and monitoring protocols for addressing milestones and metrics targets at medium to high risk of not being achieved.
- A description of methodologies used, with justifications, for examining progress and assessing risk, the limitations of the methodologies, and the independent assessor's determinations and any recommendations for the state.

Structure of This Report

Chapter 2 includes information about how the assessment was designed and conducted.

Chapter 3 of this report provides an assessment of actions Washington has taken to implement the SMI waiver, including a description of the steps the state needed to take to achieve each milestone required by CMS.

Chapter 4 provides information on the state's progress, including changes in ten monitoring metrics and six service utilization rates.

Chapter 5 provides an assessment of the state's overall risk of not meeting milestones.

Chapter 6 provides an assessment of the state's capacity to provide SMI/SED services.

Chapter 7 provides recommendations and next steps.

Methodology

The methodologies used in this report are based on guidance from CMS's "Medicaid Section 1115 Substance Use Disorder (SUD) and Serious Mental Illness and Serious Emotional Disturbance (SMI/SED) Demonstrations: Mid-point Assessment Technical Assistance; Version 1.0 (October 2021)."

Data sources

The midpoint assessment incorporates data from a variety of sources, detailed in Exhibit 2.1.

Exhibit 2.1

Data type	Data source
Critical metrics	Medicaid claims provided by HCA as part of their Integrated Client Database (ICDB).
Implementation plan action items	Data and discussions with state administrators and review of the Washington Administrative Code (WAC).
Provider availability assessments	Provider availability data provided by HCA.

Analytic methods

Metric Selection and Data sources

We analyzed 10 critical metrics and six additional service utilization measures. We used a combination of metrics calculated by the State of Washington as well as metrics calculated from raw claims, including Medicaid enrollment records that included information about each person's demographics and Medicaid claims and encounter records that identify diagnoses and services each person received. We defined the "baseline year" as January 1, 2020 through December 31, 2020, and the "midpoint year" as January 1, 2021 through December 31, 2021.

We generated estimates for each of the measures (10 monitoring metrics and six additional service utilization rates) for the population of individuals with SMI and SED.

Calculating changes in monitoring metrics

Following guidance from CMS's Technical Assistance for Midpoint Assessments, we provide the following information for each of metric:

- Metric number
- Metric name
- Value at baseline, defined as the period spanning January 1, 2020 through December 31, 2020
- Value at midpoint, defined as the period spanning January 1, 2021 through December 31, 2021
- Absolute change, defined as: *the value of metric at midpoint - value of metric at baseline*
- Percent change, defined as: *(value of metric at midpoint - value of metric at baseline)/value of metric at baseline*
- State's demonstration target (decrease or increase)
- Directionality at midpoint (decrease or increase)
- Progress (yes/no)
- Milestone risk assessment (low, medium, high)

Provider availability assessment data

We used data from the state, generating 45 measures to assess provider capacity in 12 domains in the baseline year, midpoint year, and change over time. We also used these data to describe the landscape of behavioral health care services available at the demonstration midpoint and indicated whether the needs of beneficiaries in the state were being met.

Assessment of overall risk of not meeting milestones

Exhibit 2.2 describes considerations used to assess the risk of not achieving each milestone. Risk was assessed at three levels (critical metrics, implementation plan action items, provider availability assessment, and overall). Risk was categorized as "low," "medium," or "high" separately at each of these levels. Progression towards the waiver's goals for most indicators implied low risk, whereas mixed progression or broad lack of progression implied medium and high risk, respectively. Overall risk for milestones was based on an assessment of critical metrics and implementation action items.

Exhibit 2.2: Considerations for assessing the risk of not achieving each demonstration milestone

Data source	Considerations	Overall risk of not meeting milestone		
		Low	Medium	High
Critical metrics	For each metric associated with the milestone, is the state moving in the direction of the state's annual goal and overall demonstration target?	All or nearly all (e.g., more than 75 percent) of the critical metrics trending in the expected direction.	Some (e.g., 25-75 percent) of the critical metrics and other monitoring metrics trending in the expected direction.	Few (e.g., less than 25 percent) of the critical metrics and other monitoring metrics trending in the expected direction.
Implementation plan action items	Has the state completed each action item associated with the milestone as scheduled to date?	All or nearly all (e.g., more than 75 percent) of the action items completed.	Some (e.g., 25-75 percent) of the action items completed.	Few (e.g., less than 25 percent) of the action items completed.
Provider availability assessment data	Is the state moving in the expected direction as outlined in the demonstration goals and milestones and as described in the state's implementation plan for availability assessment data?	All or nearly all (e.g., more than 75 percent) of the availability assessment data indicate expected progression.	Some (e.g., 25-75 percent) of the availability assessment data indicate expected progression.	For SMI/SED: Few (e.g., less than 25 percent) of the availability assessment data indicate expected progression.

Limitations

The assessment has important limitations. We measure changes within a single year (2020 to 2021); although the state implemented many actions to drive improvements, it may take more than one year to observe changes in services and utilization data. Furthermore, the SMI/SED waiver represents one piece of larger statewide and national efforts to address mental health services, even as mental health needs appear to have worsened during the COVID-19 PHE. We cannot attribute the changes in this study to the SMI/SED waiver alone. Disentangling the effects of the COVID-19 PHE during the 2020-2021 time period is particularly challenging. Future reports evaluating MTP will provide additional information on the changes occurring in subsequent years.

CHAPTER 3

State Actions to Implement Milestones

Overview

As part of CMS's approval of the SMI waiver, Washington State submitted an Implementation Plan outlining its approach to meeting waiver milestones. For each milestone, the implementation plan described the "current status" of SMI service delivery in Washington, the "future status" consistent with the state's strategic approach, a "summary of actions needed" to reach the future state, and a projected timeline for completing these actions. The sections below describe actions taken for each of the four milestones and their status as of July 2023. The state met all its implementation milestones by the date of the waiver's initiation or shortly thereafter.

The state is continuing its efforts to integrate behavioral health care in non-specialty settings. The Integrated Managed Care effort began in 2016 and moved all managed care plans to provide comprehensive and physical health by 2020. The state is now implementing the Washington

KEY FINDINGS

- *The state has revised MCO contracts and made assurances that participating hospitals and residential settings have appropriate licensing, oversight, utilization review processes, program integrity requirements, screening protocols, and other policies to ensure the quality of care in these settings (Milestone 1).*
- *Multiple actions have been taken to improve care coordination and transitions to community-based care, including amending contracts and the Washington Administrative Code (WAC), ensuring coordination between hospitals and residential settings and housing service providers and community-based providers, and implementing strategies to decrease the length of stays in emergency departments (EDs) among beneficiaries with SMI or SED (Milestone 2).*
- *The state conducted an annual provider availability assessment, with additional details provided in Chapter 6. The state has introduced a requirement that providers use a widely recognized, publicly available patient assessment tool to determine the appropriate level of care and length of stay and have begun to retool WA HEALTH (Washington's Healthcare and Emergency and Logistics Tracking Hub) to function as a bed registry (Milestone 3).*
- *In the area of earlier identification and engagement in treatment (Milestone 4), the state has implemented strategies for early identification and engagement of beneficiaries with or at risk of SMI or SED, has established specialized settings and services for young people experiencing SED or SMI, and has expanded the New Journeys (an early intervention program for first episode psychosis) statewide.*

Integrated Care Assessment tool, with anticipated iterative improvements to the assessment tool and data collection process, with a goal of using this tool and these data for targeted technical assistance. Overall, the state has met all of its implementation milestones.

Findings on Milestone Implementation

Milestone 1: Ensuring quality of care in psychiatric hospitals and residential settings

Milestone 1 includes six actions, detailed in Exhibit 3.1 below.

Exhibit 3.1: Milestone 1 Actions

Milestone actions	Status
1a. Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid.	Met upon implementation.
1b. Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements.	Met upon implementation.
1c. Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay.	Met upon implementation.
1d. Compliance with program integrity requirements and state compliance assurance process.	Met upon implementation.
1e. State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions.	Met upon implementation.
1f. Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	Met upon implementation.

At the time of its application for the SMI/SED amendment, Washington had 11 facilities designated as IMDs for SMI/SED care. These 11 IMDs were licensed by the state and accredited by the Joint Commission to provide treatment for mental illness.

Psychiatric hospitals and free-standing evaluation and treatment facilities are licensed by the Washington State Department of Health, which provides oversight by annual and unannounced site visits. Additional oversight is provided through Joint Commission auditing and certification processes. Before the SMI/SED waiver application, the state had implemented a utilization review process for managed care and fee-for-service contracted entities. To ensure compliance with program integrity requirements and assurance processes, all facilities must be enrolled as a Medicaid provider with the HCA, which maintains a process for conducting risk-based screening of all newly enrolled providers and revalidating existing providers. The Washington Administrative Code requires residential treatment facilities to screen all residents for co-morbid physical health conditions, SUDs, and suicidal ideation upon admission and treat the condition on-site or refer the individual to treatment.

Since these activities were already in place with the approval of the SMI waiver amendment application, no further implementation actions were required per the implementation plan.

Milestone 2: Improving care coordination and transitions to community-based care

Milestone 2 includes four actions, detailed in Exhibit 3.2 below.

Exhibit 3.2: Milestone 2 Actions

Milestone actions	Status
2a. Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.	MCO Contracts have been amended by Jan/2022; planning requirements covered by WAC 246-341-1105.
2b. Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	Revised Code of Washington (RCW) 71.12.730 was revised in 2022 and states that a psychiatric hospital shall make every effort to: (1) Inform the Medicaid managed care organization in which the person is enrolled of the person's discharge or change in care plan on the following timelines ((a) For an anticipated discharge, no later than 24 hours prior to the known discharge date; or (b) For all other discharges, including if the person leaves against medical advice, no later than the date of discharge or departure from the facility) and (2) Engage with Medicaid managed care organizations in discharge planning, which includes informing and connecting patients to care management resources at the appropriate managed care organization.
2c. State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through the most effective means possible, e.g., email, text, or phone call within 72 hours post-discharge.	Met upon implementation.
2d. Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission.	Met upon implementation.

Upon implementation, the state had already launched several initiatives to improve care coordination under fee-for-service and managed care contracts. The state updated contract agreements to require managed care organizations to be actively involved in discharge planning with inpatient facilities. These planning requirements included post-discharge follow-up calls within two days of discharge from an inpatient facility and follow-up appointments within seven days of discharge. Washington's performance in these areas was above the national average.

Additional statewide strategies to address housing for members leaving psychiatric hospitals and residential settings were supported by the Washington Administrative Code and consisted of the following five initiatives:

1. Coordinated entry programs to assist homeless or at-risk individuals in obtaining housing.
2. Institutional discharge planning toolkit that involves guidance and a housing assessment for individuals who are being discharged from institutions.
3. Focus on supportive housing and employment services as part of Initiative 3 of the state's 1115 demonstration waiver.
4. State-funded alternative behavioral housing, serving as a bridge between intensive behavioral health treatment facilities and independent living in supported housing.
5. The Housing and Recovery through Peer Services (HARPS) program, which aimed to reduce homelessness and support the recovery and resiliency of individuals with serious mental illness.

In addition to these initiatives, the state committed to reducing unnecessary emergency department visits and the overall length of stay for individuals presenting with a behavioral health issue through several strategies, including:

1. The Peer Bridges program, which delivers services to individuals in state and community hospitals prior to discharge and after their return to their communities.
2. Crisis triage and stabilization investments from the legislature.
3. Peer respite centers, funded by the legislature, intended to divert individuals from crisis services.

To improve care coordination and create a seamless transition from inpatient stays to community-based care, HCA planned to amend its contract and WAC language to require pre-discharge planning and participation of community providers no later than January 2022. As of the midpoint assessment, HCA had completed the MCO contract amendments, but the WAC language still needed revision. The state had plans to submit an emergency rule amendment with this language by June 2023.

Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services

Milestone 3 includes four actions, detailed in Exhibit 3.3 below.

Exhibit 3.3: Milestone 3 Actions

Milestone actions	Status
3a. The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports.	First Annual assessment CY2020 submitted on Sep 1, 2022. CY2021 Submitted on 3/1/23. Additional details are provided in Chapter 6.
3b. Financing plan.	The 2021-2023 legislative session ended with a total of 74 investments related to behavioral health, providing nearly $2B in spending for mental health initiatives, including $25M to establish a task force and five hospital pilot programs specifically to address challenges faced with discharging patients from acute care and post-acute care capacity and $23.8 million for long-term inpatient beds at the University of Washington.
3c. Strategies to improve state tracking of availability of inpatient and crisis stabilization beds.	Shift of funds from Health Care Authority to Department of Health (DOH); DOH to retool WA HEALTH (Washington's Healthcare and Emergency and Logistics Tracking Hub) to function as a bed registry.
3d. State requirement that providers use a widely recognized, publicly available patient assessment tool to determine the appropriate level of care and length of stay.	Met upon implementation.

Washington conducted its first annual assessment of the availability of mental health providers in 2020 and submitted that assessment in September 2022. The subsequent assessment was conducted for 2021 and submitted in March of 2023. These assessments compiled data from the Washington Medical Commission Washington's Research and Data Analysis (RDA), Department of Health (DOH), Health Care Authority (HCA), and managed care organizations and behavioral health administrative services organizations.

To improve state tracking of the availability of inpatient and crisis stabilization beds, Washington has planned to build a statewide bed registry to include all psychiatric treatment beds and secure withdrawal management beds. Currently, a web-based system called WATrac, managed by the Washington Department of Health, facilitates emergency response in King County for bed tracking. The state has applied for grants and is seeking funding from the legislature to expand this registry.

The Washington Administrative Code, coupled with managed care contract requirements at the time of implementation, required providers to use an evidence-based approach for screening and interventions, which includes an age-appropriate, strengths-based psychosocial assessment. No additional action items were needed to meet this milestone.

Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration

Milestone 4 includes four actions, detailed in Exhibit 3.4 below.

Exhibit 3.4: Milestone 4 Actions

Milestone actions	Status
4a. Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported employment and supported programs.	Met upon implementation.
4b. Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment.	The implementation of the WA-ICA (Washington Integrated Care Assessment tool) will occur across Washington State through 2024, during which time iterative improvements will be made to the assessment tool and data collection process, and opportunities for technical assistance related to general health integration will be made available.
4c. Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI.	Met upon implementation.
4d. Other state strategies to increase earlier identification/ engagement, integration, and specialized programs for young people.	New Journeys has expanded to statewide; currently pursuing centralized access point for New Journeys.

Improving care for individuals with SMI or SED includes interventions aimed at identifying serious mental health conditions earlier and focused efforts to engage individuals with these conditions in treatment sooner. The state's efforts — ongoing since implementation — include funding and training in trauma-informed care, supported employment (Initiative 3 of the 1115 waiver), and the Becoming Employed Starts Today (BEST) project. The state also planned to leverage and evaluate the effectiveness of the Community Health Aides Program (CHAP) to facilitate the integration of behavioral health care in non-specialty settings. This program is a collaboration between the state and tribes to support behavioral health aides, who can expand the capacity for tribal behavioral health services and enable more integration of behavioral health care in non-specialty settings. The state continues to evaluate the effectiveness of CHAP in addressing behavioral health, including the effective use of culturally appropriate providers, Community Health Aids (CHAs), Behavioral Health Aides (BHAs), and Dental Health Aide Therapists (DHATs).

In early 2021, the state and partners developed the Washington Integrated Care Assessment (WA-ICA) tool, which is available to primary care and behavioral health practices serving the Medicaid population. This tool helps providers track, measure, and advance their clinical integration progress across a set of domains: screening, referral to care and follow-up; ongoing care management; self-management support; systematic quality improvement; and linkages to community and social services. The state has established nine unique programs to address the care provided in specialized settings and services aimed at crisis stabilization for young people experiencing SMI/SED.

These programs existed at the time of this amendment implementation and are ongoing. They include:

1. **Wrap-around intensive services (WISe).** WISe provides 24/7 crisis stabilization services and comprehensive behavioral health care to Medicaid-eligible youth up to 21 years of age with complex behavioral health needs. WISe is designed to help keep youth with intense mental health needs safe in their homes and communities. It is community-based, providing services at times and locations that work best for the youth and family.

2. **Peer Bridges program.** This program delivers services to individuals in state and community hospitals before discharge and after returning to their communities.

3. **State Plan Services.** These services include a rehabilitation case management service that allows liaisons from the community to participate in discharge planning for individuals receiving psychiatric inpatient care.

4. **Crisis Triage and Stabilization Investments.** Between 2017 and 2019, Washington funded several new triage and crisis stabilization facilities across the state, supporting 102 crisis stabilization and triage beds across six regions of the state.

5. **Investments in peer respite centers and step-down facilities.** At the time of implementation, the Washington legislature funded five mental health peer respite centers and a new community facility type to address the need for additional discharge placements for individuals leaving the state psychiatric hospitals.

6. **Housing and Recovery through Peer Services (HARPS) program.** The HARPS project reduces homelessness and supports the recovery and resiliency of individuals with serious mental illness. One of the priority target populations for the program is individuals discharged from inpatient psychiatric care. The legislature has also funded four HARPS teams focusing on individuals discharged from forensic facilities.

7. **Program for Assertive Community Treatment (PACT).** PACT teams provide wrap-around services for individuals in outpatient treatment and coordinate care when an individual leaves an inpatient setting to ensure stable housing and follow-up care. The legislature provided funding to add eight teams to the fourteen in operation at the onset of this waiver.

8. **Additional investments to support increased bed capacity.** Washington State's Department of Commerce provided $7.1 million in grants to six health care providers across the state, adding 71 beds to facilities that help people with a wide variety of behavioral health issues. Twenty-eight new beds are dedicated as an alternative to treatment in state psychiatric hospitals. These grants are part of the governor's five-year plan to modernize and transform the state's mental health care system, shifting care away from large institutions to smaller, community-based facilities.

9. **MCO contract requirements for MCOs to incorporate the specific needs of diverse populations in utilization management decisions.** These requirements include considerations of health disparities, risk factors, historical trauma, and the need for culturally appropriate care.

No additional action items were needed at the time of implementation to meet this milestone.

CHAPTER 4

Washington's Progress on Milestones and Metrics

Overview

In this chapter, we review Washington's performance in meeting each SMI/SED Implementation Plan Protocol milestone and targets for SMI/SED metrics in the SMI/SED Monitoring Protocol. Using data provided by the state for 2020 and 2021, we quantitatively assessed changes associated with the SMI/SED waiver amendment for each metric. We used calendar year 2020 as a baseline and calendar year 2021 as the midpoint, measuring changes over one year.

KEY FINDINGS

- *There was a lack of quantifiable progress in Milestones 1 (Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings) and 2 (Improving Care Coordination and Transitioning to Community-Based Care). However, Milestone 1 included only one metric, which demonstrated a relatively small decline (one percentage point).*
- *Milestone 2 included nine metrics. Among those nine, the state only demonstrated progress on two metrics. However, metrics that did not move in the desired direction were relatively stable, exhibiting small changes (typically less than 2%). The one exception was 7-Day Follow-Up After Hospitalization for Mental Illness among Enrollees Aged 6 to 17, which decreased by 4.6%.*
- *Despite the lack of progress in Milestones 1 and 2, the state demonstrated progress in Milestones 3 (Increasing Access to Continuum of Care, Including Crisis Stabilization Services), with average lengths of stay in IMDs well below 30 days and decreasing slightly.*
- *The state also demonstrated progress in Milestone 4 (Earlier Identification and Engagement in Treatment, Including Through Increased Integration), improving in 4 out of 5 metrics.*

How to read these findings

We present overall progress on metrics for each of the four milestones, with overall statewide progress for each milestone followed by progress for selected subgroups, including age subgroups (<16, 16-24, and 25-64); subgroups of individuals with multiple chronic conditions or living in rural areas or high poverty areas; and racial and ethnic groups. Metrics are prefaced by metric numbers in brackets that are referenced in the CMS's Technical Specifications Manual (e.g., [2] Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics).

For overall statewide progress, we followed CMS guidelines, indicating whether progress (increase, decrease, consistent) was aligned with the state's approved monitoring protocol. Progress was considered any movement toward the state's overall demonstration target. If the state's target was to remain consistent with the baseline value, then no movement on the metric would be considered progress. Then, within each milestone, we assessed risk, following CMS guidelines that risk assessment would apply to each milestone but not each metric. The milestone risk assessment was categorized as low (e.g., 75% or more of metrics moving in the direction expected), medium (e.g., 25-75%), or high (e.g., 25% or less) based on all of the metrics under each milestone. We note that this approach may create instances when small changes (e.g., 0.1%) that go against the intended direction for multiple measures may result in the classification of "High Risk," even if these changes reflect relative stability over a one-year period.

For subgroup analyses, we color code changes so that progress is shaded as blue and a lack of progress is shaded as orange. In some instances, the subgroup populations were too small (N<11) or the measure did not apply (for example, a measure for pediatric populations that would not apply to enrollees ages 25-64). In these cases, we code values as "NA" (not applicable).

Progress toward demonstration milestones

Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

Milestone 1 includes one monitoring metric, Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH). This measure showed a slight decline (absolute change 1.0%) between the baseline (calendar year 2020) and midpoint (calendar year 2021) measurement periods. Since this is the only metric in Milestone 1, CMS guidelines place this in the "High Risk" category (since none of the metrics moved in the intended direction.) However, this risk assessment should be placed in proper context because a one percent decrease is a relatively small change; given that this measurement reflects only one year of activity, additional observations may be necessary for a more robust assessment of the state's progress.

Exhibit 4.1: Milestone 1 Metrics

Metric	Baseline	Midpoint	Absolute Change	Percent Change	Target	Direction	Progress
[2] Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics	64.8%	63.8%	-1.0%	-1.5%	↑	↓	N
Milestone Risk Assessment: High							

Exhibits 4.1.a, 4.1.b, 4.1.c, and 4.1.d display changes among selected subgroups. Use of first-line psychosocial care increased among the older group (16-24) while decreasing among enrollees ages 16-17. Declines were also seen among individuals with multiple chronic conditions and those living in rural areas, while high-poverty areas experienced improvements. This measure also improved slightly among Hispanic and considerably among American Indian and Alaska Native enrollees while declining among Black and white enrollees.

Exhibit 4.1.a: Milestone 1 Metrics for Age Subgroups

	<16		16-24		25-64	
Metric	Baseline	Midpoint	Baseline	Midpoint	Baseline	Midpoint
[2] Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics	65.0%	63.4%	63.8%	65.7%	NA	NA

Exhibit 4.1.b: Milestone 1 Metrics for Chronic Condition, Rural, and High Poverty Area Subgroups

	Chronic Condition(s)		Rural		High Poverty	
Metric	Baseline	Midpoint	Baseline	Midpoint	Baseline	Midpoint
[2] Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics	68.9%	67.0%	65.3%	64.1%	66.5%	68.6%

Exhibit 4.1.c: Milestone 1 Metrics for Subgroups of American Indian and Alaska Native, Asian, and Black Enrollees

	AI/AN		Asian		Black	
Metric	Baseline	Midpoint	Baseline	Midpoint	Baseline	Midpoint
[2] Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics	50.9%	64.3%	NA	NA	67.1%	64.5%

Exhibit 4.1.d: Milestone 1 Metrics for Subgroups of Hawaiian & Pacific Islander, Hispanic, and White Enrollees

	Hawaiian/Pacific Islander		Hispanic		White	
Metric	Baseline	Midpoint	Baseline	Midpoint	Baseline	Midpoint
[2] Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics	NA	61.1%	61.8%	62.8%	67.5%	65.1%

Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care

Milestone 2 includes nine monitoring metrics. Most measures remained relatively unchanged between the baseline (calendar year 2020) and midpoint (calendar year 2021). A measure of 30-day readmissions for a psychiatric condition decreased by 1.2% (an improvement). However, multiple measures of follow-up after hospitalizations for mental illness or alcohol or drug abuse showed a lack of progress, either decreasing or not improving. Based on CMS guidelines, we assess Milestone 2 as "High Risk."

Exhibit 4.2: Milestone 2 Metrics

Metric	Baseline	Midpoint	Absolute Change	Percent Change	Target	Direction	Progress
[4] 30-Day Hospital Readmission for a Psychiatric Condition	17.2%	16.0%	-1.2%	-7.0%	↓	↓	Y
[7] 30-Day Follow-Up After Hospitalization for Mental Illness (Age 6 to 17)	83.2%	83.5%	+0.3%	+0.4%	↑	↑	Y
[7] 7-Day Follow-Up After Hospitalization for Mental Illness (Age 6 to 17)	67.8%	63.2%	-4.6%	-6.8%	↑	↓	N
[8] 30-Day Follow-Up After Hospitalization for Mental Illness (Age 18+)	65.5%	64.1%	-1.4%	-2.1%	↑	↓	N
[8] 7-Day Follow-Up After Hospitalization for Mental Illness (Age 18+)	48.3%	45.4%	-2.9%	-6.0%	↑	↓	N
[9] 30-Day Follow-Up After ED Visit for Alcohol/Drug Use	32.0%	31.3%	-0.7%	-2.2%	↑	↓	N
[9] 7-Day Follow-Up After ED Visit for Alcohol/Drug Use	22.4%	22.2%	-0.2%	-0.9%	↑	↓	N
[10] 30-Day Follow-Up After ED Visit for Mental Illness	67.1%	67.1%	0%	0%	↑	-	-
[10] 7-Day Follow-Up After ED Visit for Mental Illness	55.5%	55.1%	-0.4%	-0.7%	↑	↓	N

Milestone Risk Assessment: High

Exhibit 4.2.a shows changes across age groups. Trends were generally consistent across age groups, with a few exceptions. For example, 30-day follow-up after hospitalization for mental illness for individuals 6-17 improved among the youngest group (<16) while worsening slightly for individuals aged 16-17.

Exhibit 4.2.a: Milestone 2 Metrics for Age Subgroups

	<16		16-24		25-64	
Metric	Baseline	Midpoint	Baseline	Midpoint	Baseline	Midpoint
[4] 30-Day Hospital Readmission for a Psychiatric Condition	12.9%	11.8%	16.0%	15.1%	18.5%	17.3%
[7] 30-Day Follow-Up After Hospitalization for Mental Illness (Age 6 to 17)	84.8%	86.0%	80.1%	77.9%	NA	NA
[7] 7-Day Follow-Up After Hospitalization for Mental Illness (Age 6 to 17)	69.4%	64.8%	64.9%	59.6%	NA	NA
[8] 30-Day Follow-Up After Hospitalization for Mental Illness (Age 18+)	NA	NA	69.5%	69.4%	64.5%	62.8%
[8] 7-Day Follow-Up After Hospitalization for Mental Illness (Age 18+)	NA	NA	51.7%	50.6%	47.4%	44.1%
[9] 30-Day Follow-Up After ED Visit for Alcohol/Drug Use	17.2%	21.4%	23.0%	21.5%	34.0%	33.1%
[9] 7-Day Follow-Up After ED Visit for Alcohol/Drug Use	11.9%	13.0%	15.5%	14.8%	23.8%	23.5%
[10] 30-Day Follow-Up After ED Visit for Mental Illness	80.4%	78.7%	67.7%	67.5%	63.4%	63.8%
[10] 7-Day Follow-Up After ED Visit for Mental Illness	67.4%	66.9%	55.9%	56.1%	52.4%	51.5%

Exhibit 4.2.b shows changes among individuals with multiple chronic conditions, enrollees living in rural areas, and enrollees living in high-poverty areas. Individuals with multiple chronic conditions experienced small improvements in 30-day hospital readmissions for psychiatric conditions, 30-day follow-up after hospitalization for mental illness (age 6 to 17), and 30-day follow-up after ED visit for mental illness. Many of the remaining measures were relatively unchanged for individuals with chronic conditions. In contrast, six out of nine measures did not show progress for individuals in rural areas, and eight did not for individuals in high-poverty areas

Exhibit 4.2.b: Milestone 2 Metrics for Chronic Condition, Rural, and High Poverty Area Subgroups

	Chronic Condition(s)		Rural		High Poverty	
Metric	Baseline	Midpoint	Baseline	Midpoint	Baseline	Midpoint
[4] 30-Day Hospital Readmission for a Psychiatric Condition	18.8%	17.5%	15.9%	14.4%	17.6%	15.8%
[7] 30-Day Follow-Up After Hospitalization for Mental Illness (Age 6 to 17)	83.6%	84.6%	80.8%	84.9%	83.6%	83.5%
[7] 7-Day Follow-Up After Hospitalization for Mental Illness (Age 6 to 17)	68.4%	65.2%	64.2%	66.0%	67.8%	61.9%
[8] 30-Day Follow-Up After Hospitalization for Mental Illness (Age 18+)	66.6%	65.6%	68.0%	67.6%	66.7%	63.5%
[8] 7-Day Follow-Up After Hospitalization for Mental Illness (Age 18+)	49.1%	46.4%	51.9%	48.7%	49.3%	46.0%
[9] 30-Day Follow-Up After ED Visit for Alcohol/Drug Use	33.5%	33.0%	34.6%	31.3%	32.5%	31.1%
[9] 7-Day Follow-Up After ED Visit for Alcohol/Drug Use	23.1%	23.0%	24.8%	21.0%	22.9%	22.1%
[10] 30-Day Follow-Up After ED Visit for Mental Illness	68.5%	69.0%	74.2%	70.5%	68.9%	65.4%
[10] 7-Day Follow-Up After ED Visit for Mental Illness	56.4%	56.4%	63.5%	59.5%	57.3%	52.6%

Exhibits 4.2.c and 4.2.d show differences across racial and ethnic groups. Trends worsened most among Asian enrollees (with eight of nine measures not showing progress), American Indian and Alaska Native enrollees (with six of nine measures not showing progress), and Hispanic enrollees (with seven of nine measures not showing progress). While we observed improvements for the majority of these metrics among Black enrollees, it should be noted that outcomes for this group continue to lag behind statewide averages.

Exhibit 4.2.c: Milestone 2 Metrics for Subgroups of American Indian and Alaska Native, Asian, and Black Enrollees

	AI/AN		Asian		Black	
Metric	Baseline	Midpoint	Baseline	Midpoint	Baseline	Midpoint
[4] 30-Day Hospital Readmission for a Psychiatric Condition	17.0%	15.1%	17.5%	19.6%	20.2%	19.1%
[7] 30-Day Follow-Up After Hospitalization for Mental Illness (Age 6 to 17)	75.4%	77.0%	93.8%	91.7%	78.2%	76.6%
[7] 7-Day Follow-Up After Hospitalization for Mental Illness (Age 6 to 17)	56.1%	64.0%	87.5%	70.8%	63.2%	62.0%
[8] 30-Day Follow-Up After Hospitalization for Mental Illness (Age 18+)	60.0%	56.4%	73.6%	72.2%	63.1%	61.5%
[8] 7-Day Follow-Up After Hospitalization for Mental Illness (Age 18+)	40.0%	37.6%	53.6%	49.8%	45.4%	43.2%
[9] 30-Day Follow-Up After ED Visit for Alcohol/Drug Use	28.1%	26.6%	21.2%	23.5%	19.9%	20.0%
[9] 7-Day Follow-Up After ED Visit for Alcohol/Drug Use	19.2%	16.7%	15.9%	14.3%	12.7%	14.7%
[10] 30-Day Follow-Up After ED Visit for Mental Illness	61.9%	55.7%	71.7%	69.6%	59.6%	62.0%
[10] 7-Day Follow-Up After ED Visit for Mental Illness	49.7%	45.5%	63.0%	53.3%	49.4%	51.6%

Exhibit 4.2.d: Milestone 2 Metrics for Subgroups of Hawaiian & Pacific Islander, Hispanic, and White Enrollees

	Hawaiian/Pacific Islander		Hispanic		White	
Metric	Baseline	Midpoint	Baseline	Midpoint	Baseline	Midpoint
[4] 30-Day Hospital Readmission for a Psychiatric Condition	18.8%	14.5%	13.5%	15.0%	17.4%	15.6%
[7] 30-Day Follow-Up After Hospitalization for Mental Illness (Age 6 to 17)	84.6%	73.5%	84.4%	83.6%	84.5%	85.6%
[7] 7-Day Follow-Up After Hospitalization for Mental Illness (Age 6 to 17)	73.1%	47.1%	70.8%	59.9%	68.2%	66.2%
[8] 30-Day Follow-Up After Hospitalization for Mental Illness (Age 18+)	62.1%	64.9%	59.9%	58.6%	67.5%	66.4%
[8] 7-Day Follow-Up After Hospitalization for Mental Illness (Age 18+)	46.3%	46.9%	43.8%	41.0%	50.4%	47.4%
[9] 30-Day Follow-Up After ED Visit for Alcohol/Drug Use	23.3%	24.2%	27.0%	29.4%	36.5%	34.8%
[9] 7-Day Follow-Up After ED Visit for Alcohol/Drug Use	14.9%	14.5%	18.5%	19.9%	25.9%	25.3%
[10] 30-Day Follow-Up After ED Visit for Mental Illness	62.1%	58.9%	68.2%	67.1%	68.7%	69.4%
[10] 7-Day Follow-Up After ED Visit for Mental Illness	49.7%	48.1%	56.7%	54.9%	56.8%	57.2%

Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services

Milestone 3 includes one monitoring metric, Average Length of Stay (ALOS) in Institutions of Mental Diseases (IMDs). We assess this measure overall and stratified by long-term stays (greater than or equal to 65 days) and short-term stays (less than 65 days). These measures remained relatively stable, with the overall length of stay decreasing slightly (-0.2 days). Although the average long-term length of stay increased slightly (+2.2 days), the proportion of individuals in long-term stays decreased slightly, decreasing the overall average. Based on CMS guidelines, we assess Milestone 3 as "Low Risk."

Exhibit 4.3: Milestone 3 Metrics

Metric	Baseline	Midpoint	Absolute Change	Percent Change	Target	Direction	Progress
[19a] Average Length of Stay in IMDs: Long-Term	106.7	108.9	+2.2	+2.1%	-	↑	-
[19a] Average Length of Stay in IMDs: Short-Term	10.2	10.1	-0.1	-1.0%	-	↓	-
[19a] Average Length of Stay in IMDs: Overall	12.2	12	-0.2	-1.6%	≤ 30 days	↓	Y

Milestone Risk Assessment: Low

Exhibit 4.3.a displays the length of stay across age groups. The overall length of stay decreased for individuals under 16, stayed constant for individuals ages 16-24, and increased slightly among individuals ages 24 to 64. The overall length of stay decreased slightly among individuals with chronic conditions, with marginally larger decreases among individuals in high-poverty and rural areas (Exhibit 4.3.b). Trends in overall length of stay were different across racial and ethnic groups, with length of stay increasing among American Indian and Alaska Native, Asian, and Black enrollees and decreasing among Hawaiian and Pacific Islander, Hispanic, and white enrollees (Exhibits 4.3.c and 4.3.d).

Exhibit 4.3.a: Milestone 3 Metrics for Age Subgroups

	<16		16-24		25-64	
Metric	Baseline	Midpoint	Baseline	Midpoint	Baseline	Midpoint
[19a] Average Length of Stay in IMDs: Long-Term	NA	NA	99.1	120.5	108.5	107.7
[19a] Average Length of Stay in IMDs: Short-Term	10.9	9.6	9.5	9.6	10.4	10.3
[19a] Average Length of Stay in IMDs: Overall	12.5	10.1	11.2	11.2	12.4	12.5

Exhibit 4.3.b: Milestone 3 Metrics for Chronic Condition, Rural, and High Poverty Area Subgroups

	Chronic Condition(s)		Rural		High Poverty	
Metric	Baseline	Midpoint	Baseline	Midpoint	Baseline	Midpoint
[19a] Average Length of Stay in IMDs: Long-Term	107.9	108.5	NA	108.7	109.0	102.7
[19a] Average Length of Stay in IMDs: Short-Term	10.5	10.2	10.5	9.1	10.5	10.2
[19a] Average Length of Stay in IMDs: Overall	12.6	12.0	12.0	10.7	12.7	11.5

Exhibit 4.3.c: Milestone 3 Metrics for Subgroups of American Indian and Alaska Native, Asian, and Black Enrollees

	AI/AN		Asian		Black	
Metric	Baseline	Midpoint	Baseline	Midpoint	Baseline	Midpoint
[19a] Average Length of Stay in IMDs: Long-Term	NA	114.3	NA	NA	96.5	91.2
[19a] Average Length of Stay in IMDs: Short-Term	9.9	11.4	11.4	12.3	11.0	11.5
[19a] Average Length of Stay in IMDs: Overall	12.1	14.6	13.5	15.2	12.7	13.2

Exhibit 4.3.d: Milestone 3 Metrics for Subgroups of Hawaiian & Pacific Islander, Hispanic, and White Enrollees

	Hawaiian/Pacific Islander		Hispanic		White	
Metric	Baseline	Midpoint	Baseline	Midpoint	Baseline	Midpoint
[19a] Average Length of Stay in IMDs: Long-Term	NA	NA	122.9	97.9	104.5	114.8
[19a] Average Length of Stay in IMDs: Short-Term	10.0	10.5	10.4	10.2	10.0	9.5
[19a] Average Length of Stay in IMDs: Overall	14.3	11.8	12.6	11.4	12.0	11.4

Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration

Milestone 4 includes five monitoring metrics, although Metric 29 is subdivided into metabolic monitoring for blood glucose, metabolic monitoring for cholesterol, and metabolic monitoring for blood glucose and cholesterol. This measure improved between the baseline (calendar year 2020) and midpoint (calendar year 2021) measurement periods, with the largest improvement in monitoring for blood glucose (5.1% absolute change). Access to primary care for adults with SMI also improved. However, follow-up care for adults taking a new antipsychotic medication decreased by 3.0%. Based on CMS guidelines, we assess Milestone 4 as "Low Risk."

Exhibit 4.4: Milestone 4 Metrics

Metric	Baseline	Midpoint	Absolute Change	Percent Change	Target	Direction	Progress
[26] Access to Primary Care for Adults with SMI	94.9%	95.3%	+0.4%	+0.4%	↑	↑	Y
[29] Blood Glucose Monitoring for Children & Adolescents on Antipsychotics	46.2%	51.3%	+5.1%	+11.0%	↑	↑	Y
[29] Cholesterol Monitoring for Children & Adolescents on Antipsychotics	26.4%	28.7%	+2.3%	+8.7%	↑	↑	Y
[29] Blood Glucose & Cholesterol Monitoring for Children & Adolescents on Antipsychotics	25.1%	27.0%	+1.9%	+7.6%	↑	↑	Y
[30] Follow-Up Care for Adults Taking a New Antipsychotic Medication	69.7%	66.7%	-3.0%	-4.3%	↑	↓	N

Milestone Risk Assessment: Low

Exhibits 4.4.a-4.4.d display performance on quality measures for selected subgroups. Enrollees under 16 who were on antipsychotics saw improvements in blood glucose and cholesterol monitoring, but results were mixed among enrollees ages 16-17. There were also relative improvements in these measures for enrollees with chronic conditions and enrollees in rural areas. Follow-up care for adults taking a new antipsychotic medication worsened among all racial and ethnic groups except Asian enrollees, with the largest decrease — 7.0% - occurring among Hawaiian and Pacific Islander enrollees.

Exhibit 4.4.a: Milestone 4 Metrics for Age Subgroups

	<16		16-24		25-64	
Metric	Baseline	Midpoint	Baseline	Midpoint	Baseline	Midpoin
[26] Access to Primary Care for Adults with SMI	NA	NA	94.2%	94.8%	95.0%	95.4%
[29] Blood Glucose Monitoring for Children & Adolescents on Antipsychotics	44.5%	49.9%	55.8%	58.5%	NA	NA
[29] Cholesterol Monitoring for Children & Adolescents on Antipsychotics	26.5%	29.5%	25.8%	24.5%	NA	NA
[29] Blood Glucose & Cholesterol Monitoring for Children & Adolescents on Antipsychotics	25.1%	27.6%	25.4%	23.8%	NA	NA
[30] Follow-Up Care for Adults Taking a New Antipsychotic Medication	NA	NA	68.9%	67.8%	69.9%	66.5%

Exhibit 4.4.b: Milestone 4 Metrics for Chronic Condition, Rural, and High Poverty Area Subgroups

	Chronic Condition(s)		Rural		High Poverty	
Metric	Baseline	Midpoint	Baseline	Midpoint	Baseline	Midpoint
[26] Access to Primary Care for Adults with SMI	97.3%	97.5%	95.6%	95.7%	94.4%	94.7%
[29] Blood Glucose Monitoring for Children & Adolescents on Antipsychotics	54.6%	60.7%	49.8%	57.1%	46.2%	51.7%
[29] Cholesterol Monitoring for Children & Adolescents on Antipsychotics	30.8%	33.3%	24.2%	28.2%	28.5%	28.4%
[29] Blood Glucose & Cholesterol Monitoring for Children & Adolescents on Antipsychotics	29.5%	31.2%	23.2%	27.4%	27.4%	26.2%
[30] Follow-Up Care for Adults Taking a New Antipsychotic Medication	71.7%	68.8%	71.1%	67.9%	71.3%	67.4%

Exhibit 4.4.c: Milestone 4 Metrics for Subgroups of American Indian and Alaska Native, Asian, and Black Enrollees

	AI/AN		Asian		Black	
Metric	Baseline	Midpoint	Baseline	Midpoint	Baseline	Midpoint
[26] Access to Primary Care for Adults with SMI	94.7%	94.9%	95.3%	96.2%	91.9%	92.7%
[29] Blood Glucose Monitoring for Children & Adolescents on Antipsychotics	48.7%	56.4%	45.7%	56.8%	42.2%	50.5%
[29] Cholesterol Monitoring for Children & Adolescents on Antipsychotics	23.3%	28.5%	NA	34.1%	22.3%	28.2%
[29] Blood Glucose & Cholesterol Monitoring for Children & Adolescents on Antipsychotics	22.3%	27.4%	NA	34.1%	20.9%	25.2%
[30] Follow-Up Care for Adults Taking a New Antipsychotic Medication	68.5%	64.6%	67.0%	72.0%	65.1%	64.6%

Exhibit 4.4.d: Milestone 4 Metrics for Subgroups of Hawaiian & Pacific Islander, Hispanic, and White Enrollees

	Hawaiian/Pacific Islander		Hispanic		White	
Metric	Baseline	Midpoint	Baseline	Midpoint	Baseline	Midpoint
[26] Access to Primary Care for Adults with SMI	93.2%	93.7%	95.4%	95.7%	95.2%	95.5%
[29] Blood Glucose Monitoring for Children & Adolescents on Antipsychotics	50.0%	52.8%	47.6%	53.3%	46.0%	50.2%
[29] Cholesterol Monitoring for Children & Adolescents on Antipsychotics	39.3%	NA	26.1%	28.9%	26.9%	29.1%
[29] Blood Glucose & Cholesterol Monitoring for Children & Adolescents on Antipsychotics	NA	NA	25.2%	27.7%	25.4%	27.3%
[30] Follow-Up Care for Adults Taking a New Antipsychotic Medication	68.8%	61.8%	70.4%	67.0%	70.5%	67.1%

Service utilization rates

In addition to the critical metrics, we also show changes in key utilization metrics between the baseline (calendar year 2020) and midpoint (calendar year 2021). Utilization metrics are reported as the proportion of member-months when a described service was accessed at least once. Note that all enrollment months for members with an SMI/SED diagnosis in the measurement year or the 12 months prior to the measurement year have been included in the denominator for this metric, which differs from the approach used by the state in their quarterly reporting.

These rates were relatively stable, with a slight decrease in outpatient use. Telehealth, which increased with the pandemic, continued to increase into the midpoint year, continued to increase into the midpoint year, partially offsetting some of the decreases in outpatient mental health use (the outpatient mental health services utilization measure includes in-person visits and excludes telehealth).

Exhibit 4.5: Service Utilization Rates

Metric	Baseline	Midpoint	Absolute Change	Percent Change	Target	Direction	Progress
[13] Mental Health Services Utilization - Inpatient	0.5%	0.5%	0%	0%	-	-	-
[14] Mental Health Services Utilization - Intensive Outpatient & Partial Hospitalization	1.1%	0.8%	-0.3%	-27.3%	↑	↓	N
[15] Mental Health Services Utilization - Outpatient	15.8%	14.0%	-1.8%	-11.4%	↑	↓	N
[16] Mental Health Services Utilization - Emergency Department	1.0%	0.7%	-0.3%	-30.0%	↓	↓	Y
[17] Mental Health Services Utilization - Telehealth	6.1%	6.8%	+0.7%	+11.5%	↑	↑	Y
[18] Mental Health Services Utilization - Any Services	18.6%	18.0%	-0.6%	-3.2%	↑	↓	N

Exhibits 4.5.a-4.5.d show changes in utilization across different subgroups. All of them experienced declines in outpatient mental health services utilization, with some of these declines offset by increases in telehealth. The uptake of telemental health by American Indian and Alaska Native enrollees offset the reductions in in-person outpatient mental health visits. In contrast, uptake by younger populations (<16), Hispanic enrollees, and rural enrollees was relatively small.

Exhibit 4.5.a: Service Utilization Rates for Selected Age Subgroups

	<16		16-24		25-64	
Metric	Baseline	Midpoint	Baseline	Midpoint	Baseline	Midpoint
[13] Mental Health Services Utilization - Inpatient	0.1%	0.1%	0.5%	0.5%	1.6%	1.6%
[14] Mental Health Services Utilization - Intensive Outpatient & Partial Hospitalization	1.0%	0.7%	0.9%	0.6%	1.7%	1.3%
[15] Mental Health Services Utilization - Outpatient	13.3%	11.7%	13.0%	11.5%	25.4%	22.7%
[16] Mental Health Services Utilization - Emergency Department	1.0%	0.7%	0.8%	0.5%	1.0%	0.7%
[17] Mental Health Services Utilization - Telehealth	6.2%	6.5%	5.2%	6.4%	6.7%	7.9%
[18] Mental Health Services Utilization - Any Services	16.7%	15.9%	15.9%	15.7%	25.7%	25.0%

Exhibit 4.5.b: Service Utilization Rates for Chronic Condition, Rural, and High Poverty Area Subgroups

	Chronic Condition(s)		Rural		High Poverty	
Metric	Baseline	Midpoint	Baseline	Midpoint	Baseline	Midpoint
[13] Mental Health Services Utilization - Inpatient	0.8%	0.9%	0.3%	0.3%	0.5%	0.5%
[14] Mental Health Services Utilization - Intensive Outpatient & Partial Hospitalization	1.2%	0.9%	1.9%	1.3%	1.8%	1.5%
[15] Mental Health Services Utilization - Outpatient	18.0%	16.2%	15.2%	14.0%	16.6%	15.1%
[16] Mental Health Services Utilization - Emergency Department	0.9%	0.7%	1.8%	1.2%	1.6%	1.3%
[17] Mental Health Services Utilization - Telehealth	6.5%	7.3%	4.5%	4.7%	4.9%	5.2%
[18] Mental Health Services Utilization - Any Services	20.4%	19.9%	17.5%	16.6%	18.7%	17.9%

Exhibit 4.5.c: Service Utilization Rates for Subgroups of American Indian and Alaska Native, Asian, and Black Enrollees

	AI/AN		Asian		Black	
Metric	Baseline	Midpoint	Baseline	Midpoint	Baseline	Midpoint
[13] Mental Health Services Utilization - Inpatient	0.6%	0.6%	0.5%	0.6%	0.9%	0.9%
[14] Mental Health Services Utilization - Intensive Outpatient & Partial Hospitalization	0.9%	0.7%	0.9%	0.4%	0.8%	0.7%
[15] Mental Health Services Utilization - Outpatient	15.2%	14.3%	15.9%	13.3%	16.4%	14.6%
[16] Mental Health Services Utilization - Emergency Department	0.8%	0.5%	0.6%	0.3%	0.6%	0.4%
[17] Mental Health Services Utilization - Telehealth	6.6%	7.7%	6.3%	7.3%	5.9%	6.6%
[18] Mental Health Services Utilization - Any Services	18.3%	18.7%	18.8%	18.0%	18.8%	18.2%

Exhibit 4.5.d: Service Utilization Rates for Subgroups of Hawaiian & Pacific Islander, Hispanic, and White Enrollees

	Hawaiian/Pacific Islander		Hispanic		White	
Metric	Baseline	Midpoint	Baseline	Midpoint	Baseline	Midpoint
[13] Mental Health Services Utilization - Inpatient	0.6%	0.5%	0.3%	0.3%	0.6%	0.6%
[14] Mental Health Services Utilization - Intensive Outpatient & Partial Hospitalization	0.8%	0.5%	1.4%	1.0%	1.1%	0.8%
[15] Mental Health Services Utilization - Outpatient	13.1%	11.3%	12.1%	10.7%	17.8%	15.8%
[16] Mental Health Services Utilization - Emergency Department	0.6%	0.4%	1.3%	0.9%	0.9%	0.6%
[17] Mental Health Services Utilization - Telehealth	5.3%	6.2%	4.8%	5.2%	6.7%	7.5%
[18] Mental Health Services Utilization - Any Services	16.0%	15.4%	14.9%	14.3%	20.4%	19.8%

Budget Neutrality

Washington is subject to a limit on the amount of federal Title XIX funding it may receive under the SMI waiver. "Budget neutrality," a stipulation of the SMI waiver, requires that Washington's spending on services provided to beneficiaries with SMI in IMDs not exceed hypothetical expenditures projected to have been incurred in the absence of the SMI waiver ("without waiver" expenditures). To assess budget neutrality, we reviewed Washington's Budget Neutrality Workbooks as reported to CMS.

Exhibit 4.5, Panel 1 summarizes Washington's budget neutrality status as of July 2023, reproducing data reported to CMS as part of the state's Budget Neutrality Workbook. Panel 1 shows "without waiver" spending for demonstration years (DY) 4 (December 2020) through 7 (January 2023 – June 2023) based on the PMPM expenditure limits. Years 4-6 represent actual spending; Year 7 is a combination of actual spending and projected spending. For each MEG, total spending "without waiver" is simply the PMPM amount multiplied by the number of member months. Washington's total SMI IMD spending under the waiver is not to exceed $27.428.340.

Exhibit 4.6, Panel 2 shows the state's actual expenditures under the SMI waiver for DY4 through DY 7 under the waiver. Expenditures reported for DY4 and DY5 were substantially lower under the waiver than without the waiver, while expenditures in DY6 and DY7 were slightly higher under the waiver than without the waiver. Cumulatively, Washington expects its total expenditures under the SMI waiver to be $26,949,006, $479,335 below the spending cap of $27.428.340.

Exhibit 4.6, Panel 1

MEG	Demonstration Years (DY)					Total
		4 (Actual)	5 (Actual)	6 (Actual)	7 (Projected + Actual)	
Medicaid Disabled	Total	$101,349	$3,771,931	$3,525,462	$ 1,762,731	
	PMPM	$1,138.75	$1,192.14	$1,267.24	$1,267.24	
	Mem-Mon	89	3,164	2,782	1,391	
Medicaid Non-Disabled	Total	$15,226	$691,882	$698,902	$349,451	
	PMPM	$262.51	$275.98	$295.02	$295.02	
	Mem-Mon	58	2,507	2,369	1,185	
Newly Eligible	Total	$124,238	$4,351,967	$3,624,629	$1,812,315	
	PMPM	$470.60	$491.97	$521.98	$521.98	
	Mem-Mon	264	8,846	6,944	3,472	
American Indian/Alaska Native	Total	$70,042	$2,903,727	$2,416,326	$1,208,163	
	PMPM	$14,008.47	$14,665.29	$15,589.20	$15,589.20	
	Mem-Mon	5	198	155	78	
Without Waiver Total		**$310,855**	**$11,719,507**	**$10,265,319**	**$5,132,660**	**$27,428,341**

Exhibit 4.6, Panel 2

	Demonstration Years (DY)				Total
	4 (Actual)	5 (Actual)	6 (Actual)	7 (Projected + Actual)	
Medicaid Disabled	($3,366)	$4,274,545	$5,563,791	$1,952,626	
Medicaid Non-Disabled	$873	$708,904	$1,086,382	$367,891	
Newly Eligible	$14,779	$3,781,691	$5,526,386	$1,943,173	
American Indian/ Alaska Native	$6,463	$118,380	$398,325	$1,208,163	
With Waiver Total	**$18,749**	**$8,883,520**	**$12,574,884**	**$5,471,853**	**$26,949,006**
Variance (Without Waiver – With Waiver)	**$292,106**	**$2,835,987**	**$(2,309,565)**	**$(339,193)**	**$479,335**

Summary

Based on CMS guidelines, we assessed Milestones 1 and 2 as "High Risk" and Milestones 3 and 4 as "Low Risk." Despite the "High Risk" assessments, overall, changes in metrics between the baseline (calendar year 2020) and midpoint (calendar year 2021) measurement periods were relatively small, with some measures moving slightly against the intended direction. The average length of stay for individuals in IMDs — a key metric — remained well below 30 days and decreased slightly. Several measures improved slightly, including psychiatric readmissions and metabolic monitoring for children and adolescents on antipsychotics.

Within each milestone or metric, some groups fared better than others. For example, while there was a lack of progress in most metrics for Milestone 2, the lack of progress was more pronounced among Asian enrollees (with eight of nine measures not showing progress), among American Indian and Alaska Native enrollees (with six of nine measures not showing progress), and among Hispanic enrollees (with seven of nine measures not showing progress). However, these trends were not consistent across all milestones. We did not observe any subgroups that consistently experienced a lack of progress across most or all metrics.

Although our assessment of changes in metrics showed relative stability, they reflect changes over a one-year time horizon, which may be too short for meaningful changes. Furthermore, the measurement periods include the first two years of the COVID-19 PHE, a period of extreme disruption. Additional analyses that incorporate data from 2022 may provide a clearer picture of the implications of the SMI IMD waiver.

Assessment of Overall Risk of Not Meeting Milestones

Overview

This chapter provides an overall assessment of risk, combing actions by the state with performance on metrics between 2020 and 2021.

Exhibit 5.1 provides a determination of the risk level for each milestone and recommended modifications. As noted above, Milestones 1 and 2 metrics were assessed at "High Risk," while Milestones 3 and 4 were assessed at "Low Risk." However, the overall changes in metrics for Milestones 1 and 2 were relatively small. Furthermore, the state has met all of its actions in all Milestones. Thus, we classify the overall risks for Milestones 1 and 2 as "Medium Risk" and Milestones 3 and 4 as "Low Risk." We provide recommendations and the State's response and planned modifications as needed.

Exhibit 5.1 Summary of midpoint assessment of overall risk of not achieving demonstration milestones

Milestone	Percentage of fully completed action items	Percentage of monitoring metric goals met	Risk level	For milestones at medium or high risk, independent assessor's recommended modifications	State's responses and planned modifications
Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	100% (5/5)	0% (0/1)	Medium	Action items complete; state should adopt a plan to ensure that progress is made in using first-line psychosocial care for children and adolescents on antipsychotics.	1% drop in usage may also be reflective of COVID-PHE. However, the state continues to pursue appropriate use of first-line psychosocial care.
Improving Care Coordination and Transitioning to Community-Based Care	100% (4/4)	22% (2/9)	Medium	Action items complete; state should make efforts to ensure that follow-up after hospitalization or ED for behavioral health issues improves.	Requirements in MCO contracts, revisions to Emergency Department Information Exchange (EDIE) system to make it easier for automated admission discharge transfer notifications to occur.
Increasing Access to Continuum of Care, Including Crisis Stabilization Services	100% (4/4)	100% (1/1)	Low	N/A	N/A
Earlier Identification and Engagement in Treatment, Including Through Increased Integration	100% (4/4)	80% (4/5)	Low	N/A	N/A

CHAPTER 6

Assessment of State's Capacity to Provide SMI/SED Services

Overview

Chapter 6 provides measures of the state's capacity to provide SMI/SED services. We show data on 14 different provider types, including 41 measures in total. Because there is no well-defined set of national or historical benchmarks for these measures, we provide a qualitative assessment of the current levels, noting possible needs for attention. We also describe changes in capacity since the beginning of the state's demonstration, including the direction of that change (i.e., increase, decrease, consistent). We conclude by providing a summary of any identified needs or changes in capacity that move against the desired direction.

KEY FINDINGS

- *A lack of national or regional benchmarks makes it difficult to draw strong conclusions about the adequacy of Washington's capacity to provide SMI/SED services. However, Washington appears to have the capacity to meet its beneficiaries' needs. For example, the state has at least one psychiatrist or other prescribing provider for every 12 beneficiaries with SMI/SED, at least one practitioner certified or licensed to independently treat mental illness, and one community mental health center for every 42 beneficiaries with SMI/SED. The state has one licensed psychiatric hospital bed for every 44 beneficiaries with SMI/SED, and one residential mental health treatment facility that qualifies as an IMD for every 14,000 beneficiaries with SMI/SED.*
- *Capacity generally increased among practitioners, but there were reductions in capacity at the facility level. For example, the ratio of Medicaid beneficiaries with SMI to Medicaid-enrolled facilities qualifying as IMDs increased from 13,500 in the baseline year to 14,040 in the midpoint year (a decrease in capacity). Similarly, the ratio of Medicaid beneficiaries with SMI/SED to psychiatric hospitals qualifying as IMDs increased from 3,472 to 3,651. It is possible that these changes reflect relative stability in the actual number of facilities in the 2020-2021 time period, accompanied by slight increases in the number of Medicaid enrollees with SMI/SED. In total, we assessed changes across 41 measures, and found stability or progression among 23 metrics. Following CMS guidelines, we assess the state at "Medium Risk."*
- *Although the lack of benchmarks presents challenges, capacity appears to have decreased slightly for most facilities. The state should ensure that access to these acute services is maintained or improved during the demonstration period.*

Below, we describe assessments at baseline (2020) and midpoint (2021), assessing changes across 41 measures. Most measures are displayed as ratios of Medicaid enrollees with SMI or SED to a provider measure (e.g., Medicaid-Enrolled Psychiatrists or Other Prescribers; Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals). Ten measures showed improvement, 13 showed no change, and 18 suggested decreased capacity. Given the increases in Medicaid enrollment over the 2020-2021 time period, and the construction of some metrics that could not exceed a value of 1.0, we considered "progression" to include measures that improved or showed stability. Following CMS guidelines, we assess provider availability changes as "Medium Risk."

Exhibit 6.1 shows measures of capacity for psychiatrists or other practitioners who can prescribe psychiatric medications ("prescribers"). In 2021, there were 12.44 Medicaid beneficiaries with SMI/SED per prescriber, representing a slight improvement over 2020. Exhibit 6.1 also provides information on the estimates of the number of psychiatrists in total relative to those seeking Medicaid. However, these data are limited: there is a clear discrepancy in the data, with the total number of psychiatrists reported as being smaller than those enrolled in Medicaid. The estimate of the total number of psychiatrists is derived from the Washington Medical Commission, which is the only source that Washington has that breaks out principal areas of practice. Thus, the absolute ratios reported in the last two rows have significant limitations in providing information about the percentage of prescribers serving Medicaid. However, they suggest relative stability in the 2020-2021 trends.

Exhibit 6.1: Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications

Measure	Statewide average		Change
	2020	2021	
Ratio of Medicaid beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatrists or Other Prescribers	13.22	12.44	-0.78
Ratio of Total Psychiatrists or Other Prescribers to Medicaid-Enrolled Psychiatrists or Other Prescribers	0.29	0.27	-0.02
Ratio of Medicaid-Enrolled Psychiatrists or Other Prescribers to Medicaid-Enrolled Psychiatrists or Other Prescribers Accepting New Medicaid Patients	1.39	1.35	-0.05

Exhibit 6.2 shows measures of capacity for Other Practitioners Certified and Licensed to Independently Treat Mental Illness ("non-prescribers"). In 2021, there were 3.01 Medicaid beneficiaries with SMI/SED per non-prescriber, representing a slight improvement since 2020. The ratio of total non-prescribers to non-prescribers who were Medicaid-enrolled was 2.14 in 2021, suggesting that about half of all providers in this category were registered to serve Medicaid enrollees. The ratio of total Medicaid-enrolled non-prescribers to those accepting new patients was 1.47 in 2021, meaning that about 68% of Medicaid-enrolled providers were available to see new enrollees.

Exhibit 6.2: Other Practitioners Certified and Licensed to Independently Treat Mental Illness

Measure	Statewide average		Change
	2020	2021	
Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness	3.22	3.01	-0.21
Ratio of Other Practitioners Certified or Licensed to Independently Treat Mental Illness to Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness	2.34	2.14	-0.20
Ratio of Medicaid-Enrolled Other Practitioners Certified and Licensed to Independently Treat Mental Illness to Medicaid-Enrolled Other Practitioners Certified and Licensed to Independently Treat Mental Illness Accepting New Patients	1.53	1.47	-0.06

Exhibit 6.3 shows measures of capacity for Community Mental Health Centers ("CMHCs"). In 2021, there were 42 Medicaid beneficiaries with SMI/SED per CMHC, representing a slight improvement since 2020. The ratio of total CMHCs to CMHCs that were Medicaid-enrolled was less than one, suggesting a data anomaly in the count of total CMHCs (since the number of total CMHCs should be greater than those enrolled in Medicaid). However, these ratios were relatively stable between 2020 and 2021.

Exhibit 6.3: Community Mental Health Centers

Measure	Statewide average		Change
	2020	2021	
Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled CMHCs.	43.49	42.05	-1.44
Ratio of Total CMHCs to Medicaid- Enrolled CMHCs	0.82	0.74	-0.08
Ratio of Medicaid-Enrolled CMHCs to Medicaid-Enrolled CMHCs Accepting New Patients	1.04	1.04	0.00

Exhibit 6.4 shows measures of capacity for Intensive Outpatient Services ("IOP"). In 2021, there were 348 Medicaid beneficiaries with SMI/SED per IOP institute, representing an increase of 52 enrollees per IOP institute since 2020 (i.e., a decrease in capacity). The ratio of total IOPs to IOPs that were Medicaid-enrolled was close to one, suggesting that most IOPs accepted Medicaid patients and most were available for new patients.

Exhibit 6.4: Intensive Outpatient Services

Measure	Statewide average		Change
	2020	2021	
Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Providers Offering Intensive Outpatient Services	295.50	347.73	52.23
Ratio of Total Facilities/ Programs Offering Intensive Outpatient Services to Medicaid-Enrolled Providers Offering Intensive Outpatient Services	1.19	1.33	0.14
Ratio of Medicaid-Enrolled Providers Offering Intensive Outpatient Services to Medicaid- Enrolled Providers Offering Intensive Outpatient Services Accepting New Medicaid Patients	1.05	1.05	0.00

Exhibit 6.5 displays measures of capacity for residential mental health treatment facilities for adults. In 2021, there were 1,239 Medicaid beneficiaries with SMI/SED per residential facility, representing an increase of 48 enrollees per residential treatment facility since 2020 (i.e., a decrease in capacity). Most residential mental health treatment facilities were registered to serve Medicaid enrollees and most were accepting new Medicaid patients.

Exhibit 6.5: Residential Mental Health Treatment Facilities (Adult)

Measure	Statewide average		Change
	2020	2021	
Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)	1191.18	1238.85	47.68
Ratio of Total Residential Mental Health Treatment Facilities (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)	1.32	1.32	0.00
Ratio of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) to Medicaid- Enrolled Residential Mental Health Treatment Facilities (Adult) Accepting New Patient	1.00	1.00	0.00

Exhibit 6.6 displays measures of capacity for residential mental health treatment beds for adults. In 2021, there were 82 Medicaid beneficiaries with SMI/SED per bed, representing an increase of 14 enrollees per residential treatment facility since 2020 (i.e., a decrease in capacity). The ratio of Medicaid-enrolled residential mental health treatment beds to those available to Medicaid patients also increased, another marker suggesting a slight decrease in capacity.

Exhibit 6.6: Residential Mental Health Treatment Beds (Adult))

Measure	Statewide average		Change
	2020	2021	
Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Beds	68.07	81.79	13.72
Ratio of Total Residential Mental Health Treatment Beds to Medicaid-Enrolled Residential Mental Health Treatment Beds	1.70	1.97	0.17
Ratio of Medicaid-Enrolled Residential Mental Health Treatment Beds to Medicaid- Enrolled Residential Mental Health Treatment Beds Available to Medicaid Patients	1.13	1.00	-0.13

Exhibit 6.7 displays measures of capacity for Psychiatric Residential Treatment Facilities ("PRTFs," non-hospital facilities offering intensive inpatient services to enrollees under 21). In 2021, there were 339 Medicaid beneficiaries with SMI/SED per facility, representing an increase of 105 enrollees per PRTF since 2020 (i.e., a decrease in capacity). All residential mental health treatment facilities were registered to serve Medicaid enrollees and were accepting new Medicaid patients.

Exhibit 6.7: Psychiatric Residential Treatment Facilities

Measure	Statewide average		Change
	2020	2021	
Ratio of Medicaid Beneficiaries with SED to Medicaid-Enrolled PTRFs	233.20	338.60	105.40
Ratio of Total PTRFs to Medicaid- Enrolled PRTFs	1.00	1.00	0.00
Ratio of Medicaid-Enrolled PRTFs to Medicaid-Enrolled PRTFs Accepting New Medicaid Patients	1.00	1.00	0.00

Exhibit 6.8 displays measures of capacity for PRTF beds. In 2021, there were 19 Medicaid beneficiaries with SMI/SED per PRTF bed, representing an increase of six enrollees per PRTF bed since 2020 (i.e., a decrease in capacity). All residential mental health treatment facilities were registered to serve Medicaid enrollees and were accepting new Medicaid patients.

Exhibit 6.8: Psychiatric Residential Treatment Beds

Measure	Statewide average		Change
	2020	2021	
Ratio of Medicaid Beneficiaries with SED to Medicaid-Enrolled PTRFs	13.10	19.02	5.92
Ratio of Total PTRFs to Medicaid- Enrolled PRTFs	1.00	1.00	0.00
Ratio of Medicaid-Enrolled PRTFs to Medicaid-Enrolled PRTFs Accepting New Medicaid Patients	1.00	1.00	0.00

Exhibit 6.9 displays measures of capacity for public and private psychiatric hospitals. In 2021, there were 3,370 Medicaid beneficiaries with SMI/SED per hospital, representing an increase of 165 enrollees per hospital since 2020 (i.e., a decrease in capacity). Most psychiatric hospitals were Medicaid-enrolled.

Exhibit 6.9: Public and Private Psychiatric Hospitals

Measure	Statewide average		Change
	2020	2021	
Ratio of Medicaid Beneficiaries with SMI/SED to Public and Private Psychiatric Hospitals Available to Medicaid Patients	3205.08	3370.31	165.23
Ratio of Public and Private Psychiatric Hospitals to Public and Private Psychiatric Hospitals Available to Medicaid Patients	1.08	1.08	0.00

Exhibit 6.10 displays measures of capacity for psychiatric units. In 2021, there were 2,921 Medicaid beneficiaries with SMI/SED per unit, representing an increase of 143 enrollees per unit since 2020 (i.e., a decrease in capacity). Most psychiatric hospitals were Medicaid-enrolled. There were no units in Critical Access Hospitals(CAH) (represented by the "NA" fields for rows two, four, and six). Most units were Medicaid-enrolled.

Exhibit 6.10: Psychiatric units

Measure	Statewide average		Change
	2020	2021	
Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	2777.73	2920.93	143.20
Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatric Units in CAHs	N/A	N/A	N/A
Ratio of Psychiatric Units in Acute Care Hospitals to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	1.13	1.07	0.07
Ratio of Psychiatric Units in CAHs to Medicaid-Enrolled Psychiatric Units in CAHs	N/A	N/A	N/A
Ratio of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals Accepting New Medicaid Patients	1.00	1.00	0.00
Ratio of Medicaid-Enrolled Psychiatric Units in CAHs to Medicaid-Enrolled Psychiatric Units in CAHs Accepting New Medicaid Patients	N/A	N/A	N/A

Exhibit 6.11 displays measures of capacity for psychiatric hospital beds. In 2021, there were 44 Medicaid beneficiaries with SMI/SED per bed, representing an increase of two enrollees per unit since 2020 (i.e., a decrease in capacity). Most psychiatric hospitals were Medicaid-enrolled, with stability between 2020 and 2021.

Exhibit 6.11: Psychiatric beds

Measure	Statewide average		Change
	2020	2021	
Ratio of Medicaid Beneficiaries with SMI/SED to Licensed Psychiatric Hospital Beds Available to Medicaid Patients	42.09	44.26	2.17
Ratio of Licensed Psychiatric Hospital Beds to Licensed Psychiatric Hospital Beds Available to Medicaid Patients	1.22	1.22	0.00

Exhibit 6.12 displays measures of capacity for residential mental health treatment facilities that qualify as IMDs. In 2021, there were 14,040 Medicaid beneficiaries with SMI/SED per IMD, representing an increase of 540 enrollees per IMD since 2020 (i.e., a decrease in capacity). Most IMDs were Medicaid-enrolled, with stability between 2020 and 2021. The ratio of Medicaid beneficiaries with SMI/SED to psychiatric hospitals that qualified as IMDs increased from 3,472 to 3,651, representing a slight decrease in capacity.

Exhibit 6.12: Residential Treatment Facilities That Qualify As IMDs

Measure	Statewide average		Change
	2020	2021	
Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid- Enrolled Residential Mental Health Treatment Facilities that Qualify as IMDs	13,500.00	14,040.33	540.33
Ratio of Total Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	1.33	1.33	0.00
Ratio of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs to Medicaid- Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs Accepting New Medicaid Patients	1.00	1.00	0.00
Ratio of Medicaid Beneficiaries with SMI/SED to Psychiatric Hospitals that Qualify as IMDs	3472.17	3651.17	179.00

Exhibit 6.13 displays measures of capacity for crisis stabilization services. In 2021, there were 2,738 Medicaid beneficiaries with SMI/SED per crisis call centers (representing an increase of 134 enrollees per center since 2020, or a decrease in capacity.) There were slight decreases in capacity in mobile crisis units, crisis assessment centers, and coordinated community crisis response teams. However, there were increases in capacity in crisis stabilization units, with 2,738 Medicaid beneficiaries with SMI/SED per unit in 2021, a decrease of 467 enrollees per unit.

Exhibit 6.13: Crisis Stabilization Services

Measure	Statewide average		Change
	2020	2021	
Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Call Centers	2604.13	2738.38	134.25
Ratio of Medicaid Beneficiaries with SMI/SED to Mobile Crisis Units	2450.94	2577.29	126.35
Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Observation/ Assessment Centers	1190.46	1251.83	61.37
Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Stabilization Units	3205.08	2738.38	-466.70
Ratio of Medicaid Beneficiaries with SMI/SED to Coordinated Community Crisis Response Teams	2604.13	2738.38	134.25

Exhibit 6.14 displays measures of capacity for federally qualified health centers (FQHCs). In 2021, there were 189 Medicaid beneficiaries with SMI/SED per FQHC, representing a slight decrease in capacity since 2020.

Exhibit 6.14: Federally qualified health centers

Measure	Statewide average		Change
	2020	2021	
Ratio of Medicaid Beneficiaries with SMI/SED to FQHCs that Offer Behavioral Health Services	183.55	189.97	6.12

Summary

In general, the data above suggest relative stability across most capacity measures. Ten measures showed improvement, 13 showed no change, and 18 suggested decreased capacity. Given the increases in Medicaid enrollment over the 2020-2021 time period, and the construction of some metrics that could not exceed a value of 1.0, we considered "progression" to include measures that improved or showed stability. Following CMS guidelines, we assess provider availability changes as "Medium Risk." One pattern that emerged is the appearance of small relative increases in capacity among providers (e.g., psychiatrists and other practitioners) and small relative decreases in capacity among facilities (e.g., psychiatric or residential treatment facilities). These changes may reflect relative stability in the actual number of facilities in the 2020-2021 time period, accompanied by slight increases in the number of Medicaid enrollees with SMI/SED.

In summary, although the increased capacity among practitioners is encouraging, capacity appears to have decreased slightly for most facilities. The state should ensure that access to these acute services is maintained or improved during the demonstration period.

Next Steps

Despite the lack of progress on metrics for Milestones 1 and 2, the state is generally on track to achieve the SMI waiver's goals. The state made progress on all of its actions for Milestones 1-4, having met all of them with the SMI waiver implementation or slightly thereafter. A complete accounting of the factors that affected state achievement towards meeting milestones and monitoring metric targets to date would be difficult to provide at midpoint, but much of the success is likely attributable to the attention that behavioral health services have received from the state legislature, the longstanding interest in addressing and improving mental health care, and the multiple initiatives supported by the state and the agencies within Washington.

In order to address current shortcomings and continue progress, the state should take the following actions.

First, the state should ensure that progress is made in using first-line psychosocial care for children and adolescents on antipsychotics. Although a one percent drop in usage between the baseline and midpoint year may reflect changes associated with the COVID-19 Public Health Emergency, Washington will need to prioritize this measure in subsequent years to make progress on the metric for Milestone 1.

Second, the state should ensure that progress is made on measures related to Milestone 2 (improving care coordination and transitioning to community-based care). The state made advances and met all of its actions for Milestone 2. Many of these actions (e.g., ensuring psychiatric hospitals and residential settings carry out intensive pre-discharge planning and include community-based providers in care transitions), if successful, should aid in moving Milestone 2 metrics — including follow-up after hospitalizations for mental illness or alcohol or drug abuse — in the intended direction.

Third, the state should continue to monitor length of stay in IMDs. The average length of stay for individuals in IMDs was 12 days, well below the 30-day requirement. However, this is a key metric; if the state exceeds the 30-day average length of stay, CMS will lower the threshold for reimbursement to 45 days until the average drops below 30 days.

Fourth, the state should monitor the availability of institutional capacity and consider adjustments if necessary. The IMD waiver is predicated on the notion that federal financial participation would expand residential treatment options. Although the state's capacity to provide SMI/SED services remained relatively stable between the baseline and midpoint assessment years, there were slight declines in measures of institutional capacity and residential treatment, even as the capacity of mental health practitioners showed slight increases. Continuation of this trend may necessitate a reassessment of how to expand residential and inpatient treatment in alignment with the SMI waiver.

Fifth, the state should monitor quality outcomes among racial and ethnic minority groups. This report assessed changes in metrics among a variety of populations, including racial and ethnic minority groups. Although no populations showed consistently worse outcomes across all milestones, trends for metrics in Milestone 2 were worse for several racial and ethnic minority groups, including Asian enrollees, American Indian and Alaska Native enrollees, and Hispanic enrollees. The state should continue monitoring these trends and taking action if the SMI waiver is associated with worsening disparities.

Sixth, the state should continue to advance the multiple efforts initiated in tandem with the waiver that were designed to improve mental health. Washington's waiver approval was supported by state legislation aligned with the waiver goals, including improving its bed registry to track availability and the types of services in greatest demand, centralized mental health crisis resources, and the deployment of an integrated care assessment tool to advance the state's efforts to integrate general physical health and behavioral health in primary care and specialty settings.

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Independent Assessor Description

For the broader 1115 Waiver evaluation, Washington selected an independent external evaluator that has the expertise, experience, and impartiality to conduct a sophisticated program evaluation that meets all requirements specified in the Special Terms and Conditions including specified reporting timeframes. Oregon Health & Science University (OHSU) was selected after an RFP process. Required qualifications and experience included:

- Multi-disciplinary health services research skills and experience;
- An understanding of and experience with the Medicaid program;
- Familiarity with Washington State Medicaid programs and populations;
- Experience assessing the ability of health IT ecosystems to support delivery system and payment reforms, including issues related to governance, financing, policy/legal issues and business operations;
- And experience conducting complex, multi-faceted evaluations of large, multi-site health and/or social services programs.

Potential evaluation entities were assessed on their relevant work experience, staff expertise, data management and analytic capacity, experience working with state agency program and research staff, proposed resource levels and availability of key staff, track record of related publications in peer-reviewed journals, and the overall quality of their proposal. Proposed deliverables must meet all standards of leading academic institutions and academic journal peer review. In the process of identifying, selecting, and contracting with an independent external evaluator, the state acted appropriately to prevent a conflict of interest with the independent external evaluator. The independent external evaluator has no affiliation with ACHs or their providers.

After discussion with CMS, Washington received approval to use OHSU as the Independent Evaluator for the SMI/SED amendment evaluation.

The PI of this study, K. John McConnell, has no conflicts of interest and confirms that his staff and contributors of this report have no conflicts of interest.

ATTACHMENT 2

Data Collection Tools

Data from this report were based on administrative claims data, service and provider availability data provide by the Washington Health Care Authority, and the Section 1115 SMI/SED Demonstration Implementation Plan, dated July 23, 2019 and submitted on April 8, 2020. No interviews, focus groups, or surveys were conducted as part of the Midpoint Assessment.

Washington's responses to recommendations provided by the independent assessor:

First, the state should ensure that progress is made in using first-line psychosocial care for children and adolescents on antipsychotics. Although a one percent drop in usage between the baseline and midpoint year may reflect changes associated with the COVID-19 Public Health Emergency, Washington will need to prioritize this measure in subsequent years to make progress on the metric for Milestone 1.

Washington continues to address this need through its external quality review and internal monitoring strategies. Washington state has constructed its managed care contracts and oversight processes to promote progress with this key measure in mind.

Federal requirements mandate compliance monitoring every three years, HCA conducts compliance reviews on an annual basis. Washington intends to further review midpoint assessment recommendations and tie them into our upcoming managed care quality strategy.

Second, the state should ensure that progress is made on measures related to Milestone 2 (improving care coordination and transitioning to community-based care). The state made advances and met all of its actions for Milestone 2. Many of these actions (e.g., ensuring psychiatric hospitals and residential settings carry out intensive pre-discharge planning and include community-based providers in care transitions), if successful, should aid in moving Milestone 2 metrics — including follow-up after hospitalizations for mental illness or alcohol or drug abuse — in the intended direction.

This is another area stressed in contracts with managed care organizations. Managed care represents roughly 85% of Medicaid services and impacts/drives fee for service eligibles processes and standards as well. Washington will also review these MPA recommendations and tie them into the upcoming managed care quality strategy.

Third, the state should continue to monitor length of stay in IMDs. The average length of stay for individuals in IMDs was 12 days, well below the 30-day requirement. However, this is a key metric; if the state exceeds the 30-day average length of stay, CMS will lower the threshold for reimbursement to 45 days until the average drops below 30 days.

The state continues to actively monitor length of stays in IMDs closely.

Washington's responses to recommendations provided by the independent assessor:

Fourth, the state should monitor the availability of institutional capacity and consider adjustments if necessary. The IMD waiver is predicated on the notion that federal financial participation would expand residential treatment options. Although the state's capacity to provide SMI/SED services remained relatively stable between the baseline and midpoint assessment years, there were slight declines in measures of institutional capacity and residential treatment, even as the capacity of mental health practitioners showed slight increases. Continuation of this trend may necessitate a reassessment of how to expand residential and inpatient treatment in alignment with the SMI waiver.

HCA Staff from its Division of Behavioral Health and Recovery have been working closely with stakeholders and representatives of the Legislative and Executive branch to monitor the availability of institutional capacity and develop appropriate institutional capacity, and residential treatment resources across Washington.

In 2023, Engrossed Substitute Senate Bill (ESSB) 5187 established the Joint Legislative and Executive Committee on Behavioral Health (JLECBH) to identify key strategies and actions to improve access to behavioral health services. This committee builds on prior behavioral health workgroups and committees Including: The Children and Behavioral Health Workgroup (CYBHWG), The Crisis Response Improvement System (CRIS) Committee, The Select Committee on Quality in State Hospitals (SCQUISH), Behavioral Health Recovery System Transformation (BHRST).

Fifth, the state should monitor quality outcomes among racial and ethnic minority groups. This report assessed changes in metrics among a variety of populations, including racial and ethnic minority groups. Although no populations showed consistently worse outcomes across all milestones, trends for metrics in Milestone 2 were worse for several racial and ethnic minority groups, including Asian enrollees, American Indian and Alaska Native enrollees, and Hispanic enrollees. The state should continue monitoring these trends and taking action if the SMI waiver is associated with worsening disparities.

The COVID-19 public health emergency highlighted the need to continue to identify and address health disparities as well as further incorporate health equity into the HCA's overall quality strategy. HCA took a proactive approach to both anticipate and respond to access to care challenges at the beginning of the pandemic and throughout the public health emergency, supporting workforce and system stability as well as continued quality improvement activities. As an example, HCA worked with all five MCOs to free up hospital resources by closely coordinating discharges and create capacity to address higher demand for care.

To embed a health equity lens into Apple Health quality oversight, HCA continues to explore ways to insert health equity concepts into all program areas, such as expanding the available data set to allow for deeper analysis related to health equity

and publicly recognizing the contracted MCOs currently holding an NCQA Multicultural Healthcare Distinction and/or an NCQA Health Equity Distinction.

Sixth, the state should continue to advance the multiple efforts initiated in tandem with the waiver that were designed to improve mental health. Washington's waiver approval was supported by state legislation aligned with the waiver goals, including improving its bed registry to track availability and the types of services in greatest demand, centralized mental health crisis resources, and the deployment of an integrated care assessment tool to advance the state's efforts to integrate general physical health and behavioral health in primary care and specialty settings.

Washington continues to advance multiple efforts designed to improve mental health outcomes through its integrated purchasing system. Implementation of a real time bed registry to support centralized mental health crisis resources via Washington's 988 system is underway with planning advance planning documents currently submitted, revised, and approved.

In October 2020 Congress passed the National Suicide Hotline Designation Act of 2020 (Act) which designates the number 988 as the universal telephone number within the United States for the purpose of accessing the National Suicide Prevention and Mental Health Crisis Hotline system maintained by the National Suicide Prevention Lifeline and the Veterans Crisis Line.

In 2021 Washington State House Bill (HB)1477 was enacted which established several changes to the behavioral health crisis system in response to the adoption of 988 as the phone number for the National Suicide Prevention and Mental Health Crisis Hotline. The bill established crisis call center hubs to provide crisis intervention services, case management, referrals, and connection to crisis system participants beginning July 1, 2024. The bill also charged the state with developing a new technology platform for managing communications with the 988 hotline and imposed a tax upon phone lines to support the activities. The Crisis Response Improvement Strategy Committee was established to review and report on several items related to the behavioral health crisis system.

Washington's responses to recommendations provided by the independent assessor:

The system will provide:

- *access to real-time information relevant to the coordination of behavioral health crisis response and suicide prevention services, including real-time bed availability for all behavioral health bed types and real-time information relevant to the coordination of behavioral health crisis response and suicide prevention services;*
- *the means to request deployment of appropriate crisis response services and track local response through global positioning technology;*
- *the means to track the outcome of a 988 call to enable appropriate follow up, cross-system coordination, and accountability;*
- *a means to facilitate actions to verify and document whether the person's transition to follow up noncrisis care was completed and which services were offered;*
- *the means to provide geographically, culturally, and linguistically appropriate services to persons who are in high-risk populations or have a need for specialized services or accommodations; and*
- *consultation with tribal governments to ensure coordinated care in government-to-government relationships and access to dedicated services to tribal members*.

This is an ambitious project that has required significant investments and planning. Current deadlines for implementation were extended via Senate Bill (SB) 6308 from June 30, 2025, to December 31. 2026.

In addition, we are interested in any stakeholder feedback the state may have received, which was not included in the original MPA submission.

No additional feedback was received.